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KIRKLEES METROPOLITAN COUNCIL

SCRUTINY COMMISSION - CHILDREN'S AND WOMEN'S SERVICES

CHAIR'S FOREWORD

The Calderdale and Kirklees Health Authority's proposals to reconfigure women's and children's hospital services have caused much concern locally and, as the Council has a duty to promote and safeguard the well-being of the communities that it represents, Kirklees Metropolitan Council convened this Scrutiny Commission to take evidence about the reasons behind the proposals and the possible impact the different models of reconfigured women's and children's services might have on local residents.

We have taken formal evidence from the Health Authority and from a whole range of interested parties. We have also tried to capture the concerns of local people by receiving submissions from individuals and by going out to talk to groups of people who would be affected by change, in informal settings. Some of the evidence that we have gathered in this way has been ver moving, and has underlined the potential impact on real parents and children of the proposed changes.

All this has taken many hours of attention and consideration. All the evidence was freely and openly given, and we would like to thank all those who gave their time to help us to investigate these issues, and all who helped us to put this document together. It represents the Commission's formal submission to the Health Authority Consultation and we hope that it will help to inform the decisions that they will be taking.

Councillor Annie Smith
Chair of the Scrutiny Commission
on Children's and Women's Services

D5K088

SUMMARY REPORT

The Scrutiny Commission was established by the Council at its meeting held on 14 July 1999 in response to proposals by Calderdale and Kirklees Health Authority to undertake a reconfiguration of hospital services and also as a result of local concerns as to the future provision of maternity services at Huddersfield Royal Infirmary. At that meeting the council approved and adopted the following motion:-

> "This Council believes in the basic principle on which the National Health Service was founded, namely a free, equitable service based on the needs of local people, that is accessible and available at the point of need. The present Government in its pursuance of a new, modern, dependable and reliable NHS has used this founding principle as the basis for a new NHS ensuring that local health care services are developed for local people.
>
> This Council views with grave concern proposals for a single, centralised service for child and maternity provision in either Huddersfield or Halifax which compromise the principle of local health care services for local people as near to them as possible. Furthermore, any change to hospital reconfiguration should not take place until all relevant information is within the public domain and takes into account any knock-on effects for other medical services such as Accident and Emergency provision and Child Protection issues.
>
> This Council believes that child and maternity services with Paediatricians, Obstetricians and Gynaecologists including professionals allied to medicine must remain available in both Huddersfield and Halifax. Any reconfiguration must be able to demonstrate the benefits to be gained for patients, their families and the local community that cannot be gained by any other means.
>
> This Council calls for full public consultation on proposals being considered by the NHS affecting the future of children and women's services in Huddersfield before any decisions are made. The concerns of local women who are current or potential users of the services must be given proper weight when set beside the recommendations put forward by service providers.
>
> In order to fully explore the implications of the options, this Council resolves to establish an all party Scrutiny Commission to formulate the Council's response, as a matter of urgency."

The Scrutiny Commission looking at Children's and Women's Services carried out its investigations between September 1999 and February 2000.

The role of the Scrutiny Commission was to investigate a number of options put forward by the Calderdale and Kirklees Health Authority for the way hospital services in Calderdale and Huddersfield might best meet local needs in the future with particular reference to Children's and Women's Services.

The Terms of Reference of the Scrutiny Commission as agreed by Policy Committee were:-

1. To investigate proposals for the Reconfiguration of Hospital Services namely Children's and Women's Services across Huddersfield and Halifax.

2. To consider the implications of any proposals for the residents of Huddersfield and Kirklees as a whole, taking into account for example, issues of transport, travel time, sustainability issues, knock on effects on other services.

3. To understand and seek clarification on what is a complex area of health planning.

4. To facilitate a Council response to proposals for the Reconfiguration of Hospital Services, Children's and Women's Services.

5. To make recommendations to the Council.

6. To publish and distribute a detailed account of the findings of the Commission.

During the course of its work the commission met on 9 separate occasions receiving formal evidence from some 18 witnesses, including representatives of the Health Authority, Huddersfield National Health Service Trust, the Royal College of Midwives, West Yorkshire Metropolitan Ambulance Service, West Yorkshire Passenger Transport Authority and representatives of "Save Our Hospital Services Campaign".

In addition to receiving "formal" evidence, Members of the Commission discussed the Health Authority's proposals with a number of external organisations on an informal basis. The two Trusts also made arrangements for the Commission to visit Huddersfield Royal Infirmary on 29 September 1999 and Halifax General Hospital on 24 November 1999.

Written evidence was also obtained from a variety of sources which is appended to the document.

The following documents were used by the Scrutiny Commission:-

Calderdale and Kirklees Health Authority - Hospital Services for the Future: Children's and Women's Services - Information Pack June 1999 and September 1999

Calderdale and Kirklees Health Authority - Working Together to Achieve Excellence - Public Consultation Document - December 1999.

D5K114

SCRUTINY COMMISSION ON CHILDREN'S AND WOMEN'S SERVICES

SCOPE OF THE COMMISSION

The scope of the Scrutiny Commission on the Future of Hospital Services, Children and Women's Services, was primarily to understand and seek evidence as to the reasons being put forward for change and the change being proposed, to what is a complex area of health care planning.

The context of the debate was set by Calderdale and Kirklees Health Authority in their consultation document "Working Together to Achieve Excellence" (CH&KA December 1999).

The Health Authority proposals cover three areas:

1 Maintaining general services at a high level - 90% of care needed by patients would continue to be available in Huddersfield and Halifax hospitals.

2 Developing specialist services and centres of excellence - 10% of specialist care would be split between the two hospitals.

3 Services for women with normal pregnancies will be maintained at both hospitals along with a full range of antenatal services.

The Scrutiny Commission's focus was solely on Children and Women's services and related to Health Authority proposals on "other specialist women's and children's services" - Huddersfield hospital, whilst acknowledging the impact these services have on other areas of hospital activity and the reverse effect.

Health Authority proposals for other specialist Women's and Children's Services - Huddersfield Royal Infirmary.

<u>Proposal 1</u>

* Delivery unit for normal births

<u>Proposal 2</u>

* Delivery unit for normal births
* Inpatient children's services

<u>Proposal 3</u>

* Delivery unit for normal births
* Inpatient gynaecology

Health Authority proposals for other specialist Women's and Children's Services - Calderdale Hospital.

Proposal 1

* Delivery unit for normal births
* Inpatient children's services
* Inpatient Gynaecology

Proposal 2

* Delivery unit for normal births
* Inpatient Gynaecology

Proposal 3

* Delivery unit for normal births
* Inpatient children's services

D5K086

BACKGROUND TO SCRUTINY COMMISSIONS

General

In 1993/94 Kirklees Council established a mechanism for Scrutiny Commissions to investigate issues for which other organisations, in addition to Local Government, have a key role to play and since that time a number of Commissions have reported.

The Scrutiny Commissions do not have delegated powers, only the power to investigate and report. The Policy Committee of Kirklees Metropolitan Council establishes terms of reference for each of the Scrutiny Commissions.

The membership of the Scrutiny Commissions is determined by Policy Committee having regard to proportionality.

The Commission has the ability to call witnesses or request reports from Officers of Kirklees Council and other organisations, as appropriate, to the matters under investigation. The Commissions receive administrative support from the Committee Services Unit and other support from Services of the Council as appropriate.

Commissions meet in public except when considering information of a confidential nature and will give detailed consideration to the findings in private session. Copies of the final report of each Scrutiny Commission will be submitted to a meeting of the full Council for consideration. Minority reports will not be permitted; where disagreement exists this will be noted within the report and differences of opinion highlighted.

D5K085

SCRUTINY COMMISSION ON CHILDREN'S AND WOMEN'S SERVICES

The Scrutiny Commission was convened on 29 September 1999 and held further meetings on 4 October, 1 November, 11 November, 17 November, 15 December 1999, 10 January, 26 January and 14 February 2000. A number of reports, written submissions and interviews were completed from which Members drew their conclusions and recommendations.

Membership of the Commission comprised:-

Councillors Annie Smith (Chair); Maggie Blanshard, Rita Briggs, Nick Harvey, Thelma Karran and Sylvia Smithson and Co-opted Member Christine Newton.

The Commission was supported by Feisal Jassat, Health Policy Co-ordinator, Corporate Development Unit; John Doyle, Community Care Development Manager, Social Services; Cathy Putz, Community Forum Officer, Human Resources Strategy Unit; and John Quarmby, Senior Committee Administrator, Committee Services.

D3K060

SCRUTINY COMMISSION ON SERVICES FOR WOMEN AND CHILDREN

PRESENTATION BY TONY KEIGHLEY, CHIEF EXECUTIVE, CALDERDALE AND KIRKLEES HEALTH AUTHORITY

Monday 4 October 1999

I welcome the opportunity of having this discussion. I am pleased it is informal. I hope that we can use this not only to get a few facts and figures across, but by discussions to try and understand what is an extremely complex process. Health care in today's world, like any other public sector services, is changing dramatically. There are many things that are causing that change. I thought it might be helpful if I just explained what the Health Authority is. The Health Authority is the statutory body that is responsible for improving health and reducing inequalities within its local population. Our local population is about 585,000 people which covers Halifax, Huddersfield and Dewsbury - the whole of Calderdale of course. We have to look at policies that actually look at health care standards serving that population. We have what is commonly known - certainly under the previous Government - as the purchaser provider split, in simple terms that means that the Health Authority receives all allocation of resources for health care services in its patch - that includes hospital services, community and family care services, the cost of drugs - the cost of health care in general. It is our responsibility to allocate that money to maximise the benefits again to the local population and we do that by funding General Practitioners, pharmaceutical services, hospital services etc. So clearly there is a lot of inter-action between the different parts of the health care that we have to take into account - our purpose is to look at health needs principally and to respond to them.

The Government have recently produced a changing role for Health Authorities and this is referred to in the document "Leadership in Health". The role of the Health Authority is principally to develop local strategies around the Programme. It has got to develop a Health Improvement Programme with all stakeholders including Local Authorities and it is seen as the strategic plan of the local health economy.

The debate around services locally has now continued for some months and the reason for change is that I think there are many practices, particularly at national level that are driving change in the Health Service, to the extent that we would say that there is no status quo in health - we can't stand still we can't allow existing services even though they may appear satisfactory at this point in time to stagnate. We have to be looking ahead - we have to be looking at strategic change. We are not unusual in this. This is taking place around the country at the present time for some of the reasons that I intend to highlight. I am going to cover the sort of broadbrush national policy and practice issues and then my colleagues will then focus in on some of the more detailed aspects about local debate but clearly I may touch on one or two of those myself.

The change of Government has driven a lot of change and this is not just happening in NHS it is happening in Local Authorities and across all public sector activities. The reasons are diverse there are quite a number of them - Government policy is a major instrument of change at the present time, but one of the key changes in the

NHS is changes in technology - changes in clinical practice, clinical advancement as a result of scientific progress, changes clearly in recent years allow treatments to take place that wouldn't have happened in the past. It isn't many years since we couldn't replace hips and joints and so on - but now it is common practice and elderly people are given new quality of life by treatments that were just not possible in the past. Minimal invasive surgery is obviously changing dramatically the need for in-patient stays. What is happening is that many treatments don't necessarily need to take place in hospital or if they do take place in hospital the need for a long stay is minimised. Those are some of the reasons why we need to review services.

I think the big issue facing all public sector services but not least of all the Health Service is rising demand. Often that is not triggered because people are ill or sick, it is because there are rising public expectations. Clearly there is big policy debates that both Governments have supported in recent years and that is a move towards primary care and primary GP based care - that is non-hospital care where that is appropriate and technology is allowing us to look at the potential for treatments in community sectors, in GP's surgeries, family care centres, that traditionally would take place in hospital and required quite a long time of in-patient stay. I think there are many areas that Chris Veal will highlight in some detail but there are more stringent requirements being involved on the training of medical staff and for that matter all professional staff including nursing by the Royal Colleges.

There are processes of accreditation which actually raise standards in different clinical specialities and the important thing about that is training status can be withdrawn from different clinical specialities if the minimum training standards are not adhered to. That may be a disaster, it may not, but in most cases the training in these jobs means to me the operative in the provision of health care and quite frankly that would preclude the recruitment of skilled clinicians and would mean a risk to local services. The Royal Colleges, for the first time, are now defining minimum populations which can support certain clinical specialities - we call this critical mass - a good example of that is the treatment of cancer care and we have taken strategic policy decisions in the last few years that we have to centralise certain cancer services. The reason for that are clearly that we are looking to utilise skilled medical, skilled clinical resources in a way that maximises their effect on local population and also to improve quality standards - so cancer is one example - but there are many others which I am sure Chris Veal will touch on. We have what is a new policy - we have had for those who have been close to the Health Service for many years a process called medical audits.

The Government have now introduced a process called clinical governance and clinical governance is intended to drive up quality standards - that means that services will require critical examination and review by the medical staff who are undertaking them and to identify the deficiencies in health care to local services, or failures in clinical services, examples of failures would be the Bristol Inquiry which many of you will have heard about which was set up by the Secretary of State into the high rate of deaths of young babies as a result of open heart surgery. And those are failures that clearly happened in the past. Clinical governance is designed to expose, be transparent in identifying various services and to bring about quality improvements and that is clearly the front of our agenda as a Health Authority and it is a significant plank of Government policy. The reality is poor quality or badly conducted medicine or surgery can kill or disable patients and does so and there are many cases of high cost litigations around the country and locally for failure in medical care. Particularly in obstetrics and gynaecology this is a speciality that has

forced doctors in some cases a somewhat defensive approach, certainly the costs of failures in obstetrics and gynaecology costs millions of pounds. I think the major pressure which we can't ignore is the reduced hours for junior doctors. We would all sympathise with the hours that Junior Doctors have to work in providing clinical cover. Services would not survive without the dedication and commitment that those people bring in providing services 7 days a week 24 hours a day and quite frankly any reduction in those hours have a dramatic effect on the ability to continue to provide health care in many specialities.

I think it is particularly true that the smaller specialities ENT, ophthalmology are two examples of that - could not survive without change in the way that those services are delivered and we have to move towards a measure of centralisation of those services between Halifax and Huddersfield over the past two years and that really is to ensure that proper medical cover can be provided over a 24 hour period for in-patients. We also clearly want to develop policies where the patients stay is not essential but services are as locally based as possible and if possible we find community primary care solutions that I referred to earlier. I have to say that the recent negotiations with the junior doctors representatives and Government whilst they might have introduced a settlement will have repercussions on the health service over the next few years and implementing that settlement will exacerbate the situation I have described. It isn't a matter of just looking to recruit more doctors - the doctors are not available - training requirements are more strict and there is a requirement for more hands on experience in doctors training and it isn't easy to recruit doctors in many specialities now.

Another area that we have to take account of and it is really the interests of patients is the increasing trend for some specialisation in consultant medical staff, good doctors want to specialise in developing areas of expertise, they want to improve their skills by seeing rare conditions, by having the opportunity to treat patients with complex and difficult conditions and in most clinical specialities we need a minimum call-up of qualified doctors to allow them to do that and that is the only way we will get the best doctors in our local services. Recruitment and retention of doctors is as much about doctors wanting to come and work in the locality as it is about salary, local conditions - so it is vital that we do have the sort of environment that skilled doctors, the best doctors want to come and work with us.

The local perspective I suppose revolves around some of the debates that we are all familiar with. The Health Authority has a duty to compare local health care services against the sort of national policies used as standards and to look at good practice elsewhere, to look at what works and what doesn't work, what improves health care, what reduces outcomes, makes people live longer and gives them a better quality of life following treatment. Those are the key issues which we have to take into account. So we have to develop local strategies and we do that with local partners, the local authority again is a leader in terms of stakeholders of the health service, consultant work within and there are many examples in Kirklees of good working arrangements and innovative practices working between the health service and local authorities as I am sure you know. So we are looking at the best service possible. We are also looking at the most cost effective service possible and I want to emphasise that any changes at the moment locally are not being driven by cash. They are not being driven by cash shortages but like the local authority we are a cash limited service. We get our budget £387m I think this year and we have to make sure that that is utilised effectively. In an environment where demand on the NHS is infinite I think what ever capacity is greater than the health service it will be

utilised and we have to be aware of that, we have to develop services that respond to the needs of people in the most effective way.

For the reasons outlined, and the Government's approval for a new hospital in Calderdale which would be a cause for celebration in most circumstances, I feel in our situation it is being refused in many cases and is the subject of speculation etc. What I would like to make clear is that the new hospital in Calderdale is replacing three hospitals which are not capable in themselves of continuing to provide good health care into the next century and we are fully supportive of the new hospital in Calderdale. Previous management have been trying for 20 years to achieve that hospital. The reality is that there isn't excess capacity in that hospital or additional beds that will allow the transfer of services that might put local Huddersfield services at risk, or even put Huddersfield Royal Infirmary at risk. The reality is that we want two viable high level hospitals in both Halifax and Huddersfield that can work together, we are not in a world of an internal market now.

The Government have abolished internal markets and encouraged health care services to work together, across traditional boundaries where that is appropriate because we are looking at the best health care, we are trying not to take into account parochialism, why services exist or why they where there historically in the past. It is vitally important that we do get the two managements involved in Huddersfield and Halifax to work increasingly closely together. The pressures for change are not going to go away and we have commissioned a report recently by an independent consultants to look at the effect of the national practice that I have described. Many of you will have seen or read that report or references to it. The organisation is called SECTA and they have already provided an interim report to the Health Authority on present arrangements of services across both our regions but will be making recommendations which will probably be presented to the Health Authority meeting on 21 October 1999. What we have done so far as a Health Authority is merely supported the concept of developing integrated services and integrated service models across the two hospital sites. If you don't quite understand what that means we will try and clarify as we go along. The reality is that hospitals in both towns will have a very strong future and an integral part of any planning for the future of health care services locally.

Chris Veal will develop the theme of the need for centralising certain services, most hospitals will continue to have what we call critical core range of services that will continue to be provided as always in the local hospital. There will be services which I have mentioned and I am sure Chris will mention others that will benefit from centralisation again for the reasons of complexity or critical mass, survival rates, etc. Children and women's services clearly has become a part of that. What I really want to say is what the Health Authority wants to put in this place. At this stage no decisions have been made on the future of these services except to make it clear that neonatal intensive care in this patch is at risk if we don't bring about potential changes for the future and we feel as a health authority that a degree of centralisation of neonatal intensive care is probably essential for the future.

It has, however, been made clear to the Health Authority as you are aware that consultant medical staff both in Huddersfield and Halifax who are providing that service have said that they feel that over the course of time that it would be necessary to get the best Health Care Service possible in that service by centralisation of in-patients services. That is a disappointing view but clearly the Health Authority has got to listen to it - it is very unusual for a unified approach to

come from a body of consultant medical staff I understand the cynicism and the anxiety that debating this issue has caused locally. The reality is that the Health Authority could not ignore strong medical advice if we found that decisions were challenged in the future and we had ignored the advice of medical staff then we would as a Health Authority be castigated. We have to take into account all the evidence.

We have to consider whatever high level information is available and then we have to make a decision. I do want to make clear no such decision has yet been taken. We are considering the merits and we are trying to develop information that is available. We are trying to take into account public reaction. We have not made a decision and we will only make a decision which we feel is in the public's best interests and that will be a process that will be taken following the meeting of the Health Authority, possibly on 21 October 1999, but I can't guarantee that final decisions will be made at that meeting.

Various information has been provided in a number of "blue2 books that I am sure some of you have had access to. We have tried to provide information for my colleagues on the Health Authority which will create an informed debate. When it comes to making and developing proposals and to examine the options for change then that will become the subject of public consultation, it will become the subject of informed consultation, because the debate hasn't been very well informed so far. Certainly the Health Authority hasn't actually resolved to agree any options at this stage. The consultation process will take three months. It will involve all local stakeholders, the process in the health service is that the Community Health Council are the local watchdog/representative if you like of the public interest and we have to certainly involve them closely, but we also expect to involve other key stakeholders and as far as possible take the public into that debate in an informed way. So as far as the two Local Authorities are concerned we would want to have their views. When we have a set of proposals we would want to have more detailed discussions with both Local Authorities to explain the reasons behind our thinking. We are aware of concerns and anxieties. We don't want to fuel that we want to curtail if it is possible but we can't ignore the changes, it wouldn't be fair to the public even though these things do cause immediate reaction we have got to look at the wider issue, we have got to look at how the situation will be in four or five years time as well as the impact that it is going to have on local services. What we don't want to do is be reactive in this process. We cannot allow services to stagnate or fester. We have got to try and manage a process in the best interests of everyone. We would hope that we could carry the Local Authority with us in that view to make sure that we do get the best service for local people. Just as you in the Local Authority are obliged to examine and review your responses to services relative to demand and occasionally that results in difficult decisions for you. Examples are closing residential homes occasionally and schools. I am sure Birkdale School is close to quite a number of you in Kirklees but the reality is you have got to examine the way you use resources to the same extent as the NHS has got to do and it doesn't always find favour with the public. We have a duty to critically review our needs and we have got to respond in a way which does result in the best health care services possible for the resources available to us.

D3K062

KIRKLEES METROPOLITAN COUNCIL

SCRUTINY COMMISSION ON CHILDREN'S AND WOMEN'S SERVICES

PRESENTATION BY CHRIS VEAL, MEDICAL DIRECTOR, CALDERDALE AND KIRKLEES HEALTH AUTHORITY

Monday 4 October 1999

Let me just go back a step and just talk about two years ago, the Health Authority arranged to have meetings with clinicians from a wide range of clinical groups from across the whole of the patch and involved Dewsbury, Huddersfield and Halifax. From that point of view we were basically trying to look for the future. We wanted to try and understand what the changes were in medical practice that were likely to occur. We wanted to understand some of the service's problems and the way we wanted to take things and look at where we might want to take services forward from that point of view. So the children's and women's debate came out of some of those discussions that we had and some appreciation of the problems that those services were already beginning to experience. I would reiterate Tony's point that I think that, if the Health Authority fails to take some account of the views of the clinicians who are providing that particular service at the present time, then I think we could be seen to be negligent. I want to talk a little bit about some of the issues around that later on.

My role as a Medical Director has been to explore some advantages and disadvantages of those proposals and to look at a range of options - different ways of doing things. My overriding concern I think has to be to ensure that the mothers and their children both born and unborn receive the highest quality of care. In my role as a public health consultant I need to look at the health needs of the population. I need to work at how we reduce health inequalities. I have to be sure that the limited resources that we have got available are used to the maximum effect. If you utilise resources ineffectively they are not available to treat other patients and I think that is a very important issue. We have considered issues around babies being born in the district. My grandson was born and brought up in the district as well and I need to know in some senses not only that the services are safe as a parent but they are also accessible and they are user friendly. I think there are some important issues from that point of view.

If I were to sum up briefly the current services provided to mothers and children, I would only describe them as adequate, and I would also say that without significant change I don't think they would fit the purpose in the future. That represents a situation of change. You wouldn't expect to find the services we provided 20 years ago, you would be extremely cross and unhappy about that - we have to plan for the future. I think if we leave things as they are at the moment I suspect that we will have major failings and some of those failings will result in poor recruitment, lack of experienced staff in critical care areas and insufficient opportunities for staff to practice their acute skills. If you are going to keep skills you have to use them. If we were to look at the National Health Service since 1995 we have had to pay out something in the order of £240m for negligence claims in obstetrics.

Locally the claims in the last ten years are probably likely to amount to about £50m. 60% of all health care issues in terms of negligence are around obstetrics. Tony Keighley made reference to the issues in relationship to the Bristol Inquiry and there have been a number of high priority cases around and about. I would suggest that the level of claims against the health service suggests that, if clinical governance is accurately and appropriately applied, we have problems in that particular area. This is one indication that we need to be doing something around that particular area. I am not saying all the claims are justified at the present time, but I think that they are one aspect that shows above the top it is not the visible part of the human suffering and physical distress that has been caused.

We know there are problems and there are successful litigations which shows that we haven't managed things as well as we ought to. Against that I have to say that for the vast majority of women, child bearing is becoming increasingly safer not only for the mothers themselves but also for their babies. We have seen increasing specialisation across the UK pushing back the barriers and children are surviving childhood, traditional killers including infections. We have seen dramatic improvements in peri-natal (that is deaths around the time of birth) and infant mortality deaths within the first year of life which have improved steadily since the 1930s. Even in this progress we haven't done as well locally as maybe the rest of England and Wales.

I have given you some statistics in the books that are attached, but I would say that the reductions in deaths have more to do with better nutrition, clean water supplies, the absence of poverty, than in investment in medical advances. I think as a Health Authority we have a dilemma, do we invest in preventative strategies to reduce maternal and child illness or do we invest in hi-tech solutions, ventilators, monitors, drugs, specialised doctors and nurses. I don't think that we have an option. We actually have to do both. I don't think we have done as much as we ought to have done in preventative areas. I don't think we were always given the resources or the expectation that we could do that. I would hope that obviously you would understand Tony's point there is no intention to reduce investment in patients services in children's and women's services but the way we go in future will require quite significant investment.

One of the leading obstetricians has suggested that they could possibly improve obstetrics and paediatric services to a point where they could prevent maybe one in four of the deaths of the unborn and young infants. So we are looking at producing an extra 25%. If we had better services maybe we might be able to deliver better figures than England and Wales' national averages. We need to invest. We are going to need to provide consultants initially on the labour wards for 40 hours a week. This is not to interfere in normal deliveries and get involved in that area of normal delivery, but they need to be available and responsible for the training. They need to be able to set the alert systems to say when things are going wrong. They need to be on the Ward all the time. I suspect it probably comes as a little bit of a surprise to find that consultants aren't on the wards 40 hours a week.

So where are they? Well they are in ante-natal clinics, they are in theatre, they are in a range of other clinics providing services - they are not actually on the labour ward and that is really where some of the critical problems can arise. So we need to invest in those areas and put more really experienced staff, the top level - would it be helpful to say at this stage what the hierarchy is in terms of medicine. The

Houseman is the doctor doing his probationary year, he has just qualified, he is into providing support on the Wards but needs to be very highly and closely supervised. The next one is the Senior House Officer who probably is in post for 2/3 years. The Senior House Officer in some specialities would be expected to get the first part of their professional exams. I think when you are looking at something like paediatrics you are looking at particularly SHOs in their first or second year, having to take locally a considerable level of responsibility around resuscitation of small infants.

I would suspect, and if you look at the blue book it will make suggestions, that really those people are not trained, not qualified enough to do the resuscitations to the level, particularly with the very small infants in that problem area. Above the SHO we have a Specialist Registrar. Training has changed. Training experience in hospitals has changed dramatically in the last few years. This is in line with the EEC and we are talking about a five year period of training that in the past might have taken eight or nine years so there is a compression of the training. When we talk about training we are also taking about people who provide a significant part of the service delivery, so they are providing a service as well as being trained. The Specialist Registrars can provide, obviously at a higher level, and they are there for five years.

If we look at our local hospitals, one of the hospitals in paediatrics has two Specialist Registrars the other has none. The number of Specialist Registrars in paediatrics would reduce over the next few years. There will be less of them so it is likely that the posts may not be under threat from that point of view. Why? It is to do with the number of people required as Consultants at the end of the day and we don't have any local control over the number of Consultants actually produced. The Government has set a target to increase the number of medical school places and we expect to see an extra 1,000 places going in. We have to be sure at the end of it that there are enough Consultant posts for people to go into. Even if we were to look at it now, if we started increasing medical students now - five years of training as a Houseman, 2/3 years in SHO, five years as a Specialist Registrar, it is going to be a long time before these people are going to be coming out as Consultants.

There are quite marked shortages of Consultants at the present time. Unfortunately, we are likely to see a reduction in the number of training posts available for the Specialist Registrar training and that then means that we bring the Consultants back a level in terms of doing the day to day. We talk about Consultant delivered services as opposed to consultant supervised services. It is important to understand what that implication is in terms of the Consultant workload. Consultants have been portrayed unfairly I think recently in terms of fat cat and various other things that have been said at public meetings. If we look at some of our paediatricians, again, we are talking about neonatology who want to look after the Special Care Baby Unit. There are two consultants with that special interest in Halifax, and there is one that has a special interest in Huddersfield.

We are viewing very small infants - they need a very high degree of skill and care when being looked after. Increased pressures in terms of the ventilators can damage their lungs, increased levels of oxygen produces conditions like retrolentular fibroplasia can produce fibrosis in the back of the eye preventing a child being able to see. Small changes in volumes of transfused fluids can put children into heart failure when they are very small. You need a high level of skill - you are asking people who are getting older not only to work full days, not only to cover for week-ends, but also to cover the problems at evenings and at night. You can say "there

are four paediatricians covering Halifax why don't they all do it?". Well, they do, and they do cover the neo-natal intensive care, but if there are real problems they have to get a colleague in with a specialism and so we have got people who are up all night and then have to work the next day. You know about that in terms of Junior Hospital Doctors, you don't know about that in terms of some of the Consultants who are on call.

It is important to understand what some of the implications are. The Consultants don't come cheap to the Health Service. We pay them a salary that averages out around £55,000 and then we provide them with Secretaries, office space, support nursing staff - you are really running into quite large sums of money. If they are operating, extra theatre time is needed, dealing with out-patients needs extra staff, so each Consultant is actually quite a large investment. Consultants were generalists 20 years ago, but they are increasingly specialising in certain areas. How do you provide that expertise if there is only one of you who provides that expertise in your particular district or your district general hospital? What happens when you go away on holiday and what happens when you are ill? What happens when you go away on study leave and it is important that these staff, however highly trained, continue to keep up to date and keep their skills up to date from that point of view?

There are issues of sub specialisation. We have got children with cystic fibrosis who need very special skills in terms of looking after them. We have got children with complex forms of epilepsy. We have a range of problems which need increasing efforts. They will cover and they will provide support but they can't do it all the time. So those are some of the pressures that we are seeing developing around that. Tony mentioned the issues of the Junior Hospital Doctors' hours. Junior Hospital Doctors' hours have been unreasonable for many years. We have put unfair workloads on those individuals, we have expected them to take responsibility for matters which need special training.

When I qualified I used to work a full week but when I was on call I would do four nights on the trot and I ended up having to look after an A&E Department. These things have changed, but they haven't changed enough at the present time. We are still expecting these doctors to take on responsibilities for which somebody more highly qualified would do a better job. It is adequate, but it isn't as good as it ought to be. We need to change the skill mix of our Junior Hospital Doctors, we need more skilled staff to look after those very technical areas. We need more training and support to all the staff in terms of children's and women's services. We need to keep people up to date, we need to ensure that programmes of training are adequate. We are increasingly needing more specialised nurses and midwives in particular areas such as the Special Care Baby Unit. We now send children home very much earlier than we did in the past. If you remember, you had to get past the magical four pounds before you were allowed to be discharged from hospital.

We discharge them very early - there are good reasons for that - it helps with better bonding, it helps in many senses in that the mothers are attached to their children, they are not having to travel or stay in the hospital, and the children are not exposed to the same levels of risk that they were in the past in terms of infection and other problems of being in hospital. That means more specialised staff going out into the community, it means adapting practices, diabetic nurses, asthma nurses - there is a whole range of areas of specialisms. You have to utilise those people to the maximum, you can't afford for them just to be doing it part-time. We are going to

need to continue to invest in supporting equipment, specialised ventilators, monitoring equipment. It is expensive, some of it is rarely or not often used, and I don't think that we can always as a Health Service rely on charitable donations to support our Special Care Baby Unit and neonatal intensive care in the way we have done in the past.

I have indicated some of the recent improvements in reducing stillbirths and infant deaths could be made by improving nutrition of pregnant women, reducing poverty, improving child rearing skills and support. If I could now move onto the area of inequalities. Some of you will have seen a report by Donald Acheson, which is the Independent Inquiry into Inequalities, and this follows seminal work over twenty years ago by Black who looked at the situation and found that there were considerable differences in terms of the health experiences of people who were social class 1 and 2 compared to social class 4 and 5. If anything, there is no doubt that the health of everybody has got better but the gap between the top and the bottom has widened. The middle class I think are very good at taking the advice and enjoying the benefits but we have not seen the same degree of improvements in the health of people living in deprived communities.

We do have some inherent structural problems, we have possibly one in three children living with families with relative poverty and that is defined as someone having half the income of the average national income which in 1996 amounted to 2.2m children nationally which would probably equate to about 45,000 children across Calderdale and Kirklees. There are families which have lower levels. The levels of income support falls far short of the level independent experts would agree provides a modern minimum income and are insufficient to meet the costs of an adequate diet for an expectant mother and young child. Low income levels are associated with poor nutrition, lower birth weights, poor growth in the womb, increased stillbirths, increased illness and death in the first year of childhood. We look at our district as a whole and low birth weight infants vary.

In some Wards over 12% of births are classified as low birth weight to under 4% in the Holme Valley, so a threefold difference in the number of low birth weight infants born. In Huddersfield Central PCG area some of the Wards are too small to look at data you can get variations year on year. In other wards you only need a couple of extra deaths one year to put you from the top to the bottom. In terms of looking at PCGs, we have stillbirth rates which are twice as high in Huddersfield Central as they are in Huddersfield South. Infant mortality is a third higher in Huddersfield Central as compared to Huddersfield South. Low birth weight, having mothers who are either below their ideal weight, or even something else we associate with the ethnic communities - women who are of short stature and overweight, those children have an increased risk of heart disease, raised blood pressure and diabetes in later life.

One of the reasons for the levels of heart disease in this district as a whole and across the UK may well relate to the poverty that occurred in the 1930s with low birth weights leading to high blood pressure, heart disease later on in life. I think it has been said that good health is a supreme gift that parents could give to their children. Reduction in risk factors which affect the health of young children has also a crucial effect on the development of mental illness, short stature, delinquency and unemployment - they relate. We feel if we do something about those things - you can actually improve the health of future generations.

Certainly the Acheson report recommends reduction in poverty and increase in benefits for expectant mothers and those of child bearing age and families with children. We can only start from where the health service has not got a major contribution except we can make sure people get the benefits and we are starting to look at schemes which increase the ability for women to get information on welfare rights and primary care. Improvements in nutrition provided at school including the promotion of school food, development of budgeting, cooking skills, the preservation of school free meal entitlement, breakfast clubs, pre-school clubs are all schemes being currently developed which are going to look at starting breakfast clubs in some of the areas which have a high level of deprived children.

Increased support for mothers to breastfeed results both in short and long term provides benefits for the mother - we know for instance that breast cancer is reduced in mothers who breastfeed. Breastfeeding also reduces fertility which also helps in the absence of other forms of contraception through spacing their children. Spacing the children is critically important to the subsequent children's birth weight, as well as a range of other factors, all of which have already shown need to reduce risks. In a child there are reduced risks of infection and there are some very incontrovertible proof that breastfeeding also reduces asthma.

If you look at some of the problems we have in asthma there are some benefits in those particular areas. There is a lot we can do to help - maybe we haven't always been as helpful as we could in the past. Programmes to reduce smoking in pregnancy which improve birth weight, reduce mortality and illness in children. These are major programmes which we really need to get into in a much bigger way than they are provided at the moment. There is evidence for increased social and emotional support of families living in disadvantaged circumstances which can be provided through a range of mechanisms, for example, Health Visitor, Midwife, etc and there are studies which show that enhanced support improves parents' abilities to protect their children, reduces child abuse, reduces the length of labour, promotes breastfeeding, immunisation, and will enhance parenting skills.

Sex education - problems with teenage pregnancies, sexually transmitted diseases, the timing of first intercourse, subsequent disadvantage, a whole range of things that we can do in those critical areas. I would argue that investment in preventative strategies rather than investing in duplication of expensive high-tech facilities is something that needs to be avoided. There is little evidence that some of the hospital based services provide particular benefit to deprived communities over the wealthy affluent one. People don't attend out patient appointments already. We need to find other ways of providing services into the deprived communities.

There are good studies in terms in immunisation and a range of other areas that are the same. People don't come to be immunised, we send people out to work with the families and you need to work with communities in terms of the way in which you improve immunisation levels. But we need to make those Services appropriate - there isn't a quick or easy to fix for each of those communities and there isn't a hospital solution to the problems. We have the ability through centralising some services to think about the ability to send more services out and to increase their investment in other areas. Current activities in children's and women's services is only based around 10% or 15% of in-patient activity in other words the majority of activity is actually taking place in out patients, day care, and a range of other settings.

The Health Service's preventative approach must co-ordinate with the Local Authority, which has a far greater effect on some of those areas that we have talked about - sexual health, targeted approach to children and teenagers who are living in disadvantaged circumstances - there is a whole range that we can group together. Current investments in children and women's in-patients services will need to take account of some specialisation, reduced Junior Doctors' hours, more Consultant level of care, technology, cancer treatment, etc. In the longer term I think it will be inevitable that there will need to be significant changes in children's and women's services across the patch. This should produce a safer and more effective clinical service. However, I would only expect high risk pregnancies to need this increased level of skill and technology and I actually believe that all women should have the choice of the midwife in their delivery, and it should be in appropriate surroundings.

I think there is a subtle distinction - when things go wrong and we are talking around 20% of pregnancies that are going to need some form of intervention at least, then you need to have access to those specialised services. We are talking about reducing relatively small numbers, but the cost to the parent in terms of time, emotion and everything else in getting it wrong - looking after handicapped children which we are not simply measuring in terms of what the effects are. We are not very good at having the figures in terms of those areas. If you look at the cost to the Local Authority of looking after disabled children at the present and how that is rising we have got to get better at some of the care and we have got to increase the skill mix in terms of those very specialised areas.

I would say that women spend shorter periods of time in hospital on average we are talking about up to 2 days for a women in her second or third pregnancy, we are talking about 3 or 4 days for a woman in her first pregnancy. The inconvenience of travelling an extra five miles in relationship to the range and quality of services that could be offered by more integrated services needs to be considered. Is 2 or 4 days extra travelling over 2 or 3 pregnancies such a terrible thing to travel an extra five miles. Can we as a Health Authority put more services and more appropriate services out into the community? That must be the challenge. In the future we shouldn't just have healthy infants and babies but we should look to the next generation as having reductions in heart disease, stroke and diabetes. All of which are major causes currently of loss of life and poor health.

D3K063

SCRUTINY COMMISSION ON CHILDREN'S AND WOMEN'S SERVICES

PHILIP SANDS, EXECUTIVE OFFICER, CALDERDALE AND KIRKLEES HEALTH AUTHORITY

Monday 4 October 1999

I will try not to cover points already made and in a sense try and paint a brief context on changes taking place because it is easier to focus down on the specific issues that require attention. What Chris has done is draw a very good picture where we are - we know that we have information in order to assist people in staying healthy and in order to assist most people in poorest health to get better. The Health Authority is becoming more and more aware, particularly with more recent Government Policy that that is an area that we have to work hard on. Some of you may know that when we surveyed the NHS in the early 90's and talked to Kirklees Council we recognised the linkages probably better than most across health and local authorities. What we have been struggling with in the NHS is how services and decisions made in one place affect decisions in another place so it is impossible to make decisions about service areas without them affecting something else. Chris has told us about such matters using the example of Children's and Women's Services. We know that changes in the Children's Services will also have an effect elsewhere, we know that we have to look at the surgical issues for women's and children's health. We also need to ensure that accidents and emergency services stay close and we need to look at how those services in local hospitals fit services in specialist hospitals in Leeds because some people within Kirklees will use that hospital and will also use Sheffield or in Calderdale use Manchester. So we need to recognise those connections as well. In addition it is no use looking at how hospital services are provided in Huddersfield or Halifax. We have to look whether there are any plans to change services in hospitals on our boundaries. We know within the Wakefield area that Wakefield and Pontefract are looking at how they provide hospital services and that may well impact on Dewsbury and we are working together with colleagues in Wakefield to make sure that any plans that happen there make sense with the people of Dewsbury. We know that in Denby Dale the people could as easily go to Barnsley and to Wakefield for their hospital care just in the same way Todmorden people travel to Burnley and Rochdale. We are aware of these things and we are aware of similar situations going on in those areas so the Health Authority has a responsibility and a commitment to make sure that there is a comprehensive overview not just for services in Huddersfield and Halifax but also across Yorkshire and its neighbouring areas North West Region and Trent Region. So those links are very important. The linkages also on services that people receive locally are important and any changes need to be seen in that context. An example particularly around children's and women's services is child protection issues and we know that any changes have to be fully discussed with Local Authorities and the Area Child Protection Committees in both Kirklees and Calderdale. One of the areas that has been touched on today is the new changes in national policy and there is a set of new descriptions for us to try and struggle with. Primary Care Groups have been mentioned this morning. Family care groups are organised working together with GPs. This is probably the first time in the history of the NHS covering 50 years where GPs have been formally expected to work together and come to joint agreements up until then they were seen very much as what we call

the independent contractors so that they drew their money down through national contract but in terms of their service activity they were to all intents and purposes independent. Primary Care Groups now have the opportunity to plan together for primary care and the Primary care Groups covering south Huddersfield and Huddersfield central report to our discussion groups. For national policy areas we receive notes from national service working groups where the Government lays down specified good practice and monitors local services against that good practice. The most developed one of those is the cancer framework which was launched under the previous Government with a report from Medical Officers of England and Wales and in our area cancer services have been developed to meet the expectations of those frameworks. One of the results of that is a recognition of close working across Huddersfield and Halifax to provide consistent cancer quality services for both those populations. Other national service frameworks are being prepared in heart disease and also mental health services which points out the need for much more consultation and within that, there is a specified lead role not only the Chief Executive of the Health Authority but also the Chief Social Services Officer so the linkages in terms of coming together are there. We recognise that in looking at hospital services we have got to work within that framework. We mentioned that the cash coming into the Health Service is limited. We have a specified budget and we have to make decisions within that budget. So whenever we have discussion around where we want to make investments it will have an impact elsewhere. One of the major objectives that the Health Authorities have undertaken over the past five years is to attempt to control expenditure in most specialist areas. The reality of the cost is that a lot of power has been centralised in places like teaching hospitals in Leeds, Sheffield and Manchester and up until recently we would be giving in the order of £1m. each year extra in services in those areas. Now it is of course services where it is needed and they receive a lot of high profile public support on programmes such as "Jimmy's". But as Chris has said in terms of affecting the health of local people that expenditure is very effective for a small number of people but not for the larger population. So we have attempted to control that so that we can make investments more local either in hospital services or local community services. My own view would be that over the years we have actually struggled to make the level of investment in community and family care services - that is certainly getting a greater priority in policies that the Labour Government is passing down. In terms of deciding where we make investments we can't make a free choice about investing in high level hospital services without it having an effect elsewhere. We have to understand the relative priorities that we wish to see in investing in hospitals as against investing in very high specialist services in Leeds and elsewhere or investing in services that are community based or primary care based. Again the linkage is there, but you can't spend it twice over, you can spend it in expanding hospital services, but we won't be able to expand in investing in the community type services. So I will leave you with that wider picture and wider context.

ADDENDUM

Before we break can you just summarise what the position is after the last Health Authority meeting.

TONY KEIGHLEY

The position at the next meeting is that we will receive we hope a comprehensive report from the Management Consultants. That will set out a range of proposals or a range of options that the Health Authority will consider. We hope that is informed sufficiently to allow decisions that will help us to prepare for public consultation on a range of services not just children and women's services, but we hope that there will be a greater focus on children and women's services. We don't want to rush it on the basis that it has got to timed by Health Authority meetings - it has got to be the right decision at the end of the day. I would reserve the right to say that may not be the final solution. If we get decisions that are comprehensive and we are able to make proposals for the future we will then prepare a document for public consultation and that obviously will mean perhaps more meetings like this with yourselves and other representatives, local authorities and certainly with the CHCs and in other public debates, clearly we have to develop a programme of public consultation. I would stress that that hasn't happened yet. Any discussions that have taken place in public have been on an ad hoc basis.

Question - There were a number of options put forward - is it true that you are actually looking at option 4 to develop integrated services across two sites.

Yes, I am sorry I thought I referred to that in my comments. That was the option selected and that looks at developing almost a single hospital unit across two sites if you like to make sure there is collaboration that I referred to and working together and I would say that we are looking for viable strong hospitals in both communities that clearly link together.

Option 4 was the one that we chose to pursue further work on and we are looking for the outcome of that.

KIRKLEES METROPOLITAN COUNCIL

SCRUTINY COMMISSION ON CHILDREN'S AND WOMEN'S SERVICES

QUESTIONS TO TONY KEITHLEY, CHRIS VEAL AND PHILIP SANDS

Monday 4 October 1999

Question: We know the preferred option. What services have already gone to Calderdale?

Answer: There has been co-operation on two specialities, one is Ophthalmology and one is ENT. The ENT is focused on Huddersfield and Ophthalmology is focused on Calderdale. That is an attempt at a unified clinical function for those specialities. Cancer and haematology have been linked together and the in-patients service is focused now in Huddersfield, although we expect the benefits of that to provide other than in-patients services across both hospitals or across both patches.

Gynaecology cancer, particularly of the cervix and ovary, have really moved in the direction of Halifax because of the new guidelines. It is actually quite difficult to retain services for gynaecology cancers locally. We have got to make a very good case but it means that one person has to do sufficient volumes of surgery to show that they have the expertise, and that has to be well audited. So gynaecology cancer surgery will be around the Calderdale site but it is likely that chemotherapy would be around the Huddersfield site.

Question: Would maternity and ante-natal services go to Calderdale?

Answer: It is very, very important to understand the services that we are talking about. What they want to do is to centralise the in-patients service. They would still retain all the out-patients ante natal services on both sites. The consultants already do clinics out in the community and they would be able to do increased numbers.

Question: On the figures that we have got there are between 3,500 - 4,000 people having babies. How do those figures compare with the other specialities, such as breast cancer, because they seem to be very large numbers?

Answer: We are talking about three different areas of hospital activity. One area of hospital activity have what we call small special units where there are only one or two consultants providing that service - Ophthalmology, ENT are examples of that. Where it is impossible for that small number of Consultants to continue delivery of patients services is in birth. So what has happened is that they have combined their service across two hospitals. The repercussions of that in one sense is that people now have to travel to one hospital for in-patient care. What we can

guarantee is that when they are in-patients they will receive the best quality of medical cover. The vast majority of ear, nose and throat and Ophthalmology takes place in out-patient care. On the positive side, what we have been able to do with Ophthalmology is to provide specialist services in both hospitals. So, in Huddersfield, people now can attend a specialist out-patient clinic for particular conditions so people have an enhanced service because those Consultants have been able to specialise. One of the disadvantages is that when you do need in-patient care some people have to travel distances.

The second area of service collaboration I see as very specialist interventions within the larger specialities. Chris has mentioned operations on women with gynaecological cancers where the evidence has shown that if that Consultant carried out a larger number of operations then there is a better output and better practice of what is quite a difficult surgical technique but also he/she provides the leadership to assess the necessary care, so that person is responsible for working with specialist nurses but also people from the Department so that they can work together on what exactly is the problem and provide the right surgery, the right treatment. There are other specialist areas like that, some of the vascular surgery interventions is very specialist and centralised. Some of the cancer treatment, chemotherapy treatment, needs to be very specialised. I think in those areas the public should understand intuitively that surgeons undertaking two or three operations a year may not be as capable or able as someone who is doing 20 or 30 operations.

The third area is the women's and children's services. We need to separate those out. I will separate them out briefly and hand you over to Chris Veal. The particular areas that we are looking at are, first, the ante-natal and obstetric care, the second area then is paediatric care (children) and the third area is gynaecology. If you look at the number of admissions during the year then you are talking about large numbers.

The reason why gynaecology is within that is because, as you know, Consultants practice both obstetrics and gynaecology. There are indications that, in future, possibly 5/10 years, those will separate out. What we are looking at within obstetrics is a service to women of child bearing age - gynaecology covers a broader population. Within gynaecology there are again specialist areas. We've mentioned oncology but there is also fertility where currently a specialist clinic is provided in Huddersfield from a doctor who practices in Calderdale (Dr DeBono), who is recognised as a specialist. There is also Uro-gynaecology which is a complex and different service to provide. So, within gynaecology, there are particular different areas and I will hand you to Chris Veal to talk about the similar specialist issues in obstetrics and paediatrics.

I think that when you look at obstetrics you probably ought to look really at midwifery and the fact four out of five women are going to have normal deliveries and no problems. It is the fifth where either the baby or the mother will require some sort of intervention from that point of view. The problem is that we can't always predict accurately which of the groups that related to, so the midwives have the major part, although I have to say that in Huddersfield there is no Midwife Led Unit. There is a midwife, GP led unit in Calderdale. I think you would want to see that area develop, but you want to be able to see the interchange, the hand-over to the specialist services when things go wrong; labours get prolonged, there is bleeding, there are signs that the baby is in distress. All of those things need the technical skills to be able to handle those particular problems. We have in obstetrics a Consultant who specialises in high risk obstetrics, so those are the patients who have had maybe multiple miscarriages in the past. We have got patients who have got things like heart disease or they have got diabetes, or a range of medical problems, which are likely to interfere with the growth - so, again, Halifax recruited a while ago a specialist in that particular area, and Huddersfield will be looking to do something similar within the future. In terms of other areas of obstetrics, there isn't really the same sort of level of development, everybody should be able to do forceps deliveries, caesarean sections.

Children's Services, I think, is very much an increased specialised area because what we are seeing is that all the Paediatricians are general Paediatricians, but they need to specialise in a particular area if they are going to provide a quality service. They need to see enough children with a particular problem, we can think of cystic fibrosis which affects the lungs - those children who get specialised care, get less lung damage, survive from infant into adulthood. All the adult specialists translate into children's specialists, so there will always be a combination of people coming out from Leeds and local services that we provide in terms of specialisation. All these should be able to cope with gastroenteritis and asthmas and things like that and will continue to do so into the future.

Question: How many people then need admission to hospital in Huddersfield for in-patient coronary care in a year?

Answer: Difficult to say off the top of my head. I can find those figures for you.

Question: Under your option for whole hospital modelling it is accepted that coronary care is being provided on both sites, intensive care should be on both sites. All sorts of things need to be on two sites except for the small services that need the specialists. What about women's and children's services?

Answer: I think what we are trying to do is follow the Health Authority's concerns of last year or so. In looking at women's and children's services in the same year as we looked at other services, in terms of what are the small areas that we need to specialise in and bring together, and we've talked about cancer services. We said if we bring together neonatal intensive care what would the service look like locally and we talked

this through with the local consultants. What they brought to our attention was that if we centralise the neonatal intensive care, and that is one of the options that the Health Authority is wanting to look at, then a woman being deduced as being of high risk during delivery and the likelihood that the baby would need intensive care, then they would be referred for delivery at that particular hospital. However, if during the delivery of a baby you need neonatal intensive care, then there would need to be skills to resuscitate that baby and stabilise mother and baby prior to being able to transfer them to that particular hospital.

Question: If you are going to a hospital for, say, investigations into angina, must you go to where the facilities have been centralised?

Answer: Let us follow this up in detail. The position, in terms of an obstetric unit not having neonatal intensive care, does exist around the country. Indeed, if you have your baby in Wakefield, they don't have a neonatal intensive care unit, so part of the service they provide is a transfer of a number of women to have their babies in Leeds or wherever possible for mother and baby to be stabilised and transferred to Leeds very quickly, usually in a matter of hours. What we have to assess is what is the quality of service in the hospital without NICU and is that acceptable assuming you live locally.

The second approach to that could be that the woman has a choice in terms of where she wants to deliver. Do you wish to deliver in a local unit with this range of facilities or do you wish to deliver in this unit which has a NICU, and, indeed, some women in Wakefield choose to go and have their baby in Leeds no matter what. The dominoes don't need to fall if you centralise neonatal intensive care in that other services have that approach. That is one option that we wanted to know more about.

Question: We keep meeting, on a regular basis, women who have had their babies who claimed to be transferred to other neonatal intensive care units because there wasn't space here in Huddersfield or in Halifax for them. Other people have said they have gone to Manchester. Have we actually got a neonatal intensive care unit?

Answer: You refer to teaching hospitals and specialist centres in those units and I suspect that they have conditions that require that level of specialist care.

Question: That is not what they have said. They have said to us that hospital staff were ringing round like fury trying to find a bed - which seems to be an issue.

Answer: A quota of cases come into our neonatal intensive care from other areas which suggests in a sense that in most situations we have the capacity. Just going back to your point in terms of neonatal care and coronary care unit, we have a much higher number of admissions into coronary care - there are always 4/5 people in the beds within coronary care and if you look at the number of children that we have got on ventilators in neo-natal intensive care the numbers are quite small.

I think that part of the issue relates to the transfer and also probably relates to the skills of the staff who are looking after the child. One advantages of having a neonatal intensive care unit means that you have a number of staff are skilled up and who recognise the problems of working with a situation day in day out. In other Units without neo-natal intensive care maybe their levels of skills aren't quite as high. They haven't got that same sharp edge that you get from that point of view, so it may not necessarily be the transfer, it may have something to do with the staff and their ability to recognise problems. Certainly one of our issues around gynaecology cases at the moment, and one of the reasons we would like to retain a local service, is around the skilling up of our staff locally, the ability to recognise the problems and not to lose that particular area of expertise.

I think there are issues about women being given a choice about where they want to deliver. If you talk about a home delivery then home deliveries - with everything ideal - no previous problems and the rest of it presents a certain risk and it is not particularly a high risk but there is risk attached to it. If you deliver in a unit without neonatal intensive care attached to it then there is a risk attached to that. If you deliver in a unit with neonatal intensive care all those specific complications are covered then there are other factors that you wish to take into account like do you feel relaxed in the Unit, do you enjoy your delivery or get a greater sense from that point of view because its free of some of the problems and complications that go with the technology. There are balances around. We should understand what sort of level of care that they are actually looking for. I would still prefer the option that you have those protections as soon as things start to go wrong.

Question: Is there a link between poverty and risk factors of infections? Secondly, are we looking to place improved provision of GP surgeries in those areas of highest deprivation? Thirdly, how do we expand health promotion in those areas? I think the issue about relating health services to social deprivation is a issue we ought to pursue in some depth.

Answer: Could I say that in West Yorkshire we are fortunate, certainly in the dense population that does exist and the number of hospitals that we have locally. Clearly, there are parts of the country and that includes Wales and Scotland where the large rural areas means that it's 50/60 miles to the hospital and what has happened in many of those areas is that family care is from cottage hospitals. The concepts of cottage hospitals has come back into fashion to some extent. There is a focus for primary care development. Certainly Government policy is strongly of the view that many treatments that were traditionally referred to hospital can actually be treated in family care. I think the reality is that in the future local hospitals are going to focus on much more complex care and much more complex treatment and those conditions that don't need them will take place in primary care.

The reality is that many parts of the country don't have the luxury of having a local hospital on their doorstep and we have to provide services that cater for those populations where they are needed. You refer I think to Newcastle and Manchester and Leeds in the context of intensive care, the reality is that for many years cancer patients have been referred to Cookridge Hospital because that was the only facility available. Actually the public were very happy to be referred to Cookridge because that was where the treatment existed. If we could keep services as they were we would do so for all the reasons I have tried to articulate earlier the status quo isn't an option, because of the changes that are being forced upon us. They are being forced upon the medical profession and our ability to treat conditions. The reality also is that the population even though we talk about inequalities, the population overall is getting healthier and we are most successfully treating complex conditions and improving people's ability to survive or to enjoy a good quality of life. I think there is evidence across the whole range of services to demonstrate that.

Question: In the areas that you speak about - you mentioned people having to travel 50 miles.

Answer: I worked in Aberdeen and we had women coming in further distances from Aberdeenshire - some of them travelled 70 miles. We actually had people coming in from Orkney as well - now that took a bit more planning around aircraft flights. It is possible that you do end up with a situation where midwives in Caithness haven't done deliveries for many, many years - you end up with midwives in Skye who perhaps have six deliveries a year amongst the whole group of them - so there is something about retaining skills which they have difficulties in. But you don't have to go too far to look at the distances in terms of travel - Nottingham, Cambridge, Leicestershire as you mentioned East Anglia - there are quite long distances that people expect to travel. Even if you look at Leeds they centralised the services in terms of Leeds - what is the length of time to travel across the centre of Leeds let alone - between St James - travel time is not such a major big issue - we have tried to show in terms of born before arrival - the distance people live away doesn't always relate to the number of unexpected deliveries in ambulances in other areas.

Question: One of the concerns that we have is that women living in places such as Denby Dale might decide to go to Barnsley to give birth. If we centralise paediatric services to Halifax, than people in Barnsley could go to Sheffield, Dewsbury people could go to Wakefield or Leeds - Manchester is even further out - you could end up with no local paediatric or maternity care at all.

Answer: The major balance in all this is how we balance the way to provide services locally and for them to be good quality services. That's the balance that we have to achieve.

The Trust has many plans along with the GPs of how to plan our hospitals. The balance is how can we provide good high quality services. It's no good people having to travel 6/7 miles to the local hospital when the service there isn't of the quality they would wish to have. If you ask the specific questions the scenes that we are looking at are in two stages. The first round of decisions is what are the services that the Health Authority determine should be centralised in some form.

The second decision is where should they be centralised. We have already opened up communication and asked surrounding Health Authorities where they are in terms of looking at their services. We can take that into account when looking at if those services have moved, where they have been located, and certainly the people of Todmorden have raised specific concern because they know that Rochdale are looking at their services. We know we have a job of work to do to deliver that. We need to specifically make sure that we find out what is happening in Bradford, Wakefield and Leeds so that there is an understanding of what will be done.

If I can go back to one or two of the points that have been made. On page 76 is actual information on distance from hospital and what we find there is that the highest numbers of babies born before arrival are actually in Dewsbury which has got the easiest access to the hospital site in terms of the ease of the journey.

You go to some of the other issues you raised - coronary care unit, how many people have heart attacks and possible heart attacks and why can that be provided for within non-central elements. There are two reasons why that can be provided locally, one is currently the way in which physicians in that service are altering the way in which they are looking after people who have had a heart attack, however, within our own physicians there are specialists in cardiology so, currently, if you are admitted to the coronary care unit in Huddersfield and the Consultant on call that night is a cardiologist, then you will see someone specialised in that area. If you go into coronary care on another night you will see one of the other physicians.

At the moment we feel that that is acceptable because there is considerable training across the range of physicians but in the future that might change. Chris has talked about consultants undergoing a shorter period of training and it is less likely that people in consultants work will have a skill across the whole remit of training in the future. So that may need to change in the future. The second issue about someone being admitted to the Coronary Care Unit, and Chris will be able to pick up on this one, is that the care of that person is relatively straight forward because in terms of a heart attack the guidelines and method of treatment can be laid down and implemented by skilled and able persons.

In coronary care units the treatments are very standardised but I think that you are already seeing consultant physicians with interest in cardiology moving away from general medical rotas. I wouldn't equate

the coronary care unit with the special care given in the neonatal intensive care unit in terms of specialism that is required. With small babies the margins for error are extremely small, the tolerances are small, you're talking about the differing level of expertise.

Midwives carry out that same level of care and the reality is, as Chris has already mentioned, that midwives deliver in least 75% of cases. If during that delivery problems occur then medical involvement needs to be close at hand because what is an ordinary delivery can very quickly turn into a problem where people need to respond very quickly.

Question: You said you have more doctors who are able to care for coronary emergencies than you had for those who were able to care for obstetrics.

Answer: What we said was that the clinical condition we are dealing with is much more complicated when dealing with the health of the mother and the health of a very small baby. The tolerances of treatment and the stability of that patient is very delicate. That is what is being said.

Answer: I think you do have to look at litigation problems in terms of the Health Service as a whole - you have to say we have not got it right at the present time.

Question: Let's move to parent contact. Can you tell us more about the proposals for moving services across the community. Paediatric services, for example, how would that affect services in the community? How would that affect our ability in terms of equality?

Answer: There are two areas in this. One is how we provide medical supervision, medical co-ordinating plans out in the community. Chris will talk about community paediatrics and what that is. Thursday last week there was a multi-agency meeting looking at health improvements, in particular with children. The conclusion that came out of that in terms of priorities that we working together with other agencies should be looking at were things like the diets of young children, expectant mothers and mothers of child bearing age, issues around lack of exercise, issues around parenting and stability and stimulation, smoking, specific problems with a relatively small number of families. That was interesting because that led on to another group of cross-services talking particularly about parenting.

We have got to work on these issues which are clearly not medical but these are priorities that people see as tackling poverty by means of some of the health promotion issues and that is a very different agenda from hospital services, but it is important that we do provide resources of investment in these areas. Hence the comments I made in my presentation about different choices to make. If we want to make investment in these areas (which we do because we know they can have a major effect on the community) then it means we can't make investments in other areas. We have to look at where we want to spend the money and how best to use it. We want to spend working with education, working with the home-starts, with the voluntary sector,

sure-start, through the statutory sector and all those things I have been working in SRB projects in Dewsbury, particularly dental health in young children, so there are real things that we can do health wise to help children generally.

The big instrument of Government policy that should make a difference on inequalities is the setting up of PCGs. The whole concept of that is to look to focusing on small populations to the General Practices who have the most information within their own practice populations to pool, to develop strategies within that individual locality and to divert resources, and primary care groups increasingly have the ability to transfer resources from one part of the health care sector to the other. Social Services are members of primary care groups and are there to influence joint working and collaboration across those areas. Within the Single Regeneration projects there are a multitude of initiatives that are going on. I think on some of the inequality issues that primary care groups are going to take the lead role, so that is a policy issue that will have a great impact.

We already have paediatricians who go out from the hospitals and do their clinics in the community but they are limited at the present time in relationship to how far they can go away from the hospital. In terms of obstetrics there are already community clinics, again done by consultants, but obviously mostly done by midwives. There is the ability to use mobile ultrasound, to move that out into the community in a much larger way.

When I was a General Practitioner I would have an admission every three years. That was the extent of the children's admission at the hospital because I was working with a relatively middle class community and had access to a range of resources and could look after children with croup and gastroenteritis. In terms of admissions there are quite a lot of admissions that could be prevented and I don't think hospitals are a great place for children. There has been a lot of movement in the length of time they stay in hospital. We have seen development of schemes already to get the children who are low in birth weight home very early with visiting specialised staff going out from the hospital. In terms of community services we have seen much more specialisation around areas like enuresis. There is a whole range of services that are based firmly within the community and we are seeing those extended by people like community paediatricians.

Question: Are there any links between people being discharged from hospital and poverty?

Answer: I am not sure that I see the necessary link to poverty I think it has to do with the length of time you are in hospital and the complexity of the sort of illnesses when you are actually in hospital. I think there are situations where you have higher admissions rates to hospital because services are not available within the community to provide the level of support attached to poverty.

Question: Do Primary Care Groups have responsibility for funding?

Answer: The funding is allocated through the Health Authority. We have to work out from a quite complicated formula how those resources are allocated to each Primary Care Group. There are three motives, one is to commission health care, one is to provide general medical services which is primary care principally and the infrastructure of general practice excluding GPs which remain with the Health Authority and the cost of drugs. The cost of drugs alone in our patch is about £60m so that figure is itself significant. What PCGs have the ability to do which the Health Authorities don't have is the ability to move funds between those various budgets. I have described those three budgets and they have to be devoted to each of those areas. Primary care groups within the legislation now have the ability to move funds within prescribing budgets, within hospital and secondary care budgets and within those provided in general practice. It is a move forward and it gives a bit of flexibility to respond in a more meaningful way to some of the local population issues.

The hospitals get their money from two sources. In the main, local hospitals will get money from the primary care groups. Part of that cash is to budget for hospital services so the primary care groups in the future will have more influence in deciding the level of hospital services and level of hospital care and how much they might want to spend in community and primary care. Broadly, the Health Authorities are similar to the policy core of the Local Authority in working out spending plans within each of the Directorates and areas of Services responsible for and agreeing not only the budgets but aim specific sets of policy and service initiatives. Our job in the Health Authority is to make sure that there is a sensible set of plans for how services are provided. An example of that is the past where GP fund holders had the freedom to withdraw from hospital services within a matter of weeks and take it elsewhere, and that led to a level of instability and fragmentation. That is not the case now primary care groups have the majority of budgets spent on a primary service and also hospital services. The hospitals draw their funds from primary care groups that wish to have hospital services provided.

Primary care groups can choose to use different hospitals depending on the geography, if you are closer to Barnsley or Pinderfields hospital or Burnley or Rochdale on the other side of the boundary. GPs will still have the clinical freedom to refer patients to those hospitals. It is complicated, and strategically we have got to try and keep on top of that, taking account of influences which have often been developed historically rather than in any logical sense, but those services do exist. We won't accept a situation where hospital services are undermined but we do recognise that over time primary care groups will look critically at referral patterns in hospitals. Clearly every person who attends hospital attracts a sum of money with it. That will change over time but not at a rate that will be stabilised. We have to hold primary care groups to account in terms of the policies that they are implementing and certainly we see an element of growth allowing that flexibility. But over time referral patterns will change. Primary care

groups will develop and strengthen facilities within their own services, within family care centres which actually will provide treatments that traditionally might have taken place in hospital.

(If we're going to decentralise services we have to make sure that the structure remaining is the right one).

I personally would consider it suicidal to close Holme Valley Hospital - I wouldn't be supporting policies to close it. The reality is that those facilities are extremely good facilities in that population area and if we look at Chris's earlier argument about inequalities and the health of the population the level of health care investment in the Holme Valley is exceptional relative to other parts of the patch and it maybe that that is not necessarily the way to improve health overall in terms of some of the problems that face the NHS but the reality is that those facilities are wonderful facilities for family care to cater for local population and we ought to be looking at those sort of opportunities.

(We are extremely fortunate in the Home Valley it doesn't just serve the Holme Valley it serves other areas. That was my concern, where are we going to provide these community services - are they going to be provided in doctor's surgeries throughout the area)

We went to the opening of a wonderful community centre a few months ago that was opened by Kali Mountford. Dewsbury and the Chickenley area has had significant investment and we are looking to develop primary care practices all the time. There is a long list of examples and I am sure we could furnish you with that. We don't have all that information with us because we didn't realise the breadth of the subject. It is a big subject as you will appreciate.

When we had GP fund holders the developments were not central to a larger community, they were just based on a single practice. The PCG has the ability to develop a strategy which allows developments which are appropriate to serve a population which is actually bigger than a single general practice which is what we are looking for. For Huddersfield 3 or 4 centres developed would provide a much wider range of services that wouldn't necessarily be provided by each individual practice.

In terms of the way that budgets are moving on a capitation basis, that means the number of people but also taking account of information you will see a much vaster range of growth in those areas which have the deprivation attached to them. I think there are also a number of central initiatives which also allow for extra resources. There are a range of opportunities which we have to be aware of and take advantage of.

There is a key issue around the timetable of the issues we are talking about because my experience of the NHS and Local Government is that in fact changes take a lot longer. If we are talking about developing services in the modern community are we confident about the capacity and capability on issues around that area. Are we sure

that the buildings will be maintained, are there sufficient. If we are planning to invest many more resources in the two hospital sites then that will attract the resources and we won't be able to develop community services to the same extent - in one way part of the debate is around how we make sure that hospital services are of good quality in the short term but also we recognise the changes in the longer term. We need to set the policy direction which will be in place in the next 3-5 years so we can plan buildings in the right places so we can be confident that investment and professional staff are available in the specialist care.

Can I try and get across the problem that the Health Service has always faced - there is a level of growth in the acute services sector that eats up about 1% growth per annum and that always means that you are standing still. That has actually always undermined our ability to develop services that we feel are necessary and that applies to the "Cinderella" services. When Barbara Castle was the Secretary of State, its applied to the elderly, learning disabilities, disabled services, we know that we need more investment in those but what has always stopped us moving forward is the constant expansion of the acute sector. The acute sector actually doesn't respond to the main issues in population terms that we need to address and the buildings issues is actually vital. There are plenty of buildings around this patch that are owned by public sector agencies that we could utilise. Part of the problem is to get the right quality of family care into some of those areas and work together to achieve them. We want good quality GPs, we want good quality nursing staff, we really need to focus to look at the environmental issues that include health care. It is a big subject and it is wider than obstetrics and gynaecology.

Question: Let us come back to that - let's come back to the hospital services that we are talking about centralising, because I think we are missing that. It was very significant on our visit to the HRI how paediatric services particularly are not just aimed at children but actually support families. The special care baby unit and both paediatric wards were actually not just treating children but were there supporting whole families. If we go back to the socio-economic deprivation issues - I would like to see the figures for how many of the people you actually treat on the wards are from deprived areas. The perception that we have is that the hospital service actually provide a support network. If we lost paediatric services to Halifax you wouldn't have the ability for the hospital services to support so clearly the work of the paediatrics out in the community. But there is also an issue about what is provided in Calderdale and what is provided here. I am very concerned about child and adolescents mental health services which are radically different here to what they are in Calderdale.

The paediatric ward is very important for the delivery of those services and I suspect talking about developing services for young people may become more important in the future - we had interviews with representatives from Ellersley and the Sister that works out in the community in partnership with the paediatric wards - a fine net of services and I suspect that if you move paediatrics over to Halifax that

net will be broken. If you think about the child protection issues - we saw how every child who is admitted to accident and emergency unit is checked up against the child protection register - but if you move it over to Halifax that is likely to frustrate things. If you also move Dewsbury paediatrics to Wakefield then that net is likely to be broken. In the end this sort of network of provision will actually be a lot more difficult to sustain. How can you combat that - if we lose those services what will happen.

Answer: Can I give a medical interpretation. I set up Ellersley and it feels a long time ago now. I am very familiar with the services that developed there. Since my time in paediatrics there has been a major change in the way services have been provided by paediatricians and they have moved to a community based environment and community based philosophy. That will continue we have no intention of interfering with those services I would hope that they would be strengthened. What we are talking about is in patients.

Dr Sills will tell you that paediatrics has been so successful in recent years that the numbers of children needing professional care are minimal and many beds on both sides of the patch are empty because most children are not encouraged obviously to have in patient stays and I am sure you are going to have discussions with some of the Consultants providing these services. That was a persuasive argument with me when I listened to what Dr Sills was saying. As far as the infrastructure and networking that you are talking about I don't think the Health Authority will agree any policy that actually changes that. I think we need to support and encourage development.

I think your model suggests a hospital centred service from that point of view and I think we are increasingly looking to move that focus and intention out into the community. It doesn't have to be based around hospitals - there are children in hospital at the present time who if there were better community services, would not need to be in hospital.

Question: But some of those children always will be in hospital and in fact the ones we saw were ones that were likely to be in hospital. One was actually in with serious brain damage from a road accident - she needs to be in and out of hospital. It is not saying this is a hospital based model service but that hospital provision is actually part of the grand community based provision as well.

Answer: The information might indicate that when that child was ill she needed very good quality hospital care. The information that I got from working within Dewsbury SRB is very clear information that families who live in deprived areas are lower users of those sorts of services you described. They are high users of accidents and emergency and acute services so my guess is that if you were to sit in the paediatric department you will see less families and fewer children from socially deprived areas of Huddersfield and that if you went and sat in an A&E you would see more. I think the reality is and Chris referred to this is that those families who are organised, have access to cars and telephones and are free during the day and probably don't have as

many family responsibilities can engage well with hospital based family care.

For families who have more problems we do need that community based care and the paediatric team have been working with families, with Social Services and voluntary sector because the information at the moment seems to clearly indicate that those families don't engage in an ongoing way with day services. They simply come in and out of hospital when there is a crisis and it is the more able families that actually come and respond to appointment times and work with the hospital. I think the analysis is important and I think it convinces us of community based working.

The other thing I would say about community based services is that the style of service we can offer in high risk paediatrics is not the style of service that most communities can engage in and understand. We actually need to redesign services so that we can attract women and their families from ethnic minority communities and single parents I think all of those can be better changed and made more relevant to people with high health problems. If we are to go down a road of having as full a range as possible of children and women's services on both hospitals one of the repercussions of that it that it will result in running duplicated services. another way forward may be to unify services.

What we are saying is that this should be an extension of the community services for the hospital rather than hospital services for the community.

I think there are issues about how we use hospital beds and what other sort of community types of services we have available in terms of respite care I think some of the things that happen in hospitals and the very way in which it is organised can be distressing for children, with the best will in the world they are never going to be a home from home whereas a respite centre can be very much more appropriate so I may be arguing a little bit about the appropriateness of hospital care in some of those situations and there are better models which I think we should develop.

Question: This issue about how you balance up the two different approaches across the two districts. Certainly there are very different policies, such as around child and adolescent mental health. How do you ensure that when you do centralise them you get the best service. There are obviously very different ideas between the two sites on that particular issue anyway.

As I understand it child and adolescent mental health in Huddersfield is paediatric based whereas in Calderdale it is still in the adult mental health services. It is an issue that I have looked into quite a lot from the point of view of people on my patch. We need to treat adolescent children as special cases they are not the same as the adult mental health - they do need to be treated different.

Answer: One of the issues in moving between Huddersfield and Halifax is the actual misperceptions about different services from different points of view. Certainly one of the first things that we have done, particularly with the clinicians, is to bring them together, actually asking them to share information - it actually overcomes a lot of problems from that point of view. In terms of the children's service in Calderdale it was a very innovative service when it started running. It has been running now for 15 years or more and basically it had a social worker and a trained psychiatrist in child health. She worked very closely with social services and psychology and had a strong link within the community.

Yes, there has always been a shortage in terms of beds but they did admit children to the children's ward and I know she worked very closely with family planning and with other members of the team and also with the paediatricians. It may be a service which has been relatively under-resources over a time - and I think the Local Authority has had problems at times to provide social worker support into that particular team but I think the first thing you need to do very often is to actually get both sides to look at what they are doing. To understand the differences and then to try and understand where exactly there are advantages in the way in which they do things on one side and the other. We spend most of our time correcting misperceptions in some senses of what one side does as opposed to the other side. Once you actually get groups together it is not quite what everybody thought it was.

Question: I would like to be a fly on the wall when the psychologists meet - that is not what came over from Huddersfield. That presumably is a decision made by the Trusts. How can the Trusts make decisions on what is best - if you are looking at integrated services across the two hospitals doesn't that pre-suppose you want one team of people doing things the same way?

Answer: Don't forget the Local Authority have worked very closely with Calderdale Trusts and ourselves over the years in terms of developing those services. I think the reality is that there will be different services provided in different parts of the patch. Some of them will be weak and some of them will be strong and if there are proposals that come out of this that bring about the need for change - part of the consultation process would be for you I think and others to critically examine the differences between those services. I have to say there is rivalry and sensitivity between clinicians in Huddersfield and Halifax and no doubt these will continue to be so. The M62 until very recently was a major boundary and don't forget under the previous Government, the previous administration, the Health Service operated on an internal market and it was about competition and it was about actually developing services that attracted income. Now thank God that has gone. I didn't feel comfortable with that philosophy.

We now have an opportunity to use all the resources available to the NHS in a non-parochial way to get the best services and that is what we will look at. We have still got some breaking down of history and prejudice to overcome in succeeding in that. The reality is whatever

we get as a resource locally it is in your interest and health that we spend it wisely and to the best advantage. The public may not always understand as we struggle to target resources because there is always competition and priorities in the way we commit resources, but what we are going to do is look at the NHS as a composite unit not just in terms of where it sat in the past and what it has done. If there are failures in the system that is what we need to change.

Question: But it would seem to be difficult to deliver an integrated service with two Trusts. Do you think there may be a possibility in the future of moving to one?

Answer: Yes. I would probably go so far as to say that if we succeeded in moving towards unified committee management structures on some of these key specialities where it means that clinicians really do work together and not for separate management organisations but maybe one clinical directorate that brings the clinician together under a broad umbrella. You don't have to be part of the same management structure to do that. The NHS is a national system and we are using taxpayers money.

We want to get the best advantage out of that and that is what we are trying to do in cancer services as just one example to bring the clinicians together working under one umbrella and then co-operate and work together to provide the best parts of that service overall and there is no reason why that shouldn't happen in all specialities. I suspect if you come to a point when that happens that you start to question why we need two managements because management creates boundaries and boundaries create obstacles to progress and what we need to do is work - it may take time to achieve this - but the only way we will lose some of these sensitivities and differences in practices is perhaps to work towards a unified management structure.

Question: Are we talking about hospital closures?

Answer: No. This is a report about hospital beds. Not about closures. I think Frank Dobson initiated an enquiry into how beds were being used and is there any standards and in fact the new PFI in Calderdale have had a visit from the Group that are looking at that. We haven't seen the outcome of that but the visit went extremely well and I think one of the dimensions to that is what we have been trying to say all day that you can't just look at beds in isolation you have got to look at the infrastructure that's provided in different parts of the service and so if you reduce beds in one part of the system you need to improve community services and other support in the other part of the system and it is difficult to focus in isolation.

The NHS is not about beds these days it is about taking an overview of the range of services available and what you need to provide in a certain building as was done in the past. We need a transatlantic diagnosis of clinical conditions - technology has moved on in the last 10 years to running manageable ways of providing health care. That is going to continue over the next 10-20 years. The fact of the matter is

you could have somebody on the moon and you can actually have the electronic data systems in place to make decisions - very remote from where the patient actually is. That is very important to bear in mind. Primary care development and all the technology that goes with that so it maybe that doctors working in an electronic environment are still getting the best specialists in the world giving them information about a diagnostic process and the treatment to follow.

Question: For women having babies - they have always been told that everybody in hospital is ill …. but if you are having a baby you are not ill.

Answer: 25% of women will come to a point when the birth will be a problem. The issue we have got is that that can happen within a matter of minutes - have we got the services that can change from a midwifery low level caring approach to a caring approach which is much more medically based very quickly. We have got some information on clinical negligence in terms of the issues we have talked about.

We have talked about having someone with at least 12 months experience in obstetrics either on the Ward or available within 5 minutes. for obstetrics the time when a woman changes from having a normal delivery to a complicated one is very quick and it is making sure that we have those services available and I understand that the public are worried about that and can't understand why we can't we just provide an ordinary service for 75% of births.

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KIRKLEES METROPOLITAN COUNCIL

SCRUTINY COMMISSION ON CHILDREN'S AND WOMEN'S SERVICES

PRESENTATION BY TONY MILLING, MEDICAL DIRECTOR, HUDDERSFIELD ROYAL INFIRMARY

Monday 1 November 1999

Tony Milling: Good morning. I was asked if I could just go right back to the beginning and say why we are here. The reason basically for change are that we are being driven by all sorts of outside agencies like the Royal Colleges, like the EEC, like the Government, like training for juniors, there are all sorts of expectations which we cannot necessarily meet in the situation we are at present. The Royal College for example expects us to have appropriate people for each unit to keep up the expertise of any specialist consultant who is working in that Unit. The Royal Colleges expect consultants to spend time teaching juniors, nursing, physios, etc. expect them to have a practical rest period, expect them to have time for seeking continuing medical education (CME), continuing professional medical development. The Royal Colleges have said they should not be single handed. There should always be at least two of them in a team.

All these things are leaning on us requiring us to change the way we practice. To look around so that we can try and keep best practice available, keep up to date, which is bordering on clinical governance making sure that we are up to date - we know we can't do this with a 250,000 population - we know that we have to move our services we should be able to keep people in our geographical area rather than having to move to Leeds, Manchester, Sheffield etc. If we have a well reconfigured service you can ask the drivers to drive and we should be able to recruit and retain staff. If we don't have the decent facilities, excellent facilities, appropriate time off for studying, teaching and all the rest of it, we will lose staff. I will just tell you a figure off the top of my head which I can't verify but 25% of junior doctors leave medicine after they have been registered and don’t come back. If you don't have a really good up and running, looking ahead working unit we will not recruit consultants - there is a shortage in most specialities etc. There is difficulty in recruiting good staff. There is a whole list of things that we will require towards safer childbirth where we expect an obstetrician to be on a labour ward 40 hours per week. All these things are driving us, all these things are requiring us to change and more and we are endeavouring to trying to change to keep excellent services locally.

Question: You mentioned geographical areas - what would you consider that to be?

Answer: The local area maybe Huddersfield. If it is necessary, and it probably is, Calderdale as well. People can stay within two geographical areas and some areas have bigger units.

Question: One of the reasons given is that there aren't sufficient numbers of patients coming through for doctors to get the accreditations they need. Huddersfield and Halifax are both small hospitals and even put together they mightn't be the sort of optimum site, so why would doctors then have enough patients with the merger to get accredited?

Answer: We are already working across both sites. Gynaecological cancers are treated at Calderdale rather than Huddersfield. This is partly re-working the co-operation between the two areas that keep people within the two areas. Technology changes, so less and less people have to stay or spend time in hospital.

Additional Reply: There would be an optimum size and it is quite clear that we need to keep the fullest range of services across the two towns. There would be specialist forms of treatment for people's needs. What it would do for us is sustain the broadest range of comprehensive services that we could offer. In some services, such as vascular surgery where conventional thinking is saying that you need a population based on about 600,000, what we would envisage is that across Huddersfield and Halifax we would work in partnership with another hospital so that we would have a service based on population. There would be a network of services and we would provide the fullest range of services locally so you would look at it in a broader context but you would still have a very high local provision of services. So there are different models that you could have, but the population should be adequate to sustain the most comprehensive range possible.

Additional Reply: Let us be clear about what we are talking about and the everyday options. We have specialists in paediatrics and neonatal intensive care. Paediatrics covers the care of children requiring medical and indeed surgical help and that might be intensive care or neonatal intensive care, or it might be care for medical problems in older children. There are a number of drivers for change and if I can just pick up on a couple of them. In paediatrics, first of all there is the issue of neonatal intensive care - when we start talking about the critical mass of patients going through that applies very much to neonatal intensive care. It involves highly specialist care and staff need to be kept up to speed with the practical techniques involved coupled with the need for a certain number of patients going through and instead of that actually because of advances in ante-natal care and some changes in practice in neonatal care the number of children requiring intensive care after birth is falling steadily.

In Huddersfield the neonatal intensive care unit is much smaller than it was five or ten years ago. That is against a background where the National Health Service now expects people to demonstrate that a team of people can do what they need to do with an expectation that they are getting the training and practice and are confident. It is becoming increasingly difficult to prove that with falling figures and therefore in common with many units across the country we are at risk. The staff need to be confident with new staff being adequately trained. One of the targets is looking for partnerships across a wider area to increase the number of cases the unit will see. There are issues about the number of cases seen across Huddersfield and Calderdale but that figure is going to get a lot closer to any accreditation standards. The problem of course is we don't know with clarity what accreditation standards will be set because they have not been set. People have said why don't you wait until accreditation standards are set then do something about it and that is one of the main deciders.

Ten years ago in Huddersfield the Paediatric Unit, Paediatric Ward and Children's Ward and a Neonatal Intensive Care Unit would have been run - certainly overnight by one SHO during his first 6 months in paediatrics together with a consultant and that was the same as most places really, and there would have been a rota. Nowadays Senior House Officers have to get their hours of work down. We need a second tier in between the junior doctor and the consultant. So that is one of the drivers for pooling together the more specialist bits of the service so that doctors can be trained.

Look at the options that are on the table.

From a paediatric point of view, option 3 is the same as option 1 and I will skip option 2 for now. The difference really between option 1 and option 2 is that for option 1 all of paediatrics is on one site - in other words paediatrics and neonatal intensive care. Option 2 puts neonatal intensive care on one site and has Acute Paediatrics on the other. There are pro's and con's for both those arguments.

The arguments in favour of option 1 are that they give us overnight stay in paediatrics and neonatal intensive care on one site and therefore you can concentrate staff on the site.

The arguments in favour of option 2 is that it moves paediatrics to support the surgical services There is the issue of children who undergo surgery where should they go. Paediatrics on the same site as surgical supports the issue of children undergoing surgery.

So there are arguments for and against and we are really just starting to look through the nitty gritty of what that means.

Question: If I could start with the questions on the paediatric. I think in paediatrics, more than perhaps in any other area of medicine, the boundaries between what is medical and what is social is very, very

blurred unless you know a child is treated properly and there are special needs in the way it is treated. It came over very clearly when we visited the hospital about family support.

I have great concerns that we are thinking about paediatric medicine as just medicine and missing out the social dimensions. For example, again, one of the issues that was raised when we visited was that in Huddersfield, for example, any young person who makes a suicide attempt is automatically admitted onto a paediatric ward; that is not, I understand, the case in Halifax, so we have two very different ways of the service working.

I understand that the way that the child and adolescent mental health team are managing child and adolescent mental health problems differs between the two areas. One of our concerns is that we want to see the best service that we can for our young people and children and from my point of view seeing the loss of that facility would be a serious loss of service. You would lose the availability of those paediatric beds in their local communities.

Reply: Is admission to hospital the best way of addressing that problem?

Half the Paediatric Wards have patients there for social reasons but is that the right thing to do? Is a hospital ward the right place for those children or should we be putting resources into the home?

Question: What steps are you taking to make sure that the service will not be depleted because you lose that social reason?

Reply: In the majority of cases children will be far better supported at home by the Nursing Service.

Question: The social implications of what we have seen and what we have heard from other people - may support what you have said but I have not seen that personally. I don't feel that the social issues have been properly addressed. The clinical issues have been addressed and the organisation issues addressed but not the social ones.

I have Chris Worth's latest report in front of me when from he was talking about health in equalities and how important it is for us to look at the social issues behind good health. I have a table in front of me which gives data about helpful and unhelpful help and welfare services. The helpful thing is an integrated approach and the unhelpful is services that treat health and social problems as not related. I don't feel that we have heard enough of that and maybe you should comment, maybe you feel that I am wrong.

Reply: I think we are talking about a driver for change. You want to keep up the services you see and Alex sees another way of doing it, you are trying to drive excellent services and we are as well. I think we are both saying the same thing from the other side of the fence anyway.

Question: Perhaps we should come back and take another example of the social issues. The issues around special care baby provision. We might accept the arguments about the NICU and the medical drivers for that. You do need a critical mass of patients to maintain the excellence but what about the special care baby unit.

We have seen that children in special care can be there for a very long time and we also know from a social perspective that to make it as easy as possible for parents to form relationships with their children whilst it is still at the same time maintaining relationships with children at home is absolutely crucial to the long term well being of that family. How can you then maintain that if the special care baby unit is further away from the communities that they will still continue to benefit.

Question: How will the mothers manage if their babies are in special care and they can't visit? How will that enhance their ability to look after their children if they are to go over to Halifax all the time?

We can't have a special baby care unit unless we have a Paediatrician, which means that we wouldn't be able to have a special baby care unit - the less intensive obstetric unit - we would lose our baby care unit.

Reply: If we stay as we are and don't have a special baby care unit in one town or the other we would lose both, and mothers would be going to Sheffield or Manchester.

Question: Could we have a special baby care unit in both places as we might have an obstetric facility in both places?

Reply: It would be in option 2 because you would have the Paediatricians available so that would make a strong argument then for option 2. Two issues which might help to clarify where there is Paediatrics on any site that is referring to in-patient paediatrics - it is envisaged that the other site is going to require a paediatric facility of some sort that would be there during the day to support children coming through the A&E Department. So it is going to need some kind of Paediatric provision on that site and these are some of the issues that we are still working through in terms of describing what these models might mean and what they mean for each site and how the service is going to be provided.

The other side of that is that you have got an optional low risk obstetric provision on each site as well, again, what does that mean? What do we mean by low risk obstetrics and where do you draw the line between low and high risk obstetrics? All of these issues are still being worked through and what we have agreed with the Health Authority is that over the next three weeks we will sort out some of the professional detail around this and advise the Health Authority. A lot of this developmental work is still going to continue.

KIRKLEES METROPOLITAN COUNCIL

SCRUTINY COMMISSION ON CHILDREN'S AND WOMEN'S SERVICES

PRESENTATION BY JIM FEENEY, CONSULTANT OBSTETRICIAN/GYNAECOLOGIST, HUDDERSFIELD ROYAL INFIRMARY

Monday 1 November 1999

Mr J Feeney: Thank you very much. I think one of the most enjoyable books I ever read was Ian Fosters, "A Passage to India". In that he said the past is a foreign country - they do things differently there - I don't think he was referring to obstetrics in Huddersfield when he wrote that, but he might well have been. When I came to Huddersfield on 22 May 1978 it was a very foreign country to what we have at the moment. For example, we had 3,200 deliveries, we had two Obstetricians and Gynaecologists. I was a third, I was the addition and the perinatal mortality rate was 23 - that meant for every 1,000 babies born, 23 were either born dead or died within the first week of life. Now if we moved forward to today we have 2,600 deliveries, we have four Obstetricians and Gynaecologists and the perinatal mortality rate is 8. A lot of that is due to the social changes that have been created, links with the community makes an enormous difference, but it is only part of the difference.

Perhaps an equal part of the difference has been made by medical advances, mostly by my colleagues in paediatrics, but to some extent by us in obstetrics as well. The year 1978 was a very different world, expectations were very, very different, for example, when I paid my professional indemnity fee when I came to Huddersfield in 1978 it was £12 per annum. The professional indemnity subscription now for somebody doing obstetrics is £8,600 per annum and that, of course, is why crown indemnity has taken over. If you have got people in Birmingham/Leeds working in the private sector their indemnity is 600 fold what it was 20 years ago. So there has been a huge explosion in expectations. Nobody sued obstetricians 20 years ago - now it happens all the time.

The other big change of course is that when I was an obstetrician and gynaecologist here in 1978 I was a specialist full stop and that was the end of it. Obstetrics and gynaecology was a speciality in itself. However, if you are an obstetrician and gynaecologist today you are regarded as a generalist because there are so many sub-specialities that we need and, for example, foetal medicine, those are the people who see that babies are alright in the uterus in the early days of pregnancy, they check chromosomes and so on. They do specialist tests for babies' growth. We have labour ward management, then we have infertility.

As I was saying, in 1978 obstetrics and gynaecology was a speciality in itself but now it is regarded as being a generalism and there are specialisms in great areas of endeavour, there is foetal medicine as I explained to you already, there is Labour Ward Management which is absolutely vital, there is infertility, there is uro-gynaecology to deal with problems of incontinence in women which is a huge hidden problem which needs to be addressed better than it is. Then of course there is oncology, dealing with cancer in gynaecology, both the surgical aspects and some of the non-surgical aspects, and associated with that is colposcopy which is the speciality of looking through the microscope at a cervix where the woman has been found to have an abnormal smear and it is an essential part in the accurate diagnosis and management of abnormal cervical smears. So here we have 4, 5 or 6 sub specialities in obstetrics and gynaecology all of which we are expected to provide at the moment and all of them are going to want the accreditation that you have heard about from Dr Hamilton.

Now we haven't got accreditation yet in most things we do in oncology and that is the reason why even now here in Huddersfield we are sending all or nearly all of our gynaecology patients to Mr Choi in Halifax. Because in this patch there aren't enough patients for two or three people to take an interest in them and of course if somebody is going to do a vital job like that they need to be properly trained and they need to have an adequate flow of patients going through their hands. Take, for example, cancer of the ovary. I feel I have always done a very good job, and I have been doing it for 25 years, but I have done an average of maybe 4 a year. Now if we get Mr Choi doing all of them, and he is doing 26, 30, 35 a year, he is clearly going to be far more expert at dealing with cancer of the ovary than I am going to be and this accreditation is absolutely vital because otherwise if we don't do it we are going to have inappropriate people doing inappropriate things at the wrong time.

We end up in sort of a Bristol type situation and I think Government, and the NHS is very aware of this and is trying to ensure that everybody is properly trained and has the proper amount of patient flow through their hands before they are regarded as an appropriate person. Now that is in already in oncology, it is with us already in colposcopy and unless you do a certain number every year you will not maintain your accreditation. Now in Huddersfield we probably have enough colposcopy for two people to be accredited and probably someone else to be accredited as well, but that means we have another couple of people in Huddersfield who will not be accredited in colposcopy but it is an example of accreditation which is on the way and has arrived for some of these sub specialities and inevitably over the next few years will arrive for all the other ones. Accreditation equals expertise and we need skilled people providing a local service as much as possible.

That is one of our problems in obstetrics - we have four or five or six sub specialities which need to be adequately covered. The biggest problem that we have in obstetrics is the availability of neo-natal intensive care. Because if we haven't got any neo-natal intensive care it obviously strikes very much at the heart of the obstetrics service. Now if we are going to deliver certain categories of babies we really must have a NICU available for them. Examples would be very premature babies and we get a lot of those in the North of England - up to 11% of babies are born prematurely; growth retarded babies, babies who are already damaged by their environment in the uterus when they are delivered. You really must have a NICU available for them, it is not always possible to predict in advance which ones are going to need NICU. Then of course we have got babies who run into trouble in labour and when babies suffer from lack of oxygen in labour they need very skilled and very early attention not just in the Special Care Unit but in the Neonatal Intensive Care Unit.

If you have an obstetric unit with no Neonatal Intensive Care Unit, what does it mean? I think here you need to look at the experience of Kirkcaldy in Scotland who have looked at this very carefully. The first thing it means is that you have got to exclude about 20% of the women from booking at that Unit, because you could anticipate that they may run into the sort of difficulties that we have talked about. The second thing that you will find is that up to 15-20% transfer in labour because of things going wrong and you will have 3% of babies and mothers being transferred after delivery because things have gone wrong. So we are talking well in excess of 50% of people here who would not be suitable for an Obstetric Unit that didn't have a Neonatal Intensive Care Unit and for this reason the obstetricians in Huddersfield and at Halifax feel that it would be very difficult and unwise for local obstetrics to run two delivery units one with a NICU and one without.

The reason we feel that is because it would condemn a large number of mothers who transfer in labour - we don't think that is a very good idea, so obstetricians don't favour having an off-site midwifery led Unit because of the inevitable transfers. Notice I said "off-site" - we would be extremely happy to have an adjacent midwifery led Unit if that is what the women and if that is what the midwives want. So there are two big reasons why we need change. NICU and all the sub specialities. There is another one as well. I have talked to you already about litigation and how it has increased our indemnity fees growing to a huge extent over the past 20 years. If you take Yorkshire, 21% of the claims are for obstetrics, but if you take the expenditure in obstetrics it is about 80% of the total because people are claiming for brain damaged babies. Huge amounts - the going rate is about £2½m and nationally we expect that over the next three years brain damaged babies are going to cost the NHS £200m plus. So this is a vast amount of money that is wasted on the NHS and quite apart from the heartbreak of the human situation for brain damaged babies, if we could save the finance it would make an enormous difference.

The answer to the problem in part as seen by the Royal College of Obstetricians and Gynaecologists and also seen by the Clinical Negligence Scheme (CNS) for Trusts is that you have direct consultant supervision of the labour ward. That means that the Consultant is there, not doing anything else, not being called for anything else, is available to make decisions - decisions are more important than the actual mechanics of delivery. There to make the decisions, do the deliveries, supervise the deliveries, act as a leader for the medical inputs of the delivery suite and act as a liaison person with the midwives and the anaesthetist.

The Royal College and CNS feel that we need 40-60 direct Consultant hours per week spent in the delivery suite and there is no way we can manage that by ourselves. We think we can manage it quite well if we were to amalgamate or if we were to co-operate with somewhere else, but we have no hope because of the other duties that we have got to provide that service currently. The evidence to this improvement comes from St Mary's Hospital in Portsmouth where they have instigated a policy practice like this and even though it is early days and it takes years before you know where you stand with regards to litigation but when it comes to babies suffering birth problems good evidence has shown that they are on the right track and we feel that this is something that should be done quite apart from the financial aspects of it. Having handicapped brain damaged babies is the greatest disaster you can have and I think that we should do something about it.

I was in Lancashire last week at a meeting in Warrington where they are trying to overcome this problem on a regional basis with the North West. They looked very carefully at the criteria involved and one thing that I found absolutely fascinating was that they awarded an extra obstetrician from Ormskirk and Southport, if they put their delivery suites together, they advised Rochdale and Bury to think about putting their delivery suites together and they would consider an extra obstetrician. Our colleagues in Lancashire in the North West are currently thinking very much along the lines now mentioned and are much further advanced than Yorkshire and they feel that we have got to reduce brain damage, we have got to have a resident Obstetrician and small units can't really do it.

So, what do we do in Obstetrics? My view from what I have said to you is that we can't really go it alone and we need to co-operate. If we co-operate in my view we can have a high quality delivery unit at the most local level possible, we will have the availability of the new specialisms that I spoke to you about locally and people will not have to go away for them and overall my view is that it will mean less travel for women and for the babies and I think it will ensure a local service for us here in so far as we can see ahead.

Now, let us say we try to go it alone - we go by ourselves. What does it mean? Well, I think we are going to lose accreditation and most of the specialisms I have talked to you about, we are going to have large numbers of women going elsewhere for expert services and of course from my point of view it means really the death of the unit because if we are not recognised, if we are not accredited who is going to join us, who is going to work for us, how can I go along to the bright Registrars working in Leeds and Manchester and Newcastle and ask them to come and join us - they would say well look you are not going to have a NICU, you are not going to be recognised in oncology, you are not going to be recognised in foetal medicine - this is not a professionally challenging job for me, I am going to go elsewhere, I am going to somewhere else where they have got their act together.

So I feel that we shouldn't go along because it's against our interests. Also, to quote Margaret Thatcher, I think we have got very little choice. Let us say we don't co-operate - what is going to happen? By far, the likely scenario in my view is that some Government agency will tell us in three or four years, do it - get on with it. Leeds wouldn't be able to take the babies, Manchester won't be able to take the extra babies, Sheffield won't - what will happen is we will be told get on and do it. I think that is what we ought to do at the moment - we should start to co-operate actively and try to have a better service.

So that is how it affects obstetrics. The three different scenarios that come in the Health Authority document don't really make all that much difference to us. Clearly we would see as ideal the obstetrics, the gynaecology and NICU and paediatrics as on the same site and that is the one that we would recommend. As far as the second option is concerned that is where obstetrics, gynaecology and NICU on one site and paediatrics on the other. Well that wouldn't make any difference to us because all our clients after they are born are tiny little neo-nates and if we have got NICU on site that is no different to us whatsoever. It may be different for our colleagues in paediatrics but it is no different for us.

Again, as far as the third option is concerned with obstetrics, NICU and paediatrics on one site and gynaecology on the other site - well, that would not be our chosen model because it means that our specialities are divided. But it is something we could get over and, providing we have increased staffing levels, it wouldn't make any difference to accreditation, providing we had increased staffing levels and that is something we could very well manage.

Question: At the end of the last Health Authority meeting it was noted that we should have low risk obstetrics here, but both sites would have obstetric care but one site would have to be low risk while the other was high risk. What you are really saying then is that is not really an option.

Answer: It is only an option if you want 20% transfers in labour and I don't want that.

Question: That means then that there will be no obstetric cover - is that what that means? I don't necessarily understand what low risk means. What would a low risk obstetrics be?

Answer: I would see a low risk obstetric patient as being one who terminates in a normal delivery and if somebody is going to end up as a caesarean section or likely to end up as a caesarean section clearly they are at high risk and this is the sort of patient we are talking about transferring. It something we couldn't achieve to be doing caesarean sections on two sites. If we are going to have a low risk unit that means no caesarean section.

Question: So if there was an emergency in the low risk unit, because you can't predict when the caesareans will be - what would happen?

Answer: They would need to go by ambulance to the other unit.

Question: So it is not really an option?

Answer: It is something that I would counsel very strongly against.

Question: You are saying that specialisms will require the accreditation and the only way this can be achieved is by increasing the catchment area. In this case Huddersfield and Halifax. The conubations with the greatest number of houses.

Answer: I have been in London, I have been in Manchester, Newcastle discussing this and the discussions that we are having are going on everywhere throughout the country. I think it is a new agenda brought in by the Government that makes the biggest driving change and the Government are absolutely convinced and rightly so that skilled people and adequately skilled people should be doing this and I think that is the single factor to drive us - there are lots of them as you mentioned, but I think the new agenda and appropriate people doing appropriate things with proper training and good throughout. That is the agenda now and that means big change and it is very worrying that people like me who have to operate and I don't mean using a scalpel I mean to operate to work in a different way.

Question: At the moment you operate as two different teams don’t you - one in Halifax and one in Huddersfield. If you were operating in one team would it make a possibility of say a low risk obstetric unit operating say for example during the day with obstetric cover? Could obstetricians go to people rather than people to the obstetricians?

Answer: People always have the option of a home confinement and the sort of set up that you are suggesting isn't far different from a home confinement as far as risk is concerned. If we have a 9.00 a.m. to 5.00 p.m. obstetric unit are you going to transfer all your patients at 5.00 p.m. in the afternoon.

Question: Isn't there a lot more elective caesarean and management of when labour occurs now?

Answer: When we are talking about caesarean sections we were talking about the inductions of labour. These people are the people that have been induced because there is something wrong. They are having the caesarean because there is something wrong - with very rare exceptions you get patients who demand caesareans but with the exception of people like that people are in the medical process because they are judged to have some sort of abnormality and therefore putting them in a unit with part-time medical staff I think not only would it be inappropriate but highly dangerous.

Question: So there is no sort of halfway house?

Question: You couldn't have neo-natal intensive care on both sites?

Answer: Through the accreditation system we do not have enough babies going through to give accreditation on both sites but we do have reasonable accreditation criteria for one site.

Question: You have already started to build a hospital at Calderdale - so somebody must have made this decision sometime ago. So why didn't you think about accreditation earlier? We are going to have to join the two sites together, so why wasn't a site found that was much closer?

Answer: The current hospital buildings in Calderdale are absolutely dire and do not compare with the facilities that we have in Huddersfield. The Calderdale buildings just do not stand looking at they have some incredibly poor physical facilities. The Calderdale Health system was trying to get a new hospital and it has been trying to get a new hospital for 20 years. The plans that have been approved by the Health Authority and we in the Huddersfield Trust have absolutely nothing to do with this process. Plans were approved by the Health Authority in Calderdale and they were developed on the basis of health needs of several years ago. A lot of these plans take 10-15 years to come to fruition - you might have some familiarities with your own planning processes it takes a long time for these to come through. We have argued constantly from Huddersfield that the best thing to do would be to join the services and have one hospital that actually serves both populations.

Quite frankly we are where we are. We have two hospitals, one is being built and we have the Royal Infirmary, and we have to make the most of the hospitals that we have. Huddersfield Royal Infirmary has had £34m invested in its infrastructure in the last four

years. Calderdale hospital has got £70 odd million currently being invested in it - we will have some of the best physical facilities in West Yorkshire available to provide health care across the two towns. If we can't find some service solutions to run across those sites that actually work for us provide us with centres of excellence and give strong clinical services in the future quite frankly we don't deserve to be doing this job. That is what we are trying to do - to provide some solutions but quite frankly the buildings we are given - they are not going to be bulldozed down and we are not going to get a new hospital at Ainley Top. It is recognising the limitations. We argued against the Calderdale PFI we said that we did not think given the debate we knew where it was heading we thought that it was the wrong thing to do. It was the wrong type of building, but we are where we are.

Question: How would a midwife led unit operate? What level of cover would be available and are there examples of where this is working?

Answer: I am sure colleagues will want to say something but, just coming back to that those levels of detail we are still working through, we have been given an amount of time by the Health Authority to look at the different models around a low risk obstetric unit and describe what that might look like - we don't have all the answers to questions but I am sure that colleagues would want to share their thoughts.

Question: One of the things that concerns me is the way gynaecology does seem to get lumped together. When we visited the ward we looked at the issues and one of the services for example they provided was for scans for people who had miscarriage or problems with early pregnancy which seemed very sensitively provided - would you necessarily have to take that out? To do something like that is totally different from treating gynaecology cancer.

Answer: You wouldn't need to take that out. There maybe a scenario - we are hoping that things like out-patients services, day care services, day surgery, people assessment units and early pregnancy assessment units would stay on both sites so it wouldn't make any difference at all to the sort of service you are talking about.

Question: Would the consultants form part of the team.

New Voice: Absolutely. The ideas being that we have 10 of us for example, they would all have to develop various expertise and provide it right across the patch instead of having 10 generalists we would hope that everybody would have a specialism provided across the patch with somebody based in Halifax redirected to Huddersfield and vice versa and indeed into the community. One of the things that has been overlooked in plans is the fact that what we are trying to do is to keep as much of the service community based and as an obstetrician and gynaecologist we are very happy to go out into the community.

We don't need to work so much in obstetrics because GPs and midwives do that, but there is a whole range of gynaecological services, the infertility services, the cancer services at colposcopy level are maybe two good examples of things that would be very suitable to be done at say Holme Valley Memorial hospital or somebody's health centre or wherever. Yes I would see people going right across the patch in providing services wherever they are needed.

Question: Would that not then be an option of tackling this problem of accreditation if the doctors travelled without necessarily having to move the patients?

Answer: But the numbers aren't going to increase. Numbers are what count for accreditation and hopefully you could get a Consultant coming from Leeds in order to get his accreditation of the patients. Accreditation is down to throughput through the consultants particular expertise and I don't see whether seeing them at the hospital or in the community makes any difference in that regard. For example, in colposcopy you need to have to maintain your accreditation 100 new patients per annum. Now it doesn't make any difference whether you see them in Halifax or in Huddersfield or Holme Valley Memorial Hospital - providing you achieve 100, that is what you need to maintain you accreditation.

Question: If any one consultant has to be in contact with a certain through put why can he not see that through put on two sites?

Answer: That is what we are trying to do.

Question: But only for out-patients.

Answer: There is not a lot that needs to be in-patients. Gynaecological cancer surgery very definitely. The foetal medicine we can take to both hospitals that is no problem, colposcopy both hospitals is no problem, the delivery suite well I said we feel one site with multiple specialisms we can work across two.

Question: So if, for example, somebody came with an early pregnancy and it looked like there was something very seriously wrong with the foetus, they could have the exploratory treatment - the diagnosis - but if they then chose to have a termination of that pregnancy they would have to go to the central unit?

Answer: It depends because you see we are talking about providing day facilities and some of the terminations now are done medically and could be done on either site. It is true that some of them would need to go to the central unit under the plans that we have talked about, but 70% of them could be done in the unit of their choice.

Question: Could I just ask you about the accreditation - how are the figures worked out - who decides?

Answer: The great and the good in the profession, as defined by the Department of Health, and, for example, in colposcopy, the British Society for Colposcopy which is an eminent body recognised by the Department of Health - they set down the criteria on behalf of all of us - you see, I think you are looking at this in the wrong end, the object of this is to try to get the patients to have the best possible treatment. It is not going to interfere with local services, people want to have the best local services they can but I think everybody would agree that if you are going to get some sort of treatment you need to have it done by somebody who is competent, somebody who is experienced and somebody who has a large number of cases going through his or her hands, and then they will do it better than somebody who doesn't. I think that has to be our guiding principle and it is not important whether the patient is seen in her home or in Halifax or in Huddersfield or the GP's surgery. What is important is that you get the best possible treatment.

I would be able to maintain my accreditation in colposcopy but there would be no way that all of us would be able to maintain accreditation on one site. We don't want everybody to be a generalist, we want people to have particular specialisms that they are really good at. I won't be doing foetal medicine or infertility, somebody else will be doing that but I hope that I will be jolly good at doing the colposcopy - much better than the chap who will be doing the infertility.

Question: Have you thought about the transport implications arising from the proposals? There are likely to be a lot more patients and visitors.

Answer: The Health Authority have commissioned some transport surveys and these are mentioned in the SECTA document.

Question: I think the ones that they have been done are totally inadequate. I think it is important that social issues are brought forward. The travelling of 8 months pregnant women is very different from travelling for a one off visit. We do need to think about the implications for the particular patients who are travelling.

If they do have to become an in-patient either because they have to take bed rest before the baby is born of if they are involved in the special care baby unit than travelling and transport is really crucial.

Diane Whittingham: I was just going to add a few separate items just to explain where we are. Very quickly - this debate is not unique, it is happening all over the country and key sites have been mentioned that are going through this. Virtually every Chief Executive I meet in the Health Service at the moment is engaged in service rationalisation, so it is not unique to Huddersfield and Halifax and they are all trying to work through similar issues to ourselves in terms of critical mass and future viability. We are all responding to drivers for change but

are being driven externally. The one thing I would say to you is these are not medical models that are emerging. There is a myth that this is all around doctors. It is not all around doctors - the same issues are driving changes in all the different professional groups that work and this is about getting a safe, viable, clinically excellent service into the future and getting them as close to people as we possibly can. The one thing I will say to you is we are well aware of the dynamics in terms of how we work with other organisations, not just yourselves but other groups that use hospital services.

We are in the middle of a developmental process working a lot of these issues through. That is why we haven't got all the answers. We are where we are in the process and we are working to solve some of the issues, as you are, at the moment. The three options that have been proposed - they all have some benefits - they all have some limitations - there is no optimum solution. Elaine touched on it earlier when she said that depending upon the option, depends on what scope there is to provide services on each site. Where paediatrics is located is important in terms of what other support and input we can provide - where there is gynaecology that is important too. The three options themselves offer different scope in terms of what the final service model would look like and again there are issues which we need to work through.

What the Health Authority have said going into this exercise is that they are committed to providing two full A&E Departments in the future - they have stated that within these models 90% of the work that we currently do - 90% of the contracts we have won't change. The information sheet that you have accounts for 10% of the work that we do and children's and women's is an element of that so a vast proportion of what we do within the hospitals doesn't change and it is about creating centres of excellence and retaining viable services. I hope that we have convinced you that no change is not an option. If we don't change then the journey to Leeds becomes an option for a lot of people. We will lose local services, have no doubt about that. We are not scare-mongering. We will lose local services and what we are trying to do with these changes is keep services local but keep services at a high standard and attract the professionals that we need to run them.

Within Huddersfield we are keen to see within these options the development of a low risk obstetric unit. You have heard today that there are issues around medical cover, there are differences in views between professionals and we are obviously looking at models about midwifery led units and seeing how we can provide those. We would like to see a normal delivery unit, but we are well aware of the debate around the issues that have been shared with you and we see the next few weeks as actually describing what that might look like. The safety issues are paramount within this and we have to take account of them.

I think we honestly shared with you our concerns around that but we are keen from a Trust perspective to see a facility in Huddersfield for women to have their babies if they wish. What that will look like we have yet to describe and work it through with colleagues. You asked me to comment specifically on A&E. What I would say to you is that the support services for A&E is the surgical infrastructure that we have around it and all of these models provide for a very strong surgical infrastructure within Huddersfield and we believe the future of the A&E service in Huddersfield is not under threat with any of these models.

Paediatrics is obviously important in terms of where it sits and how you deal with children coming through A&E. One of these options is for paediatrics in Huddersfield and in the other two it isn't. But what we would envisage is that if paediatrics is not in Huddersfield there is a facility within the hospital whereby children coming through A&E are appropriately cared for and can continue to access the services in Huddersfield and have the proper care that they need. Again those models are currently being worked through, but we believe that the options on the table give a strong viable A&E in Huddersfield in the future and that was something specific that was asked.

You mentioned you thought paediatrics was the key to this, paediatrics is the key, you are absolutely right and a lot of issues that we have talked about revolve around where paediatrics is sited. Many of the issues talked about are dictating where paediatrics is located and what kind of model is adopted so that is a critical part of the debate and obviously there are different options on the table in terms of how paediatrics is provided. We believe that we have to support the options and help the Health Authority to develop them further. We don't believe at this stage that any of the options are totally unviable. We believe that they have some benefits and we said that we will work both with the Calderdale Trust and the Health Authority to help to develop the detail around them.

We are currently looking at things like the physical resource fit around options and we are looking at strategic viability of the options. We said we would feed all that back through to the Health Authority within the next three weeks. We have a joint team that we have set up with the Calderdale Trust and we are working together on exploring issues for both sites. Three weeks is not a long timescale and that is not going to give us all the answers to all the questions. We will obviously use our best endeavours to meet that.

You asked me in your letter to talk a little bit about the impact on the organisation as whole and what we thought the organisational implications might be. We believe that all of these models will only work if the services are provided by a unified clinical team and that means basically that it is one service that runs across two sites. So, for example, A&E will only work if the two services work as one, with joint teams of staff that work between the two units. It is absolutely vital. We have heard how paediatrics will work across

two sites, how obstetrics and gynaecology will work across sites, we have to work as unified clinical teams and we all believe that none of these options will work unless we can achieve that. Once you have all your staff working laterally across organisations it brings into challenge the organisations as currently structured.

Part of the discussions that we are having with the Calderdale Trust is exploring the implications of that and whether merger is the only option for the future. In Huddersfield we believe merger is an inevitability if these options are to work but obviously we are exploring that with colleagues from Calderdale. We are also looking at other management models that might work, but when all your staff are working across two sites it is very difficult to run separate organisations with separate rules and separate policies and separate procedures.

How do you do it? It just makes a mockery of the whole situation. You need one organisation with everybody working together. The process is we have three weeks to help the Health Authority to develop some of these options further, we understand the Health Authority intends to go out to consultation in mid-November, we will work with them. We, being ourselves and Calderdale, with others to help to develop a consultation document which is obviously critical in terms of getting messages across and having solutions and answers to the questions that you have posed today.

The Health Authority is to go out publicly with these options and as we say the devil is in the details. The Health Authority have committed themselves to public consultation of not less than three months and they said that they are likely to take their final decision at their meeting on 20 March 2000 so that is the timetable. It gives us limited time in terms of developing these options. Hopefully, that brings us to where we are and as I say we are working with colleagues to get some answers

Question: Are there any proposals for A&E accreditation?

Answer: The best advice we have so far is that, providing you are part of a network of services where in-patients paediatrics is available, then that does not affect A&E accreditation. Naturally I think you would prefer to see in-patient paediatrics on site supporting an A&E, it cannot be on both sites supporting both A&E's and the issue is which site does paediatrics go onto. We understand that as the accreditation criteria stands now that paediatrics will not - say if it was in Halifax - that that would not have an immediate effect on the accreditation for Huddersfield A&E providing you have access to those beds and it is part of your organisation. It could well become an issue I believe if it were part of a separate organisation.

Question: So we would not be in danger of losing that facility?

Answer: Not so much losing the facility but there are lots of examples around, for example, we have specialist children's hospitals. Where you have very good A&E departments that are accredited and children's services are provided on another site. Nationally there are many examples of that. The advice that we have is that providing you have access to in-patient paediatric beds then you can transfer into them through A&E but that will not directly affect your accreditation but I think it is important that you can demonstrate that intention organisationally.

Question: Because you are not sure about what is going to happen with the accreditation, could that change?

Answer: The accreditation rules change all the time and they develop and move forward. We would like to see in-patient paediatrics in Huddersfield.

The issue of merger of the two Trusts is being debated. The Huddersfield view is that if these options are to work then merger is inevitable between the two organisations and it is not a matter of if - it is a matter of when. There are differences of view on that and those differences of view are being worked through. It is not within our gift to say we will merge. It requires two partners to come to the table and agree on a way forward and we are currently working that through with colleagues from Calderdale.

Question: With regard to accreditation, if the goal posts move, which is highly likely, does that mean that Dewsbury Hospital will be affected? Similarly with reconfiguration, will Leeds Hospital be affected? Will it result in yet more mergers?

Answer: Well I hope not. One hopes that the people who rule our lives at the very top have got common-sense. At the moment they talk about sort of units looking at ½m people and that is the optimum size. Even with Calderdale we are not quite that, but we are not too far away from it and even though nobody can see into the future it would be my view that with sensible people looking after it accreditation would should be ok for the foreseeable future for most things. Clearly we are not going to be involved in heart transplantation you need a population of 5 million for that but I would think that when it comes to the sort of things that we do now and the sort of things that we are hoping to do we should be ok for the foreseeable future - I can't prove that to you - all I can do is put my faith in the good sense of the people who make the decisions.

Chair: Thank you ever so much for coming to talk to us.

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KIRKLEES METROPOLITAN COUNCIL

SCRUTINY COMMISSION ON CHILDREN'S AND WOMEN'S SERVICES

PRESENTATION BY MR JOHN ROEBUCK, CHIEF EXECUTIVE OF CENTRAL HUDDERSFIELD PRIMARY CARE GROUP AND MR BILL PARKER, CHAIR

Monday 1 November 1999

John Roebuck: The main functions of the Primary Care Group basically are three fold. Firstly we have got to look at improving the health and health inequalities of our local community because that links into a lot of the work that you have referred to already in the Annual Health Report. It picks up not just the health but also the social aspects which have an impact on health, secondly we have got to develop primary and community services; that relates to the services which are provided through the GP practices and through the wider Primary Health Care Teams, and that includes people like Health Visitors, School Nurses, the District Nurses, Community Psychiatric Nurses, and a whole host of people who would be more associated with working in the community rather than working within hospital settings. You mentioned midwives and they are also included. They are a crucial part of the team and pertinent to today's debate.

Thirdly, we have a responsibility for commissioning a range of hospital services which meets our patients needs and we as a Primary Care Group are described as a Level 2 Primary Care Group. What that means is that in this current financial year it is our responsibility to commission everything up to around 40% of the hospital services. If we are to continue as a Level 2 Primary Care Group that means that for next year we will be required to commission up to 60% of hospital services provided to patients within our Primary Care Group. That is quite significant in terms of the whole hospital planning work that is currently ongoing because looking into the future then we, as opposed to the Health Authority, will have the actual day to day responsibility for determining what services are provided either in hospital or in primary or community settings.

Our mission statement is to improve the health and well being of the people of South Huddersfield and clearly that does include the social elements and we do see our role as certainly working with the Local Authority, working with voluntary agencies to look at the holistic approach to improving health care rather than just purely what might have been conceived as a medical model in the past. We do fulfil that mission. The four main aims of the Primary Care Group are:-

(i) to work jointly with partner agencies in an honest manner;

(ii) to ensure that patients and carers are our first priority;

(iii) to help them make informed decisions about their health and health care services which again is clearly pertinent to the discussions we are having today; and

(iv) to improve the co-operative working by the different health and social care professionals who are responsible for delivering those services.

One of the progressions for Primary Care Groups is to move to Primary Care Trust status and I think all Primary Care Groups over time will move towards this status and basically that brings in much more partnership working. It gives the opportunity for joint budgets between health and social services it enables us to look at the situation in our communities from an holistic point of view and engage not just health and social care or social services but wider services provided in the community, e.g. education, housing. The Primary Care Trust may well be a vehicle whereby services can be brought together and made more sense of. There are boundaries as we are aware within the Council or between the Council and the Health Authority, and they need to be broken down. A Primary Health Care Trust may well help us to achieve that.

Characteristics of our Primary Care Group - we actually represent 15 GP practices in the area and 51 individual GPs who are independent contractors. We do have a budget of £48m of which £28m at the present time is invested in Huddersfield NHS Trust services, whether it is primary, community services, acute services or mental health services. Our share of the overall Trust budget is around £28m so clearly we are accountable for that money. We need to make sure that it is used efficiently and effectively. Our practice population covers 87,000 people, these are all the people who are currently registered with the 15 GP practices in our area and within that 87,000 population we do have 18,000 women between the age of 16-44 which is 20% of that population and clearly again the debate that we are talking about has a significant impact on them for many reasons. The areas that we cover are the following wards - Holme Valley North and South, Kirkburton, Denby Dale, Colne Valley West and Newsome and Crosland Moor.

In Newsome and Crosland Moor we have something in the order of 4,000-5,000 patients in each of those wards so we do feel we have a responsibility to ensure that services across all those areas are of a good standard and regardless of where a patient might live that they get the same sort of service in those areas from our Primary Care Group. Two areas I would particularly point out - the University practices is part of our Primary Care

Group and that comprises of approximately 7,000 students at any one time based at the University in the centre of town, but we have also got around 1,500 students up in the Kirkburton Storthes Hall Campus. We have also got the Nolan practice at Meltham Road, Lockwood in our Primary Care Group which accounts for the majority of people living in the Newsome and Crosland Moor wards. We have got quite a wide geographical spread. Transport is a key issue in accessing hospital services.

We have provided a position statement on children's and women's services and this has resulted from discussions amongst the 15 general practices that we are related to and also our Board Members who comprise not only GPs but also members of the Social Services Department (Ian Donaldson, who I am sure many of you will know is the Social Services representative) and two nursing representatives, and we do have a Health Authority Co-opted member and a lay member on our Board. Basically our view is that we would wish to see two high quality delivery units, one in each town to be supported through this reconfiguration.

We accept the arguments that Mr Feeney has put forward that NICU does need to be centralised to make a long term future for that Service in a locality, but we do believe that special care baby units can be provided in both hospitals whether NICU is in Huddersfield or Halifax. We do feel that a special care baby unit ought to be provided in both areas. We are also of the belief that in-patient paediatrics should be provided in both hospitals. I think, likewise, for in-patient gynaecology, again we would wish to see capability on both sites, with specialist services centralised on one site. We do need to have that expertise for what are very limited numbers of cases in comparison to such as the numbers going through a delivery unit. We do share the concerns with yourselves about transport, the time taken for travel and what sort of contingency plans might be put in place.

Our overall view is that we do need the amalgamated hospital provision as Diane Whitingham suggested, that there needs to be a merged Trust which can provide services on two sites. We believe it can be provided by larger consultant teams - that is the views of our Board and local GPs. They are covering practices with an 87,000 population. What we would say in terms of the SECTA report, having received it only very recently; I think first and foremost that we recognise that the Health Authority has the lead strategic role to undertake this configuration and that we presently as a Sub-Committee of that Health Authority have more of a responsibility of a day to day commissioning arrangement in terms of services to be provided. We do support integration of services across the two sites which is referred to in the report, because again, as you have heard from people from the Trust, it does seem the only way forward to be able to achieve the accreditation for 400,000 population.

What we do believe is that there needs to be further work undertaken on the financial consequences of all the options, and clearly not just the financial consequence but equally issues around quality of service and issues around access. We do work from a framework in the NHS where six areas are taken into account and those include areas such as quality of health outcomes, quality of clinical effectiveness of the treatment, issues around the efficiency of services, what the patient and user view are and that they are seen to be taken into account. These are a number of areas which we feel they ought to judge the proposals against before any final decision is taken. What we do have to say is that from our Primary Care Group perspective there has been no formal consultation by SECTA with our Board.

There have been informal meetings with myself along with other Primary Care Chief Executives from Huddersfield Central and from Calderdale and that has been on two occasions where I think SECTA were looking to understand where we were coming from. Within the report, which talks about community services investment, SECTA themselves feel that the proposals can be accommodated without major investment in community services. Our view is that until they start talking with us, until we determine where some of the services are going to be located, whether there is the capacity available other than staffing, then it seems to me something of a bit of a nonsense to put a comment in the report as such.

If you simply took the Kirkburton area right out to Denby Dale, Skelmanthorpe, Clayton West, then GP practices cover around 25,000 population and if the services are to move to Halifax, the people in those areas are much closer to Barnsley and we, being responsible for commissioning, will need to have to make a judgement as to where we feel the best services are. You have heard this morning that this debate is going on across the country and Barnsley is no exception so they will no doubt be in discussions, if not now then in the near future. Having said that, we have still got to consider what is best for our patients in terms of provision of maternity services and 25,000 population overall may have a significant impact in terms of our budget shifting from one provider to another.

I would say at the present time that our Primary Care Group's aim is to provide as much service in Huddersfield as possible, we believe that something around 95% of our population use Huddersfield services as opposed to anywhere else. Having said that, we have got to look to the future, we can't do as we have always done. I think we need to bear that in mind. Two final points - it is essential to ask women what they want, it is crucial that people who are affected by the changes are consulted sufficiently well and that the services that are put in place do have their support. At the present time I am not aware of any work that has been done to actually demonstrate this.

In closing the presentation, just a couple of questions we really want to pose. First and foremost, what sort of improvement in health care outcomes, cost savings, are expected to be achieved from this service rationalisation? We do have excellent facilities in Huddersfield as far as maternity services are concerned and we know from audits that have been undertaken on such matters as neonatal intensive care that we are the second best in the North Yorkshire region, so why change something that isn't broken? Services can be achieved by other means, there are only three options actually set out as we have heard again this morning - there are different permutations which may provide solutions to the problem which are outside those three options but seem to us potentially achievable.

The final question we would pose is what is the cost in terms of reduced access and choice for patients and families and how will those be addressed? Clearly we are talking in terms of transport as one direct issue; we know that further work is being done by the Health Authority. We are aware of evidence based research which suggests that the further people are away from services, the less likely they are to take them up. So we have clearly got to consider the geographical aspects, the access for services to people, and how we as a Primary Care Group might want to actually address this.

I think my final comment is that it is very early days from our point of view as far as the SECTA report is concerned. We do need to look at it again as the Trust are doing in more detail and take up issues with them and get answers to some of the questions that are still there in the report. I have put our position statement - this is what we feel our proposals are as regards the reconfiguration of children's and women's services, and I have tried to highlight some of the issues that we as a Primary Care Group are looking to take forward.

Chair: Thank you very much.

Bill Parker: Just to re-emphasise some of the points that John has made. It is a changing world. It is as big a change in the National Health Service and provision of medical care as the mill chimneys coming down in Huddersfield all those years ago. In fact it is a tremendous move forward, increasing technology, increasing expertise, whole avenues of pushing boundaries back. When I came to practice 25 years ago I was pleased when I got my patients to 70 years of age and I thought the rest of it was a bonus. Now I expect all my women patients to live to 85 and the men to 80 so even in that short time we are making progress. The District General Hospital cannot supply the levels of care and specialist expertise, as I am sure has been outlined to you, and a properly constituted merger between Halifax and Huddersfield has our full support, but these are quite threatening

times because we think of distancing a service, loss of control of a service, loss of ownership - when we start thinking about loss of ownership we start thinking well, what motives have these people really got? We have to be part of that change.

Health is governed by social issues and we have to be in partnership because they are part of our institutions here, they are willing institutions, they are dedicated institutions but they are institutions nevertheless. There are about 3,500 employees involved and they have a force of power of their own. The Health Authority has an enforcement power and these forces and powers need to be balanced up by other forces and powers such as Primary Care Groups and Primary Care Trust. This debate is just beginning to balance. The reconfiguration is led by the Health Authority and we are the commissioners but we can't commission what there isn't there to buy. In years gone by - and it is changing - we had an open dialogue with our professional colleagues but we don't want to be in a position where what we want to buy isn't on the shelf. We have no real argument with all this apart from where Huddersfield women go to have their babies.

We believe we have to take all these things into account, but where is the balance between capital expenditure, what capital investments will be lost in changing over to another hospital, what is the capital expenditure involved, could a movement of those funds be allowed to fund extra staff as required? Staffing isn't set in stone - specialist nurses are leaving the service - so it was a breath of fresh air to me that when I saw that big efforts could be made on both sites, it follows that with a little bit of will if that is what you really want to do you can have a special care baby unit that will service the delivery suite in Huddersfield. We had to close St Luke's and, in due course, the Princess Royal was closed because they didn't have the immediate specialist backup.

My hard feeling is that if you don’t have that specialist backup you are into the nightmare scenario of transfer of patients with problems in late labour. I think that is what the public debate has been about - the distance to travel. They have got to travel further on a snowy night over Ainleys in late labour. They recognise the problem too. I would say that if you can't have a proper delivery suite at Huddersfield, it is better not to have one there at all, because there is no such thing as no risk maternity - there is always risk. I think that we have to look at every way possible of having an up to date fully comprehensive delivery suite in Huddersfield. There is one book you must read - a doctor is good at telling people what to read - it is by the Audit Commission "First Class Delivery 1997" - The Policy Agenda for Maternity Care - Women Centred Services.

It identifies efficiency and effectiveness of service objectives that emphasises information, choice, continuity of care and flexibility and listening to women's views is paramount. It recommends that we ask women what they want, ensure services have local women's support and deliver efficient and effective services with good clinical outcomes. There is an increasing role for the midwife, there is more continuity of care, there is better information indicators. Women have to have more informed choices. We are a primary led health service now and we have to ask our patients what they want. I talked to all the ladies I know, and the older ones have different perceptions of travel. The childbearing generation need to be approached before we make any decisions. We have got to go out and ask the questions otherwise decisions will be made and we could have done something better.

Question: Do you think that this argument that we cannot afford to have two high quality maternity units is not true?

Answer: Our preference is for two units but we don't know whether it is true or not, but we feel that the secondary tertiary questions need to be asked to test that hypothesis out.

Question: They could have a centralised team of obstetricians there is no problem with that. The two Trusts should merge but that shouldn't necessarily mean that the services have to go to one place.

Question: How would a NNICU sit alongside a special care baby unit

Answer: Neonatal Units are a spectrum of care and the Neonatal Intensive Care Unit could be part of the special care baby unit at one site. Huddersfield could have a special care baby unit facility on the other site.

Question: At the moment we transfer babies all over the country. We are actually in the process of getting information from the Ambulance Service about what there opinions would be about this issue of transferring. Do you think - perhaps I should address this to the GPs and the Midwives - we have got enough care beds now for Neonatal Intensive Care.

Question: How much money has been spent on improving services in Huddersfield and Halifax

Answer: In respect of the Huddersfield side. Over the past four years £7m to new theatres or replacement theatres to update them, a new intensive care unit which has now got six beds in it, a new oncology ward part funded by appeal, new pharmacy facilities, Huddersfield is providing good quality care as you could expect from a District General Hospital without going in to the tertiary centres.

On the Halifax side, the £76m to fund a new hospital which will enable two others - specifically Northowram and one towards the centre of Halifax, to close and I don't think anybody will dispute that there is a need for new facilities in Halifax. We have upgraded wards at Huddersfield Royal Infirmary which are in better condition than some of the existing wards in Halifax and that gives you an indication. I don't think there is any dispute about the investment, only about how the services are organised.

Question: The people of Huddersfield want maternity provision in Huddersfield but what can we do about it? If we cannot attract the consultants, will Huddersfield become a "Cinderella" service?

Answer: I think it will only be a "Cinderella" service if the two organisations stay separate. If you have one organisation covering a 400,000 population then there is no reason why you can't have quality services on both sites. Accreditation is all part of one organisation for a 400,000 population.

Question: The biggest issue is about the knock-on effects on some of the services for A&E there are requirement in terms of treating children and if you have paediatrics on the Calderdale site you need to be very careful about what is on the Huddersfield site to maintain the A&E accreditation. Any ambulance picking up a sick child is going to take them directly to where the in-patient facility is.

Question: Where exactly is the new hospital in Halifax?

Answer: It is at the top of Salterhebble Hill.

Question: I think there are very clear messages for the way public transport is delivered - that means not just planning where the services go but actually expecting the Health Authority to put money into some of the services. Most of the bus services are provided commercially and what we are talking about is not going to be provided by commercial operations.

Question: How do you think community care/primary care bases can be developed in response to this issue of configuration?

Answer: I think at this time we need more information about what is being proposed to say what will be provided in the community. We know that there are a number of areas where services would be better provided in community settings and those might be out patient clinics for dermatology and haematology. It is really those services where there isn't a need for high technical support or technological equipment. We have got to treat each case on its merits and see what is already provided, see where services can be provided, what sort of staffing is required, whether there is capacity available within existing centres or

whether we need to invest in new centres. It is difficult to be able to say one way or another what we could put in place. The opinion of our Primary Care Group is that the more we see in community settings the better.

With regard to ante-natal care the vast majority of ante-natal care should be done in the community but with regard to paediatrics I think it would be an absolute rarity for a child to have to go hospital for almost anything and it is a good job because hospitals aren't the right place for children. With regards to gynaecology we could see for example the development on the Holme Valley side. They could quite easily do colposcopy which is a quite advanced examination of cervix, cervical cancer and the treatment of cervical cancer. Some development of the Holme Valley site would cater for this. We are a diverse area so we are basically planning on a hub and spoke basis with proposed community development at Kirkburton Health Centre not just to house an extended private health care team but to provide wider facilities for services and also developments at the clinic in Slaithwaite.

Question: So the decisions about that would be yours, or would it be the hospital's?

Answer: At the end of the day we buy the services from the hospital and we would look to be purchasing services in community settings to provide for the needs of the patients and we thought that we would have a joint approach to that. As the consultants have said this morning, they see no reason why that shouldn't be the case and in a sense it is the reconfiguration that is helping them to make that decision. You have a whole service approach. If a patient has a particular problem, we don't just move them out of the general practice box into a hospital box into another box. What we say is what is needed for that patient's needs - how do we get them through their illness and back again to the mainstream of their lives. For example, in central Huddersfield you could practice primary care in a secondary care setting. You do that already with the PENDOC (out of hours GP service) based at Huddersfield Royal Infirmary out-patients department, so GPs are in there doing primary care in a hospital. It is about getting the balance right so our arguments are stronger - we carry as much weight as other institutions.

Question: You talk about clinics in Slaithwaite and Kirkburton - is there any money to develop these clinics and where does the money come from?

Answer: Some are already in place. There are dermatology out patient clinics in Holme Valley Health Centre. Certainly dermatology could come out into a community setting. The ophthalmic out patient service is again in Holme Valley. They are already in place but they aren't as frequent as we might like. I think partly what made the hospital do that was fund holding practices

basically requesting that service in the community. Primary Care Groups have groups of GP practices who will be in a strong position to get the hospital to actually provide the services on that basis. It is a case of over time seeing more and more services coming into communities. We do have funding available to do that. It is not just a consultant led service but it is also a nurse led service.

Two of our main priorities are around diabetes and leg ulcer care and we hope that we can have a community based nurse led leg ulcer clinic in place early next year. We also expect to have a community based optometrists service in place where for example opticians will provide services for eye screening as opposed to the people being sent to the hospital to be seen by a consultant. So we will gradually move services into the right settings for people to get the right access to.

Question: So Kirkburton is ready and waiting to take the community?

Answer: Potentially. We have got to build a Health Centre for a start off and that will be a two year job. Having said that, once that is in place then we can't expect consultants to go around every single clinic as that is not an efficient use of their time, but what we would be looking to do is set up a primary care centre. There are 15 practices in our group referring their patients for eye tests, leg ulcers whatever it might be into specific clinics for patients to receive the care more local to home.

Question: So where do paediatrics fit in to this? How do you see the impact on your care of children if paediatric services are transferred to Halifax on the way you care for children in your GP practice?

Answer: To some extent their is specialisation, a dichotomy of the paediatric services. There are consultants who are keen on the high tech neonatal work and consultants such as Dr Sills who see a vast amount of paediatrics being carried out in the community and they have a whole raft of specialist services that are already out there in the child clinics, the enuresis clinics, clinics for disabled children.

Question: If you think about where you are referring children from, if they are going to be receiving treatment on an in-patient basis, then the actual ability to keep their families with them is very difficult the further away from the home you get. It seemed to me that the children that were in the hospital - (I don't have any figures on this) but there appears to be a certain sector of children who are likely to be constantly going in - it maybe they have asthma, maybe they have disabilities, they seemed to have frequent hospital stays.

There also seemed to be a whole network of services associated with that so the hospital wasn't just treating them in isolation. There is a Community Paediatric Nurse who visits these children. There are all sorts of issues about the way they are working around child protection. I haven't got that sense of how invaluable these informal contacts are that they have with one another I know from the Education Social Workers for example, that in some of your areas suicide attempts by young people are a very serious concern. It would seem to me you would be losing something if you lost that paediatric service.

Another very prominent issue is the effects on the mental health services team. In Huddersfield they are dealt with in a paediatric setting but over in Halifax they are dealt with in the adult mental health services and they are very, very different. The health issues that young people present - the mental health issues are very different to the adult ones.

Answer: It depends what you class as a separatism. The services at Acre House set up for adolescent mental health services is right next door to the hospital. You could argue that again is providing a separate setting to the hospital and it is a professional service and people are waiting to access it. It is only the referrals from there which probably in extreme cases need to go into paediatrics for overnight stays.

Question: What they said to us was that any adolescent presenting themselves who had made a suicide attempt was as a policy - their policy - admitted at least overnight to stabilise their situation and assess what the dangers are.

Chair: Thank you ever so much for coming and giving us your presentation it has been very interesting and it continues to be very interesting. Every time we leave one of these meetings we leave with more questions than we had when we came in.

Final Statement: From my perspective we are getting together with the two Primary Care Groups who are affected, Huddersfield Central and Calderdale, and then we are expected to put a response back to SECTA. We will take it forward to our Board. I am sure each of the Primary Care Groups having got copies of the SECTA report will want to ask further questions. I think, to be fair, time has been a bit difficult in a sense as we have been trying to establish ourselves as a new organisation. We are Sub-Committees of the Health Authority and it has been difficult in terms of what our role is. From our point of view we feel the need to put out a statement on what our view is on children's and women's services. As and when the consultation comes out we will be able to put our opinions forward.

New Voice: Thank you.

D4K025

KIRKLEES METROPOLITAN COUNCIL

SCRUTINY COMMISSION - CHILDREN'S AND WOMEN'S SERVICES

CHERRY HUNTER, CHIEF EXECUTIVE, HUDDERSFIELD COMMUNITY HEALTH COUNCIL

Thursday 11 November 1999

The first piece of information that I want to give you is the letter which has been sent by both Community Health Council Chairmen to the Chairman of the Health Authority expressing our concern at the process that they have undertaken. We have said we are willing to meet with the Health Authority but we feel that they have taken decisions unlawfully. Obviously that's a very serious letter and we have taken legal advice with regards to our stance.

So, if I just talk a little bit about the process. It is important when you look at the papers that went to the Health Authority on October 21st because the options that were put before the Health Authority assumed the centralisation of NICU and SCBUs and they assumed that the centralisation of women's services is o.k. Now what the CHC's are saying, is that we are not willing to go out to consult merely on the location of services without having consulted on the principle to centralise services in the first place. The Health Authority are not empowered to make that kind of decision without consultation. So that's where we are with that. There are concerns about the way the goal posts have kept changing all the way along - we started with children's and women's services, oncology and haematology. Yes, we accept those and we did say to the Health Authority that these must be seen within the context of the whole hospital but we need to understand what the impact is going to be on these Services. But then in October we got new things that had never been seen before and that's not acceptable to us. When we go on to the specific proposals we feel that they are a mish-mash that is more about bed numbers and what fits where, than a really logical exercise in looking at clinical adjacencies and providing a better service or opportunities to provide a better service. Some of the statements in the cancer report are somewhat curious and SECTA are supposed to have done an objective review of hospital services and yet they say in all proposals surgery will be in Calderdale because they have a consultant. We also have a consultant in Huddersfield who does hand surgery. So those are the kind of logicalities which there are.

If I can go down the list. What we feel is that SECTA has not clarified the difference between neo-natal intensive care unit and special care baby unit but they've lumped them all together and that is not necessarily what we should be doing. Yes there may well be a case for centralising the neo-natal intensive care unit but we would argue that that is not the same as centralising a special care baby unit. There's really no definition of what they thought about high risk obstetrics and we would challenge some statistics that they are quoting about this being between 20 and 40% of all women who give birth. In Wakefield where there is no neo-natal intensive care unit less than 8% of the women go elsewhere and give birth to their babies. We have seen similar figures from other parts of the country where there are no neo-natal intensive care units. So we've clearly got to get their definition of high risk

obstetrics. With regard to low risk obstetrics, and this is a contentious issue, again there is no definition. We have spoken to the Trust in Huddersfield and the Chief Executive said as far as they were concerned some kind of low risk maternity unit should be given to Huddersfield. However, there are concerns about this because wherever you have a midwifery-led Unit or low risk unit or whatever, you've got to have certain support mechanisms for that Unit. You've got to have consultant input, that's what the midwives actually say they require in order to make sure they can provide a safe service. There has to be consultant input. There has also to be somebody who is qualified to resuscitate the baby if the baby should be in any kind of difficulty. It doesn't always have to be a doctor but it does have to be a highly qualified nurse as a minimum who has to be specially trained in resuscitation techniques for small babies. The problem is that if you don't have paediatrics on the same site you might not have the specialist nurses who could undertake those resuscitation techniques. So there are still a lot of questions about low risk obstetrics. The two proposals, if you look at them, everything hinges on this centralisation of NICU and SCBU and it does not necessarily follow. It has not followed in other parts of the country. We've been a bit dismayed in as much as we've all been or the Health Authority and Trust have been talking of generalities, about drivers for change national drivers for change but we have not seen those translated into a local circumstance to say what is actually happening, why the NICU in Huddersfield might be under threat. There are some rather spurious arguments that have been put forward to say that if we don't do this now we will lose out to Leeds. Quite frankly, what's going on in Leeds means that they've got all on to cope with their local demand, never mind take on business from elsewhere. So Leeds is not the spectre that's being portrayed in this argument at the moment. There are changes taking place anyway in Leeds in as much as there is a proposal being worked up to centralise all of maternity services on to the Clarendon Wing of the LGI. Now Leeds Community Health Council has some concerns about that because it means that nearly 8,000 babies will be born at the Clarendon Wing each year. When you add on then that Wakefield and Pontefract also contract with Leeds for NICU you start to see the demand in Leeds, they can't cope with any more. You referred to the Wakefield consultation. If that consultation is firmed up there is an interim solution (I'm not going in to why it's got to be done), but there is an interim solution that will move maternity services from Wakefield on to Pontefract Hospital site until a new hospital is built and they have to do that as an intermediate solution. That then rules out Wakefield as an alternative part of our population, the Denby Dale area in particular. It means that the only alternative, viable alternative, if they don't chose to come into Huddersfield or Halifax is Barnsley.

With regard to the linkages that have been made, yes, we are talking about in-patient services but the correlation of the inter-linkage with out-patients services has not really been made. I'll give you an example of this. Gynaecology. In two of the three options its suggested that gynaecology should go to Halifax. What does that do for women who require an abortion? Yes, Halifax does undertake abortions, but the counselling service which is excellent in Huddersfield should remain in Huddersfield. Halifax does not have a similar standard of counselling service. So there are linkages and they are not being tied up within these proposals. Let's look at paediatrics. In all the options in-patient paediatrics is located in Calderdale because SECTA have put in their reasoning it should go where NICU and SCBU is centralised. However, there is an argument that says the linkage between NICU, SCBU and in-patient paediatrics is not as strong as with major trauma surgery. 40% of all trauma work is paediatrics.

And, so, on to the other proposals. The majority of specialist surgery and general surgery would be on the Huddersfield site, but without the paediatrics how viable is it because they would be losing 40% to another site? What are we actually talking about here? Yes, we can understand that there is a shortage of paediatricians who are skilled in paediatric surgery, and that because much more effort is being made to prevent the need for surgery in young children they may not be seeing as many patients as they did before. Why can't we have the consultants travelling between sites if they are currently working in a team? Why does it have to be the children? We have had examples with the centralising of ENT, the ophthalmic service, where we had centralised beds for ENT in Huddersfield and centralised beds for ophthalmology in Halifax. Someone can be discharged home and they seem alright, six hours later the situation is vastly different. They go back to the hospital but the local hospital can't deal with them, they've got to go to the hospital where they had their operation, it's a mess because nobody knows where the records are. There will be mechanisms put in place to sort that out but that's a lot further down the line than the changes to the services, its going to take longer to bring that all about. Although the proposals show Huddersfield as what we call the 'hot hospital' dealing with major trauma and the specialist centre for surgery, that may not be sustainable if you don't get training accreditation for the doctors in A&E and doctors in anaesthetics, and I have to say that the staff in the anaesthetics department, consultants and nurses, have not been consulted or brought into the discussions at all. That is true for both Huddersfield and Calderdale.

There is another issue we are now starting to hear about, i.e. one hospital on two sites/possible Trust merger. I was not aware of this but you cannot consult on the Trust merger at the same time as you are consulting on reconfiguration of services. But some of the proposals here are only achievable with a Trust merger; with a single management structure and with a unified budget across both hospitals. Otherwise they are unachievable. So what are we actually talking about? In a way it's almost topsy turvey and it would have been easier to have this kind of review of reconfiguration services if the Trust merger had preceded it. All along the line the Health Authority has said that what they wanted was two viable district general hospitals with two A&E departments. We still have not been able to get an assurance from them that when they talk about A&E it means a fully functioning 24 hour A&E Service. You might still talk about two A&E departments but under these proposals whilst it might not be immediately apparent what the long-term consequence would be, i.e. that Calderdale would become a minor injuries unit and Huddersfield would be the major trauma A & E department. So that's how it all hangs together for children's and women's services and we hear all day about the linkages about vascular surgery and all the rest of it, but there are other things. What about the diagnostic services, what about services in the community as well?

I have to say that we remain cynical that what's been suggested again does not really make the proper linkages with what is going to go into the community or the development of primary care. When the Primary Care Groups met they said you need to be talking to us about developing community services because some of this again is only deliverable when you've got that underpinning of a full comprehensive community service. The trouble has been for the last ten years that whilst we have been advocating for a shift of services from the hospitals into the communities there has been some but nevertheless the acute hospitals suck a vast amount of money and once it's sucked in it's very difficult to then get it out of the hospital budget into community services. As you develop a service in the hospital you are almost committed to continue with it and then you can't let go and get it out into the

community. Now the situation could well change if we were two years on and we were talking about Primary Care Trusts. We say it is not about stopping change, we're not Luddites, but we want to see that any change is for the benefit of patients. To date we have not received or been involved in discussions or received information that has convinced us that these proposals are for the benefit of patients. Mrs Whittingham was quite strong with the CHCs in saying that changes don't just have to be about benefits for patients you could bring about a change if it means that you retain the service rather than losing it elsewhere. We have not received what I would call convincing factual information that allowed us to really participate in the discussion.

I think the other thing is that I don't want this to be interpreted that I am saying that people are telling deliberate lies because they are not. They are not lying deliberately. But there is a lack of information, there is a lack of transparency about all of this. In one conversation we've heard, that this low risk obstetrics unit in Huddersfield was proposed to satisfy the clamour. When I spoke to another informal group of professional people they said this is because Calderdale doesn't have the room to cope with 5,000 births a year so there has to be some births in Huddersfield. They simply cannot cope with the space required for the delivery of 5,000 babies per year. Where the truth is I can't actually tell you and that's a fact. It shows you how bad it is when I cannot say I do not know the truth of the matter, and that is just how it feels. My colleague, Judith, in Calderdale Health Council, we talk to each other daily and we just feel as though we are floundering. Our Councils both feel they are floundering because we can't get to the bottom of anything.

There are issues, other issues that infringe on all of this, and this is something that we've been saying to the Chief Executives of the four Health Authorities within West Yorkshire, can you show us your strategic master plan of where services are going to be for the people of West Yorkshire and there isn't one.

Questions are still being asked about why aren't we looking for partnership with Dewsbury. That would be a linkage with Dewsbury. The Region is looking at cleft lip and palate services which is for a small number of people a year across the region about a 100 new cases of babies born with this kind of deformity, needs very specialised services. Because of centralisation and developing expertise it was decided by the Regional Working Party that there should be two centres - one in Newcastle and one in Leeds, then they refined it down. It is just going to be Leeds because they would lose fewer people from the northern part of the region, who would go over the boarder to Glasgow to receive this service, than they would do if the service was centralised in Newcastle because there would be lots of people in the South part of the region who would go to Manchester or Sheffield. They haven't consulted on it yet. They forgot that they needed to consult for comment until it was pointed out. So that is going on, consultation on that will start quite shortly. But that impinges on both paediatric services, oral surgery and orthodontics, and yet nobody knew anything about that when this was being discussed. I take the point there is no overview, there is no real strategic planning and it is worrying. It isn't just about the people having to travel, travel is a very important issue and I would not under-estimate its importance, but for very specialist services people will travel if it means they are going to get a better service and I think we would all accept that. But when there is no guarantee that a better service will be provided at the end of it and when we haven't had much information about the actual outcomes, not just present outcomes but the targets of what is to be achieved, change for change sake is not acceptable.

QUESTIONS AND COMMENTS

Question: So really there is no strategic planning on understanding of what the situation is?

Answer: Our opinion is it is more a reaction to circumstance than being proactive and in the fullness of the picture. There are too many jigsaw pieces missing.

Question: You mentioned whilst you were talking you couldn't have a reconfiguration at the same time as a Trust merger. Why is that?

Answer: We were told this at a meeting with Diane Whittingham that it would be frowned on to discuss Trust merger or have a consultation about a Trust merger at the same time as you were consulting on changes to services.

Question: Surely that would be the most logical way forward?

Question: What do you think the social impact of the amalgamation of the women's and children's services would be on the two communities of Halifax and Huddersfield?

Answer: Disastrous, absolutely disastrous. There are difficulties in any hospital service changes about the impact on social services, that is a big concern. When you are working across two Local Authority boundaries then those difficulties are going to be compounded. The other thing is, and I found it quite amusing, that in an article in the Huddersfield Examiner where Jim Feeney was reported, he talked about the improvements that had been made in maternity services over the last 10 years and he said that in actual fact most of women at high risk were due to social factors. In other words, women at high risk are very often in the lower socio economic groups in our region. Those women, for whatever reason, find it very difficult to access services sometimes. They find it difficult to get up to ante-natal clinics at the hospital. So if they found it difficult to get to ante-natal clinics in their local hospital they are going to find it even more difficult to travel to another town. And when they come to have their baby they are also the women who are least likely to have access to private transport. They are going to need an ambulance, but then it has an impact on their families because they are also the women who are likely to have to stay in hospital longer than 24 hours, up to 2/3 days. It means they are isolated from their families and there may be other siblings in the family. It could have a disastrous effect on how that baby is then welcomed to the family, it more or less just compounds the problems, it exacerbates them. So that is one social impact.

When you talk about travelling, we are talking about travelling fairly short distances when compared to other parts of the country, but our transport links are not particularly good. I think it is fascinating - a lady who works in our office - her husband works for Yorkshire Water - he rang up on Sunday night and he said "hello Jill, don't go on the Halifax

Road because there is a rising main burst on Calderdale Way, go round the back because you won't get down, the traffic is already backed up to Ainley Top". They cured that burst - you might not know this - but on Monday morning the main burst lower down so they had the same problem again and on Monday night and Tuesday evening it was taking people from Huddersfield Royal Infirmary 55 minutes to get down to the roundabout. So those are the kind of problems. Now what does that actually mean? It wouldn't have made much difference to a blue light ambulance - they would still have been stuck in the traffic because it was backed up in a single lane - they wouldn't have been able to get through and those are the kind of issues because there is really only the one transport link, the one route between the two hospitals once you have reached Ainley Top. There is another road round the back but it takes you down to the same roundabout at the end of the day - Calderdale Way - it all comes out there and then you have just got one route up through into the new hospital. That is an issue and we have already got communities that are isolated. Our own Chairman recently said - "I want to finish at 12 o'clock because I have to go home to Emley to pick my daughter up to take her to the dermatology clinic because there isn't a bus she can catch" and that happens not just to Emley but there are other communities like that where buses are only two per hour or run early for workers. It is not a joke - there are people in my village who will have to catch a taxi from where they live to the bus stop and then the buses are every two hours to come to Huddersfield. If they had to then go to Halifax you would be packing up for a 12 hour visit. That may be emotive because we have received assurances that out-patient clinics will stay on both sites.

One argument that was put forward to persuade the people of Halifax that they only needed one hospital, i.e. the new hospital, was that the clinicians were saying at that time that two site working is unsafe. These are the consultants and clinicians working in Halifax and they were saying that we need one hospital on one site because it is not safe for us to work across two sites one mile apart. So what are we actually talking about, one hospital on two sites seven miles apart. It is alright for the Health Authority to say it is only four miles apart - that is as the crow flies, it is not the transport route. You can understand that the people in Calderdale are saying that they treat the argument to suit themselves.

You will have heard that accreditation is in two parts - you need it to provide the service and you need it to train Junior Doctors, but it is also important to train Nurses. Whilst ever the consultants might be able to move between the two sites in order to provide cover or the Junior Doctors might be able to move between two sites, their training status is retained. What does it mean for the nursing staff, because if you want a nurse qualified in child care you need to be dealing with both the in patients side as well as the out patient side and the community outreach for continuity of the patient. The nurses now come under the University of Huddersfield which is under contract to train all the nurses in West Yorkshire, apart from Leeds. The wards are accredited to provide training.

If you look at orthopaedics, that training status would be lost if the nurses who were working in Halifax and only dealing with elected surgery - (hip or joint replacement) - and the nurses in Huddersfield - because we would have some non-elected surgeries still as well as the trauma - couldn't attend the training centres. So it is not just about the consultants having to work on two sites. If we are going to be able to train nurses they will be required to be able to work across two sites so that they deal with a full range of patients and their circumstances. That is particularly important with regard to paediatrics. I think the needs of the nurses and how their training is organised has been overlooked.

Question: I was particularly interested in your mention of records. Have you any knowledge of any proposed system of how records will transfer? Where will the records be kept?

Answer: We haven't really started to discuss that. I am aware that the Medical Records Officer for Huddersfield was asked, over a year ago, to look at the differences between Halifax and Huddersfield and start making some suggestions about how they could be reconciled. If you look at some of the difficulties, in Huddersfield there is one patient number - used to identify the records - in Halifax they have three different ones - so people in Huddersfield don't know which number they should be using to retrieve the records in Halifax. You would be able to have electronic transfer of medical records by pulling them up on computers, but that means a vast amount of work to start to input. People who have already got a case history are going to come under a new system. You don't just need what is going on now, you also need to know of past history, a vast amount of work - very expensive work - of people inputting that kind of data to bring it up to date. We do not have compatible systems yet and we are talking about the use of funds within what is called the NHS modernisation fund which seems to be almost totally used for updating IT equipment at the moment. You can't believe just how difficult that is. I am a member of the District Diabetes Advisory Group and two years ago some money was put aside to compile a register. It has been done now but we were over two and a half years getting consultants to agree a standard format for inputting the data. They all have different requirements and they all think their system is best. I give that as an example of saying - if anybody thinks this is just simply an administrative exercise - sorry, but you are not in the real world.

Question: This has really serious implications, perhaps even more serious because what we are talking about is centralised paediatrics. What about child protection issues? If you are doing it across two hospitals with different systems it is a nightmare.

Answer: I totally agree. The other thing that they have that has been coming is over quite a number of years has been what is called "hand held records". That patient would have a little booklet, something like a filofax that would have details of what happened in the past, but that is fine until we hit a crisis. You are not going to be carrying that round with you all the time are you? What is required is unbelievable - it is

vitally important 40% of trauma is paediatric work - so there is an awful lot of crisis. I was with Mike Clayton, the Consultant, and he was saying there are 50,000 admissions to A&E. We see 50,000 patients - so you are talking about 20,000 children going to A&E in Huddersfield alone - a similar number in Calderdale. Not many of those children will actually be admitted but they might need to be assessed so part of in-patients paediatrics is going to need an assessment ward anyway, assessment beds and an assessment unit. So it is still doubling up.

Question: We hear that reconfiguration is happening all over the country. Are you aware of Community Health Councils who are having similar problems?

Answer: We are still trying to get in touch with other CHCs about this. If you received a copy of our information pack the Health Authority did indicate a number of examples where this was happening, but if you looked at the aggregated population it only totals the population of Huddersfield or of Halifax alone. We haven't come across one yet where there have been two populations of a similar size to Huddersfield and Halifax. The nearest thing that is happening is Pontefract and Wakefield. They are both slightly smaller populations and again the situation is extremely fraught over there, but they have already had a Trust merger. They had their Trust merger over a year ago, Wakefield and Pontefract Acute Hospital Trust merged and what they also have is a separate Community Trust across Wakefield and Pontefract - they always had a combined Community Trust - the situation is slightly different but the arguments are just as fraught over there as they are here.

Question: I was intrigued and concerned about the figures we have been given by obstetrics about the numbers we have been given. Apparently 25% of women are diagnosed as high risk with a further 25% becoming high risk.

Answer: I agree those were the statistics that were quoted.

Question: That seems to me to be a very high figure.

Answer: The CHC does not agree with that figure.

Question: I think one of the things that seems to have been moved from this Trust is that they are envisaging no obstetricians on site and that is unacceptable to them.

Answer: It is unacceptable to the midwives - we need to have a midwifery-led unit - to have one ostensibly in Halifax but of course that is still on the same side as the consultants. SECTA stood up and said that they had got a copy of a report which indicated that low risk units were very successful, but I have been in touch with certain people to see a copy of the report that SECTA said would be made available. I am not disputing that that report is not there, but we haven't seen sight of it as yet. I think in the statistics that we gave out what was interesting - if you looked at the case that we gave with regard to Oxford which was

one that had been proposed by the Health Authority as being similar that the hospital in - Banbury which had less than 1,000 births per year retained that service when it went to judicial review because the inquiry said that the impact on the local community meant that this should stay. The case for saying that there aren't any small units around the country is simply not true.

Question: I still don't think we have explored the social implications of centralising paediatrics.

Answer: I am not the best person to ask about that. Although I am involved in community services, it would be unfair to comment because we are not in touch with those women and their families on a daily basis and there are others who will have a much better understanding - it wouldn't be fair for me to comment. Other issues that we have not touched on is the social impact on all disadvantaged people and I do feel quite strongly about this. I don't deny that people who are from an ethnic minority background have particular needs with regard to accessing services but amongst disadvantaged people the level of literacy skills is very, very low indeed and they have exactly the same kind of problems in accessing services as people who do not have English as the first language, and yet nobody ever talks about it.

Question: What would be the first option for maternity services of the CHC?

Answer: A full consultant led obstetric service in both hospitals.

Question: With a NICU on both sites?

Answer: No. I think we are able to recognise that there are arguments for a centralised NICU. The SECTA report has confused high dependency with special care which may be about containing the situation, stabilising the baby, resuscitating, make sure it is alright, you can transfer a baby from a Special Care Baby Unit to NICU so it is not necessarily about NICU being on both sites but a fully consultant supported maternity service on both sites which again means that you will have to retain the required amount of Special Care Baby Unit cots to enable you to resuscitate and stabilise a baby before transferring them on. Similarly you would hope that the baby would not be transferred without the mother accompanying.

Question: There is also the issue of transferring babies back into the Special Baby Care Unit after they have been to NICU, which is perhaps a longer term process.

Answer: In the SECTA report there is section where it says there should be a review of the Neonatal Intensive Care Units with regard to influx from other centres as well as the outflow. It has been significant when you talk to consultants, in Huddersfield they transferred very few babies out to the more high-tech service in Leeds or elsewhere, Halifax do or have done, but Leeds and Bradford, if they can't cope with their demand, then Huddersfield is their next choice. I can't believe that a proper review of that has not been undertaken which should include talking to

consultants in Leeds. There may be potential of developing NICU services in Huddersfield and Halifax that would pull in babies from other places including Dewsbury, Bradford.

Question: Your own personal position in the stance you have taken in talking about the reconfiguration. Do you feel able to talk freely at this meeting about what is happening because I understand you have received threats?

Answer: I feel confident in this scenario about being open and saying what I feel about things, but I have to say that some of the bullying that has gone on has modified my behaviour.

Chair: Thank you very much for attending the meeting.

D4K049

KIRKLEES METROPOLITAN COUNCIL

SCRUTINY COMMISSION ON WOMEN AND CHILDREN'S SERVICES

HELEN DAVIES, NATIONAL CHILDBIRTH TRUST

Thursday 11 November 1999

I thought it might be useful to give you a little bit of background about the NCT.

The NCT offers information in support of pregnancy, childbirth and parenthood to enable every parent to make informed choices. The NCT is working towards ensuring that its services, activities and membership are fully accessible to everyone. The NCT actively campaigns a choice for all women and their partners and it is to ensure that women can make informed choices about the care which is appropriate to them, have no vested interest in arguing for any one particular style of care just that women have full information to make the choices that are appropriate to them. I am Helen Davies, I have been an ante-natal teacher for the NCT for over 10 years and in that time I have talked to hundreds of women with their partners. I was also the Chair of the Huddersfield Maternity Services Liaison Committee for nearly four years. I resigned in April as I took on outside paid employment. I have been a member of the Huddersfield MSCL for almost 7 years.

So why have we decided that this is important enough to come. We have long been part of the debate both within the NHS and outside and we wanted to make sure that in all the discussions the debate and the decision making that the voice of women and their partners is not forgotten or glossed over in reporting jargon that consultants can use. Having all had children locally we are very aware of the key part that skilled caring professionals play when women are expecting babies and deciding where to have them. We read carefully the report by SECTA which had been made available to us and any other information we managed to glean from meetings, press reports, discussions with interested parties. Perhaps our unique perspective at least for this Commission is that we have made it our business to talk extensively to past and present users of maternity services not just NCT members but in playgrounds, ante-natal classes, toddler groups etc. asking for their ideas and opinions and they include what we are going to say today.

We have decided at this point to match the SECTA report and not to refer to research based evidence. However, there is a great deal of research behind what we say and if it is considered appropriate we would be prepared to submit a more detailed written form.

We are actually refusing to accept the seemingly fait accompli that Huddersfield at best can hope for the optional low tech unit. It seems rather like trying to push up hill a ball of enormous proportions but we are not prepared to admit that we are squashed yet. Our aim is to ensure that we retain a complete fully funded, well staffed maternity service, responsive to the needs of the local population in all its diversity. However, we are very well aware that arguments we may use to support this position may in turn be used against us. If we have to re-group around retaining

as much of the service as possible here in Huddersfield we are sure members would recognise this paradox. The irony of Calderdale and Kirklees Health Authority moving to public consultation when the range of options are already severely limited and closely focused on one hospital does not escape us. Much is made in the SECTA report of the drivers for change. However, we would ask you to critically review the arguments behind those assumptions. Before we begin to make our specific points there are three very general points which underpin our remarks. We argue that maternity services is not a service which responds only to medical emergencies. For the majority of women birth is a normal and uncomplicated event, I believe that Cherry Hunter referred to challenging statistics earlier.

The professional safety net of the high tech backup is often not used at all. Even the SECTA report points to the fact that in low tech units women on the whole have shorter labour with less intervention than is the average in the standard consultants unit. It is also a well documented fact that so called high risk women who chose to deliver their babies at home do far better than they would do with a comparable group giving birth in a high tech unit which is another interesting paradox. This points to one of our central beliefs that birth is about far more than the mechanics of delivery. It is actually an emotional event, psychological event. It is also a service that is going to be used either directly or indirectly by the overwhelming majority of the population. Most of us will either have babies or be partners of women who have babies and we would suggest that to lose such a core service from the local population is fundamentally different from moving the service.

It is mentioned in the report that community services will be increased, however we note that this is not followed up in detail within that report and we have grave concerns about the specifics, about how that would be implemented, where it would happen, how it would happen what resources would be made available and what part that would make within the strategic plan. Contained in 'Changing Childbirth' are ten indicators of success which are still effectively supposed to govern the aims of our maternity services - one of the central arguments is that maternity services should be delivered as close as possible to the point of need. It is a truism that midwives are often considered to be the guardians of normal labour and we were very concerned to see that although midwives were mentioned in the report the central focus was on services, structural considerations and on consultants and doctors. Yet we know that other than meeting a GP many women do not see a consultant or a hospital doctor throughout their pregnancy, labour, birth or postnatal period. It is the midwife who discusses options for care of the women and with the women ideally together with her plans and delivers the appropriate care.

Moving on to specific points for each of the options. I am sure you will realise the majority of these points will refer to more than one option. Option 1 where all services are centralised in Halifax reduces the choice or perceived choice available for women and in fact for many women perception is reality, many women do not have access to other modes of information and other areas they can go for extra support. We also note that through the report the low tech unit suggested for Huddersfield is merely a "could have". There is no commitment to providing this service. We are also concerned that some GPs and midwives don't support this option. We also have concern about the definition of low risk. How conservative would this definition be? If there is a lot of concern from the medical professionals about women giving birth in a low tech unit for all kinds of reasons with which we may wish to argue, we could find that increasingly large numbers of women are being moved into a supposed high risk category. But we also need to be aware that

"high risk" is not only a medical assumption but it also has mental health implications for that woman. If she is moved into the category of high risk she views herself and the progress of her pregnancy, and the expectations of her labour, very differently. Continuity of care for women moving from a low risk unit, if one was available in Huddersfield, to a high risk unit and back again needs important consideration because continuity of care to women means meeting the same midwives at the same times regularly. The definition often adopted by Hospital Trusts and Health Authorities is making sure that the relevant information pertinent to that woman is passed along with that woman. Additionally, some women are high risk for part of their pregnancy, for example, if they have had recurring miscarriage and then would have traditionally fallen back into a low risk unit. Will there be increasing pressures to keep women in a high risk category even though they have only need for high levels of care for part of their pregnancy.

We are all aware of the publicised cases where there are no beds available in local neonatal intensive care units and by its very nature that provision has to out strip demand. That is very difficult to accept within a cost conscious culture, but we wonder what creative thinking was employed in developing ways in which the temporary and used capacity, nursing capacity can be used to the benefit of the hospital trust and the community as a whole. I wonder how the capacity of the problem would be overcome within a joint unit. Can we be reassured that provision will be adequate and local women won't face the further disruption of travel onto Leeds or beyond. With this particular option the gynaecological services will actually be focused in Halifax. If a woman is presented at A&E with abdominal pain, what would the A&E department do? Abdominal pain in a woman of child bearing age may well be an indicator of eptopic pregnancy, at which time speed can be of the essence. What is going to happen to cases like that?

Option 2 where paediatrics is retained on both sites. We wonder what kind of in patient paediatric cover would be provided at both sites. Will it include services across the age range or will one site presumably Huddersfield for major emergencies provide a stabilise and transfer service. Sceptically we wonder whether in fact this is a short to medium term proposal which acknowledges that such a service will be able to highlight short comings easily and then argue the transfer of all services to the one site. The SECTA report highlights difficulties in recruiting and retaining high quality staff at the present site. There are no details about how the situation would be turned around and again we wonder how attractive paediatric posts would be on a site where there is no in-house in-bed maternity provision.

Option 3 where the gynaecological service remaining at Huddersfield. We feel here that particular consideration will need to be given to women and their partners who are suffering a miscarriage. When would they stay in Huddersfield and come under the gynaecological ward and when would they go to Halifax and be considered part of the maternity service remit. We are very aware that for some people suffering a miscarriage even very early they prefer to have the links with maternity services where they feel that their pregnancy, even carrying the baby for a short time, demands this acknowledgement. This often conflicts with the medical definition of a miscarriage. This option and option 1 has particular problems we feel, particularly for families with children having babies in Halifax time, distance, cost, childcare arrangements, arrangements for having to take time off from work.

It is well known and well researched that, generally, children and families do better if close contact can be maintained, particularly if a hospital stay is extended. Similarly, there is a great deal of research evidence to show that babies who have close contact with their parents progress better, even if they need the high tech support services, the special baby care units or neonatal intensive care units. This contact has positive health benefits for the babies and positive mental health benefits for the family. If the opportunity to retain maternity services is lost in Huddersfield, there are several comments about the low tech suggestion that concern us. Will the low tech option actually be taken up? We note that the language in the report is conditional and this is at odds with the rest of the language in this report. We believe it is very clear on careful reading.

We are aware of comments from some medical staff suggesting that they would not be happy with this option and that some GPs have already said that they would not wish to refer women to this service. Again, one of the central arguments in Changing Childbirth was that the women should be given the option of who was the lead person in her care who would, except in exceptional circumstances, deliver most of her care. The intention of this was to give women access early in pregnancy to a maternity services expert who would ensure continuity of care within the limits of NHS cash. We know that this has not happened locally although it has in many areas of the country. We know that the majority of women we have spoken to over the years were never given the option to have a midwife as the lead professional or given the choice of where to have their baby.

The GP has effectively acted as the gatekeeper, deciding what options to offer the women. Would this be the same with a low tech birth unit? Some GPs have taken the decision that this was not an option they favoured and therefore not given women a choice of using it or dissuading them if she chose it for herself. This may seem like paranoia but I think as Cherry has pointed out it happens. Therefore we would like to ask what steps would be taken to ensure that the low tech option was taken up. Would it form part of an integrated maternity services strategy both for the short, medium and long term? How would it be promoted and supported to become a centre of excellence, as they have in other areas of the country? For this to happen, adequate funding needs to be available and a sound strategy employed to recruit staff to this unit who actually want to work in a unit like this who have the confidence in their own skills. I would have to say that if this does not happen I feel, and I think my colleagues would agree, that the Health Authority and Local Hospital Trust would be open to the accusation that this is merely a sop to the local population for the short term taken with the clear understanding that in the medium to the long term this service will wither on the vine.

I have already mentioned lack of continuity in care. Often women comment: "I never saw the same midwife twice", "my midwife was away on a course", "I want to see my midwife but the doctor had to see her". The opportunity for developing the relationship where the woman feels able to raise even small problems is very easily lost and continuity of care using the written notes approach is not a replacement for it. The centralised service may be able to continue to provide continuity of care but often you get a de-personalised service. You only need to ask, as we have done, women who are using much larger units to find how difficult it is for them to feel anything other than they are being processed. How are we going to avoid this locally? What specific plans can be made so that care looks after the psychological needs of the woman for support as well as ensuring that her medical needs are met?

We feel the prospect of having increased care in the community is an exciting prospect, however, again, we note that there is a distinct lack of precise options and information about how the Health Authority would see this developing. We feel that if the maternity services get centralised in Halifax this really must be clarified and committed to with integrity. So far there is very little convincing evidence presented by the hospital and the Health Authority to demonstrate how changes will lead to improved quality of care and choice for women. We are particularly disappointed to see in the SECTA report that no reference was made to the research which actually backs up the options that they are suggesting. I am also very saddened to read the quality of the handout produced by the Health Authority which gives a nice overall gloss but again refers to very little of the essential issues.

We note the lack of emphasis on midwives and their role. How it will be protected, enhanced and developed in line with changing childbirth interface and the Audit Commission's Report "First Class Delivery" is another cause for anxiety. The emphasis of the report leans on consultants and doctors which seems to marginalise the key element of the service and one for which the majority of low risk women co-ordinate amongst all of their care. Kirklees and Calderdale Health Authority have come up with a 75% of women being low risk, that is an extremely conservative estimate. Again we are concerned that this points to an increasing medicalisation of childbirth. Will arguments about the safety of the delivery in a low risk unit without consultant cover and special care baby units support mean that this option will eventually be abandoned locally, even though there are numerous examples all around the country of low tech units working extremely well and achieving high safety records? All of these anxieties refer to women centred care and the effect the changes will have on them.

Of particular importance to us is how the equity of services will be ensured for all groups in the community. We all know that the experience and choices offered for women who are articulate, who have the personal ability to access information and access research are very different from other women in the community. We hate to feel that that would be perpetuated with these moves. This is particularly highlighted when considered the difficulties of travelling which I was pleased to see you have taken up. Again, most of these things have been mentioned before ad infinitum but I do think they are worth emphasising. The effects of hospitalisation of high risk groups, where families have to travel by public transport is extremely difficult. You only have to go and sit in Leeds and listen to the stories that people tell about how difficult it is for them to get there from Huddersfield and Halifax.

Having ones child is a time of Catharthis and there is a huge need for family support. That support is severely stretched when you have to undertake significant journey times incurring extra childcare arrangements - do you go and not be given the support because you have got two children running around your feet who are being frowned upon by everybody else. These are very practical things that women and their families have to face day by day. Travelling by public transport is extremely costly. How will this affect women? Will they actually find that more women miss ante-natal appointments than is at present is the case because they cannot afford or cannot face the difficult journey? We all know that parking is bad enough in Huddersfield, but in Halifax it is even worse. What steps are going to be undertaken to ensure adequate car parking is available without increasing the already difficult situation for local residents living around the hospital? Having gone to visit a friend I had to park about half a mile away.

It is quite interesting to note as well that there will be times when women need to be transferred whether a low tech unit is here or not and women who will decide to have babies and need to travel to Halifax in the rush hour. There is always the risk of women giving birth on the A25, but I think there is a serious consideration that we must face of women getting stuck on the Elland by-pass and delivering their babies early, particularly with second and subsequent babies. The other side of the coin is will the fear of having a baby on the journey lead to early hospitalisation when we know that early hospitalisation during labour leads to increased intervention. I think we also need to face the fact that significant numbers of users of the service will "defect" to neighbouring hospitals. If you live in Denby Dale I guess you won't necessarily want to trek to Halifax. We know already some women choose to go to Barnsley for example. If Doctor X in Denby Dale use Barnsley for maternity services why not use them for orthopaedics as well etc. etc.

We wonder whether a realistic study has been carried out to estimate the effects of these "defections". We also wonder what effect this will have on other services in Huddersfield, particularly in the medium to long term - will A&E be at risk? Without paediatrics possibly and maternity expertise, how viable will an A&E become? Will the difficulties of recruitment, which the SECTA report refers to, be exacerbated? Pure logic would appear to suggest so. I wonder why, if I was a Paediatrician, I would chose to sign up for Huddersfield if there was no in-patient maternity services. There is already a problem with staff morale.

If you talk to midwives in the street as I do then they are not very happy. How can cultural issues surrounding staff morale be addressed? How can we start to rebuild relationships whatever decisions are made? If even the low tech is not taken up, how many midwives would want to practice within the Huddersfield district when there is very little opportunity to practice intra partum care, when they would be delivering, one presumes, ante-natal and post-natal care? We note that there is no mention about the option that is available to all women of having ones baby at home. Again, we wonder what services would be put into place to ensure that this remains a viable as well as a legal choice.

The next point is a point which is particularly dear to NCT hearts - we were instrumental in setting this up. Huddersfield hospital currently have a milk bank where volunteer drivers act as collectors to women who are prepared to donate breast milk to very sick or premature babies. This is of proven benefit to babies in neonatal intensive care or a special care baby unit where the baby's own mother is unable or unwilling to breast-feed her baby for whatever reason that is. There is no milk bank at Halifax and we would suggest that it is unlikely to transfer due to the set up costs, extra travel time and the fact that in Halifax there are no women who at present donate breast milk - in Huddersfield there are those women. We would be losing donors, potential donors and drivers.

Finally, we want to ask on what basis the decision is being made? The options that are coming out of the debate are centred on Halifax - why? There is no reference to that in the report I have seen. Other hospitals have similar numbers or fewer deliveries and maintain a neonatal intensive care unit. Why are the options for retaining all the services in Huddersfield not being considered, or at least not in the public arena? Is it, one might wonder, whether the Hospital Trust haven't fought hard enough? We all know midwives are told not to discuss openly what they felt. It is hard to maintain our trust in the Local Health Authority when these debates have gone on behind closed doors. Are considerations financial? It could well be. Should

not the research based evidence be made available to help us form a more objective decision?

The cynic might recall that Halifax is to have one of the first PFI hospitals in the country and we may wonder how much influence this has had on the decision making so far. We finally would ask that, even at this stage, all parties reconsider and that you, as a Commission, use whatever means it has at its disposal to ensure a satisfactory outcome for all parties.

QUESTIONS AND COMMENTS

Question: Can I ask you if your organisation has anything to say about the proposals for the special care baby unit.

Answer: There would be increasing pressure on GPs to advise women not to deliver locally because they are going to be concerns about the lack of back-up which may be needed and I think it just adds to the pressure that was mentioned during Helen's presentation.

Question: There is a difference between neonatal intensive care and special care. You can be in special care for many days and that has a very serious implication for a mother wanting to maintain a proper sort of bonding both with her baby in special care and with other children at home. You mentioned breast-feeding, it is very difficult to maintain breast-feeding when you have got a child in special care.

Answer: If you talk to women who have had babies in special care and possible neonatal intensive care for any length of time it is a huge issue. How to find enough time to spend with your baby when actually you have got other responsibilities at home and this mental tussle is really quite great for many women.

Statement: I would be grateful if you could take that back into your organisation I would like to hear the evidence of people who have experienced this.

Statement: I think midwives will be very unhappy with a low tech unit where there is no back up.

Some midwives were saying to us in October that there understanding was that the low tech unit would remain in Huddersfield with a special care baby unit. It was only later that it was made clear to them that that was not the case.

Statement: That is different from what we have heard from Trust Members. They say they can provide it on both sites.

New Voice: We heard evidence two weeks ago about the cost of litigation resulting from problems at birth and the professional advice was that this area required more specialisms.

Answer: I think actually what we need is a degree of honesty within the debate about childbirth, because actually childbirth carries some degree of risk, but however much you centralise services, however much high tech is put in place, you will not guarantee 100% of babies safely delivered. In fact, the neonatal services in terms of perinatal neonatal mortality for both women and children and babies have virtually not moved in the last few years and if you compare those high tech units with very low tech units there is very little difference.

It is very easy to believe that the more high tech you have got on site, the better outcome, but it is just not backed up. One specific example - I had my first baby when electronic foetal monitoring was brought in and I remember sitting in conference, heavily pregnant, being told that if every woman were to continuously monitored during labour then cerebral palsy would be a thing of the past and, in fact, the rates for cerebral palsy barely moved at all because it was based on a false premise that cerebral palsy occurred during labour when, in fact, it is as a result of a long based insult to the baby during pregnancy. So I think it is very easy to say driving is dangerous therefore we will all drive in tanks, when actually driving is dangerous and we need to take care.

I think the response you got was a typical medical response. There is enough evidence - I haven't brought any but it can be furnished - to say that if you involve people in their care process whether they have got a normal situation as a pregnancy or whether there are disease processes present - that the more you engage with that client as a clinician, the less likely you are to have problems, because there will be a better understanding, a better dialogue, a much more available exchange of appropriate information and therefore greater medication and treatment confines, so the outcome is going to be much more favourable. Therefore the consultation process needs to be taken at an individual level.

In the United States, where childbirth is medicalised in a way which we have not even begun to consider, the litigation rate is phenomenal, so actually having a high tech unit and low litigation rates does not follow - one is not a consequence of the other. Additionally if you talk to women who are complaining and I guess Cherry may well have covered this, one of the things which makes people go on to make formal complaints is because they have not been kept informed because nobody has said "I am sorry, we should have done better" actually accepting initially some lower level - if you like - failure is one of the large contributory cause to women actually going on and getting very, very angry about what happened. If they had met with less defensiveness, very often women will have backed down and come to some sort of arrangement. It is actually again a psychological process which they undergo. It is long understood that there are other ways of dealing with this. It is a cultural problem and there is no evidence to suggest that you will reduce the number of claims just because you go to a high tech situation.

Question: If there are two special care baby units, what is your opinion about that option?

Answer: I think it is very different and I think all us, because of our own backgrounds, will have different ideas of what we would consider to be safe. I personally, and I can only speak personally, feel that it would be good to have some consultant cover, however, I am very mindful of the fact that there are lots of units who only have minimal consultant cover and yet don't have a huge problem with increased

problems, if you like - complications, because they are very good at detecting problems early. You have a high level of midwifery and women interface, they can then detect early what is going on, whereas, at the moment, if you go into a hospital unit you have very little contact with the midwife who is caring for you often because she has a high workload and other things to be done. I think it would be essential to have some sort of medicalised backup.

I think you can look around the country. If we have to settle for the low tech unit in Huddersfield then you can go and see what is the best in the country and find out why it is the best, but it will be the best because of the support that the midwives have around that Unit and not because it is a complete stand alone unit. The detail of that isn't included in the report so it is difficult to comment on, but there are low risk units that run very successfully.

Statement: So, if we move down that line, it has got to be properly planned using all the research that is available so that we actually get a proper balanced service. You could say that about all the other services because we have no evidence of that as being done in any of them.

Statement: Just a personal perspective. I worked in a country in Africa that was in civil war and one of the issues for that population during childbirth was to be at a safe place to deliver and there was a strategy to accommodate that. The end product of that process was to get women into the city to be delivered safely. Distances of perhaps only 15-20 miles away actually created a phenomenal impact on the emotional and mental health of the families and the women themselves, and in fact that strategy went further because they tended to induce the babies earlier as well and so we had some consequent problems around that. Having said that, the point that I want to raise is that when women are actually put into a position of having to undergo a normal birthing process away from their natural environment where it might well be just as safe is that that itself imposes a lot of mental health problems on the community.

Statement: So a mother giving birth in fear of not understanding what is happening is more likely to have medical problems than one who goes through the process of fully understanding and is totally relaxed.

Question: Does a high tech unit actually result in higher litigation costs than a low unit or does it depend on the culture of the unit?

Answer: I think the culture of the unit has a great deal to do with it. I think where women are fully informed of decisions about their care and can understand why things go wrong and are kept informed step by step about what is happening then, yes. I can go to my book shelf and find research which is soundly based which says that low tech units have a lower intervention rate and most of the problems around litigation are around intervention.

Question: I think it is worth exploring. Litigation costs are enormous. Is it when intervention was for safety or is it when there was intervention for other reasons or both?

Answer: I think that in discussions of whether intervention was appropriate we need to consider the 'laying off' of blame because if there is something wrong with my baby I may find it easy to come to terms with it if I blame someone, therefore I blame you.

Statement: Childbirth and child care is actually a partnership between the services and the women involved not something that services do to women. I think what comes over loud and clear that is that both the Trust and the Health Authority do not see it like that.

Statement: The more you specialise the less you have a partnership. Actual specialisation can mean a narrowing which leads to departmentalisation problems.

Statement: For partnerships possibly the obstetricians and specialists are people you don't necessarily need, they need to be in the background but the people providing the real partnership are the midwives.

Statement: I was talking to someone at the ante-natal classes last night - we were talking about birth plans and we were talking about what ifs - what if you need a caesarean section, what if you need forceps and she said it is really interesting, I sat down with my midwife the other day and we filled out a birth plan and we were discussing this that and the other but when it came to my preferences for forceps or a caesarean section she said "don't bother to fill that in" and this woman said to me that she felt the evidence between them is quite strong from the midwife that in those cases then it really was their job to do everything and that she would not have any say.

Now, of course, we all know that you don't have a baby like you drive a car, you don't depress the clutch before you change gear - it is actually far more complex than that and we do know that some units have very low intervention rates but very good outcomes. So actually there is room for negotiation around caesarean section rates, around forceps, around induction rates, but if the pressure all the time saying this is the professional stuff keep out then it makes it very difficult for women to continue to feel part of their camp and to continue to be part of the action which again is detrimental to their ability to cope with the experience.

Chair: Thank you for attending the meeting.

D4K078

KIRKLEES METROPOLITAN COUNCIL

SCRUTINY COMMISSION ON CHILDREN'S AND WOMEN'S SERVICES

JANE BOOTH, CHAIR, AREA CHILD PROTECTION COMMITTEE

Thursday 11 November 1999

Jane Booth: I thinks it's important to say that some of you will be used to seeing me wearing a different hat, but I have been invited here as Chair of Area Child Protection Committee and I shall try and stick to my brief. There may be questions you want to ask me about the implications of this for children care in Social Services in Kirklees which is my other hat, you may want to do that as part of this and we need to distinguish which is which or you may wish me to come back to do some of that another time given the time constraints you've got and I would be happy to do that if you wanted to go beyond the child protection brief.

Area Child Protection Committees operate in all Local Authority areas and the Area Child Protection is one of the agencies that will be consulted by the Health Authority as they progress towards the reconfiguration of services. The Area Child Protection Committee has not expressed a view about the current proposals and may not be able to do so given that it is a consortium as it were of all member agencies involved in child protection including the Health Authority and the Trusts, but what the Area Child Protection Committee will do is to make sure that it raises with the Health Authority those issues that it feels must be taken account of in reaching a decision. Safeguarding of all children is the priority and, as Chair of the Area Child Protection Committee, I recognise that clinical excellence and sound child protection procedures shouldn't be seen as competing issues and that we ought to be aspiring to a model that can achieve both. So that's where I start from.

We've heard a fair bit about the framework for child protection services. Child protection services are set within a national framework and they are currently regulated by the Department of Health and set out in a guidance document called Working Together under the Children Act. That document is approaching ten years old and is to be replaced in the Spring by a document called Working Together to Safeguard Children. Those documents are issued under a particular framework that give then the force of law so they are a requirement upon Authorities to comply with them. The existing guidance and the new will both require that an Area Child Protection Committee should exist in every Local Authority area and specifies the responsibilities, we'll just quickly run down those. Because I think as we look at the responsibilities of the Area Child Protection Committee, what I hope we'll do is begin to think about how those might be affected if the work of protecting children

routinely spans more than one Authority. In certain circumstances, of course, with individual cases that already happens, families don't stay put, families move around, but what I've tried to address is what the impact might be if routinely we were managing services across more than one Authority.

The Area Child Protection Committee has a responsibility to set out inter-agency policy and procedures which are subscribed to by all participating agencies, the Health agencies, the Education Service, the local Police Authority, the local Probation Service. A wide range of agencies subscribe to and adopt the policies and procedures agreed within the Area Child Protection Committee. The more players there are in that role, the more complex the matter becomes. Currently the Kirklees Area Child Protection Committee procedures look like this and there is an equivalent document in Calderdale. They arise from the same Government guidance but the contents is subject to local interpretation, reflects local structures, local practice and local thresholds in terms of child protection registration, and although the framework is the same, the detail of the contents differs significantly from area to area and there is no intention on the Government's part to introduce a national standard.

There will be a national framework with locally applied and locally interpreted procedures. It's the expectation of the Area Child Protection Committee that this is accessible to every practitioner, whatever service they work in, who has a responsibility to work with families in relation to child protection and should be available at every work base and be accessible. It is this document that the Government turn to if there is a tragedy to say local procedures have been adhered to in cases where there is a child death that is suspicious or the death of a child on the Child Protection Register. So it’s a significant and important set of guidelines. My experience is that it is well used by staff. Staff do turn to these procedures, agencies do prioritise training and induction in relation to child protection procedures in their localities. So that's one significant area of work that would need to be addressed in a particularly different way if we were going to run our child protection services routinely across more than one Local Authority area.

The second responsibility, and this is a summary of the new guidance which we expect to come into force during the spring, will be to evaluate the effectiveness of services. At the moment both Kirklees and Calderdale have systems for evaluating professional practice and those differ in content and nature. There would be no obstacles to thinking about linking those systems together but you would need to take account of the added complexity of evaluating workloads and management of cases under different frameworks at different times. Establishing performance indicators, again no major obstacle in doing that on any combination of the services you chose but more complex the bigger you get. Developing good working relationships across agencies and mutually agreed definitions and thresholds is actually an important area to think

about. The Department of Health published last year a book called "Messages from Research into Child Protection".

One piece of research, which was done by Christine Hallitt and a woman called Birchill, looked at the level of inter-agency co-operation and collaboration and concluded that the expectations of policy makers in respect of good working arrangements were mirrored by professionals' own willingness to enact the guidance. It wasn't simply a paper statement in the guidance that people should work together. They found a lot of evidence that professionals actually themselves saw the importance of doing so and the benefits of doing so. But what they did say was that it ain't easy and that it depends on good communication, on common value base for the work that is being done, on joint training, and a good working knowledge of each others' practices. I'll come back to that when we begin to talk about how you might manage particular cases, but I think that's an important thing to remember, that there is an enormous willingness for people to work together and to work well, but it's a complex affair. It needs to happen at all levels, it needs to happen in terms of political will for procedures and practices to be synchronised. It needs to happen at an officer and policy level, it needs to happen at an inter-agency level and it needs to happen at a practitioner level. We've got to get it right at all of those if its going to work.

Promoting a learning culture informed by research maybe not contentious in this context, undertaking case reviews, this is both at two levels, routine case reviews to look at practice in terms of evaluating effectiveness but also statutory reviews where there is unfortunately a death of a child where the circumstances are suspicious or the death of a child whose on the Child Protection Register in whatever circumstances. These case reviews are reported to the Secretary of State via the local Social Services Inspectorate and it's on the basis of these reviews that the Secretary of State determines whether or not to call a public inquiry. They are often difficult reviews to undertake, they often need to look at professional practice in a great deal of detail, they often require agencies to develop a level of openness and willingness to discuss issues. That is more easily done when professionals are used to working together.

I think it would be very complex to set up a review system that routinely intended to span a number of Authority areas, but none of this is impossible. Establishing frameworks for shared responsibility, again the Area Child Protection Committee is largely seen as the vehicles through which that is done. The new guidance does say, and it's particularly thinking about small unitary authorities, that there might be some cases where Local Authorities would consider having an Area Child Protection Committee that spans more than one Authority, and that might be something that we would have to come back to and consider seriously if we were looking at configuring women's and children's services across more

than one Authority, and to ensure inter-agency training and development is delivered.

In Kirklees the Area Child Protection Committee has a sub-committee that manages training for all the agencies. It provides induction training at Level 1 which is freely available to all staff who might come across child protection issues in their work and then more detailed and more specialist training in other areas. This is funded largely through the Social Services Training Budget and the Training Support Grant available from the Department of Health. Our professionals, in feedback, say that one of the things that they find most beneficial in the training is that they find themselves training alongside the professionals with whom they are working on a day to day basis. So that we train Social Workers alongside Health Visitors, alongside teachers, alongside paediatricians in order to get a common basis to the way in which we take work forward. And the third one raising community awareness of the need to safeguard children, again perhaps not contentious in this context.

The co-operation between agencies that is required in order to manage Child Protection cases well, like the Area Child Protection Committee, is also mandatory. The Children Act 1989 has two sections within it that empower Local Authorities to request the co-operation and collaboration of others, Section 27 and Section 47, which are about assessing risk and managing child protection risk once an assessment has been made. The guidance requires Health Authorities to consider how they might manage the interface with Local Authorities and addresses two issues that are perhaps relevant in relation to boundaries. The guidance, specifically the first one, is a quote, the second one is a quote with a bit missing out of it, from the new guidance which specifically addresses ACPC boundaries and I'll just read it to you in case its not easy from the back:

> "Where boundaries between Local Authorities, the Health Services and the Police are not co-terminus. There can be problems for some member agencies on having to work to different procedures according to the area involved, having to participate in several ACPCs."

This doesn't just come as a thought to some civil servant somewhere, this arises out of the Department of Health analysis of 20 case reviews into child protection deaths and where there is a significant finding that boundary issues can impair communication if not well managed. In a significant number of cases where families were dealt with in more than one Local Authority area by a number of agencies, history has shown that sometimes people fail to pass on relevant information and that's particularly important for those working with families where children are vulnerable to understand the procedures and the thresholds and practices of those Authorities who need information in order to protect children.

The second quote on here is about how hospitals and Community Health Services should structure themselves in order to facilitate child protection work. It says each National Health Service Trust providing obstetric and child health services (and it includes Primary Care Trusts) is responsible for identifying a named doctor, a named nurse or midwife who will take professional lead within the Trust on child protection matters, and it goes on to all staff should be aware of local protocols know the names and contact details of relevant named and designated professionals and should be familiar with local procedures. Now, at the moment, that's achieved because we are all signed up to an ACPC within Kirklees and we need to make sure that if the way services are configures in relation to health care change that those issues are carefully addressed.

I'd also like to talk about some of the legal issues that might arise. Responsibility for child protection cases, and particularly for a child who is perceived at this point in time to be at risk, lies with the Authority where the child is. So, if today, a child is admitted by casualty in Huddersfield who belongs to Rotherham or Rochdale or wherever, the initial responsibility to ensure that child is safe rests with us in Huddersfield, until we can persuade and be satisfied that Rotherham or Oldham or wherever they have come from is making proper and robust arrangements for the protection of the child. The child's address might be in Rotherham, and Rotherham equally have a responsibility to ensure that because the child is normally resident with them, the child protection issue is properly addressed. But it does mean that both systems have to be capable of taking on board that issue and working together successfully on it.

We know it’s a difficult area, we know there are difficulties we currently experience when children are out of the Authority or other people's children are in the Authority in marrying up practices and procedures. I have to say that it doesn't please me that sometimes we have difficulty in agreeing the risk assessment and that there are occasions where there have been concerns expressed by one Authority about a child that are not shared by the other. If we were to suppose that we had only one site dealing with neonatal intensive care and paediatrics for the Huddersfield and Halifax area, then both Authorities would have a responsibility for the initial child protection assessment when the child was out of theirs. So if the neonatal intensive care unit happened to be in Huddersfield and a Huddersfield child was there, then the system would be as it is now. If it happened to be a Halifax child who was there, then both Kirklees and Calderdale would have some responsibility in the first instance for assessing the risks to the child and making sure a plan was put in place. Until they negotiated an agreement about whose responsibility it was, many children who it would be considered to be high risk will unfortunately fall disproportionately into those for whom there might also be seen to be a child protection risk.

You're previous witness (Dr Brian Gill) was talking about some of the people who might be considered to be high risk and I think he said that up to 50% of births might be considered to be high risk, but within that 50% he talked about people one third having their first pregnancy, didn't refer to but I will, those parents for whom there is an issue about drug use, and we are well aware that we are doing and increasing number of pre-birth assessments in relation to child protection issues. A high proportion of those births will be deemed high risk births and therefore likely to be delivered or recommended to be delivered on a site where there is going to be high quality clinical care at the point of delivery. That will be the same in Calderdale, they will be in exactly the same position. It raises practical issues about how you manage child protection cases.

If we've done a pre-birth assessment and recognise the child is at risk, it's very likely that a recommendation will be made that the child's name goes onto the Child Protection Register at the point of birth. If a child who belongs to Huddersfield was born in Calderdale at the point of birth, the Calderdale staff will need to invoke the Huddersfield child protection procedures in order that a Case Conference is called to consider whether or not that registration should be continued. If the child from Huddersfield is born in Calderdale and we've done a pre-birth assessment and decided that we think the risk is manageable but requires statutory involvement, we need to take a Care Order. There will be an issue about jurisdiction and to which Court you go to seek emergency Protection Order and subsequently an Interim Care Order. These are all issues that can be resolved but they are all things that need to be taken account of. There are issues about family time and staff time in relation to managing child protection meetings where precious clinical time often requires us at the moment to hold those meetings at the hospital, because we recognise that clinical paediatric consultancy time is precious. But the further distance that is away from where the family, are the more difficult it is going to be for us to enable them to fully participate in those processes.

The second issue would be that often a pre-birth assessment leads us to a point where we know there are some risks and we want to facilitate mother/child relationships and assess the quality of relationship that develops and the quality of care that's given. Again, wherever the central unit is will be the Authority in whose area it is not. That poses just a bit of an additional challenge as to how you manage that slightly at arms length. Where cases fall within the ambit of a slightly older child, and maybe a child has been admitted to hospital following an injury or because of neglect, then if this model were to result in all paediatrics and particularly in-patient services all being on one site we would then have to consider the implications not just for new-borns but for older children who were seen to be at risk. Again, if a child were admitted in an emergency and the assessment was that the injury was significant and non-accidental then all the issues about case

conference, care proceedings etc. would need to be well managed and, in my view, would be more complex than they currently are.

Often when we are doing assessments we seek to try and facilitate the maximum parental contact and the issue you were raising with the previous witness. If we have a mother whose parenting skills are of some concern, the last thing we want to do is to disrupt an early mother/child relationship unnecessarily. That applies to neonates but it also applies to other children who are in hospital. and it has to be said that, although we don't do it often, there are occasions when we get co-operation from hospital staff to maintain the child in hospital because we can actually facilitate a higher level of contact by the mother being virtually able to live at the hospital with the child than we could if we moved the child out into foster care. So those are a few of the things that I just wanted to put on the table really.

As I say, I do it from the perspective that whatever model comes out of this, I think arrangements can be made. Systems can be made to work but I wouldn't wish to pretend to you that I think it's a simple matter. I think there are lots of complexities in there.

New voice: So, from the Social Services point of view, we should be looking for amalgamation with Dewsbury, not Calderdale?

Jane Booth: If you were looking from a Local Authority perspective that's where you would be looking. I have to say there are other concerns because I don't think it's just about Kirklees and Calderdale. My belief is that if we go down this model you will find people on the peripheries going out elsewhere so that I think you find, for example, child protection agency staff working in the south of Kirklees will find themselves needing to get their heads round Kirklees procedures, Calderdale procedures and Barnsley procedures because I think that that's what would happen there. I think for Calderdale staff they will find themselves working with Calderdale procedures, Kirklees procedures and Rochdale procedures because I think people in Todmorden will go in the direction of Rochdale.

Question: If we have the same thing over in Dewsbury, it would also end up doing Wakefield and Leeds?

Jane Booth: Yes, and we already do have to manage complexities in relation to Leeds. I'm not saying we end up with an unsafe practice, but it is more complex.

Question: Have you looked at other areas to see how child protection issues work?

Jane Booth: I've tried to have a look at what's happened with Local Authorities where boundaries have changed recently, and some of the unitaries have gone down the road to saying let's try and have one Area Child Protection Committee that spans a wider area. There may be

some advantages to that. Certainly, in terms of criminal proceedings, which is another complexity in here, if a child is in hospital as a result of an injury which may have resulted from a criminal offence, then the investigation of that is the responsibility of the Police Division where the offence was committed, so in the same way the Child Protection procedures would have to work across Local Authority boundaries. Police investigations would have to work across Police Divisional boundaries.

I have tried to look at what's happening in other areas and, as I say, I think these things can be made to work. North Yorkshire has always had to manage a sort of high level of centralisation, simply because of their geography. If I lived in Scarborough and needed neonatal care for my baby I would be in a much worse position. So I support some of this is relative. But certainly in the London boroughs where people hop about hospitals and Local Authority areas they have found communication to be a real problem. The benefits that we get from having staff who routinely work together are difficult to maintain in those circumstances.

Question: One of the things I have been trying to get at with other witnesses is the way hospital services are used for things that are not necessarily about acute needs of children, but about the more social aspects. One of the paediatricians said you should never have a child in hospital unless you have those particular acute medical needs, but I suspect that other people would have slightly different views about that because other evidence we get from psychologists and some of the nursing staff suggests that the availability of the hospital place being very important for the maintaining of health of a child in a sort of broader sense. You've touched on that. How often does it happen? Does it happen for other reasons as well as just the acute non-accidental injuries?

Jane Booth: It sometimes happens to reduce the number of changes the child would experience because of administrative reasons. To be honest, I'm not promoting it as a good model, but if for example a child was going to be ready for discharge from hospital tomorrow, and needed to be accommodated in Local Authority accommodation and the foster carer was available on Friday, it may well be that, with quite a bit of grumbling about each other, a pragmatic approach would be taken and the child would remain where it was until it could move to a place where there was stability. It's not a good practice model I have to say.

You would like to think things are lined up nicely, but on occasions when things don't go that well it is possible for a child to find themselves staying on the hospital ward, getting good contact with the mother and not having to have an additional move because of the willingness of staff to work together in the best interests of the child. There are other occasions when children not needing treatment will find themselves on wards for observation in sort of grey areas where there might be issues of growth and development. It's not an everyday occurrence.

Can I just say, now, I know you want to move on, but there is only one reference in the documents that I have about child protection, and I think it relates to the cross-boundary stuff. It is a legitimate point in that what it does say is that, despite all the concerns I've raised, there are some people who currently hop between Calderdale and Kirklees in relation to hospital, and particularly Accident and Emergency, for whom you could legitimately argue a one service perspective would be beneficial.

Chair: Thank you for coming today.

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KIRKLEES METROPOLITAN COUNCIL

SCRUTINY COMMISSION ON CHILDREN'S AND WOMEN'S SERVICES

MS DENISE CAMPBELL, HEALTH VISITOR, THE RIDDINGS CLINIC

Thursday 11 November 1999

Denise Campbell: I'll read from some of the information that I have gathered over a period of time. The background starting with the presentation public meeting on 4 July in discussion with a few people I am saying a few people for reasons I will explain later. There was a welcomeness to change in terms of response to need which is a fundamental requirement but there was no doubt about the medical expert's ability to do their job or their intention to work towards achieving improvements in the service they deliver. The public need to respect the clinicians views on how they believe they can do their specialised job better particularly their conditions and their working environment.

The media profession's acknowledgement of the vital contribution for the services and professions enabling them to jointly achieve the best quality care was welcomed. However, all the medical clinicians need to improve their communication to share more effectively and to work better together to support and enable high standards of practice which is currently termed clinical governance. Relocating or re-configuring services will not however appropriate the environment enforce better communication and raise standards of practice. The medial representation by implications suggest there are current low or unacceptable standards of care and I believe that if this is the case centralising services are more likely to transfer and concentrate the low standards rather than improve them. Unless all service personnel are trained and have a will to work better together replication of low standards will be perpetuated.

The point of the holistic model is to see that the whole picture is relevant to the service users not the service providers. The consequence of an action affecting other issues which are likely to be as enduring and equally problematic. Primarily change should come as a response to user evaluation as well as developing science and surely the skill of the practitioner is the art of interpretation of knowledge and understanding for the benefit of the user not simply moving service sites around. The question came up, "has anyone done an analysis of the complaints of the service in the last five years or the litigation cases to evidence the

model for change". Why take away the local provision of maternity led services from the majority of women who consider and wish to be treated in a way that pregnancy and birth is a normal natural process and what was "Changing Childbirth?" all about? Where's the evidence to say that local people are dissatisfied with the current services and, where this evidence exists, what has currently been done to address it?

The only hope in the presented model are the proposed community sites but even these are focused on a consultant and not on the level of supporting normal maternity care and delivery or strengthening primary care services. About the matter of change - the Health Authority have a well documented and celebrated Health Needs Assessment process to identify need and in collaboration to plan solutions to needs with the general public or specific user groups. This is a model that has been well researched and produced by Dr Judith Hooper and Phil Longworth. Consultation with public is intrinsic to change process and seems to have been avoided in the first instance here.

Some of the basic points - whilst the current process of the reconfiguration issues fails to be an inclusive process from the outset, there has been no fundamental difference in choice of options in the existing debate and what has been available has been at a level that has generally excluded people at the margins of social exclusion and has little substance to promote an honest debate. Why for instance is this not being linked to the Young Citizens Plan and the children's HIMP. There are the women who are less likely to attend for appointments, less likely to seek anticipatory guidance but equally likely to make high demands, seemingly inappropriately following a crisis, and these particular women live under the umbrella of being defined as being socially excluded.

The issues of providing evidence from statistically minuscule numbers is seemingly meaningless. The simple logistics of available delivery beds within projected birth rates seems to be nonsensical. How many beds are at Halifax, how many beds are at Dewsbury, plus how many babies will be delivered? I think we will be having them tiered, don't you. Centralising services will reduce the accessibility and acceptability of the services for a large group of the population its seems crazy to talk about shuffling a population group of 5,000 to 6,000 around over a period of a year for 5,000 to 6,000 births rather than a team of experts of ten people. It certainly makes much more sense from polluting the environment.

Maternity services may well need to change but this must be done with the causes of need in mind particularly the socio-economic factors which are often the real reasons why maternity services actually fail, not just the requirements to achieve clinical excellence or professional kudos. There is an issue that is very rife within the community and this is one I thank that has been marginalised, and that's one of civic pride. There is nothing more important to people to actually declare where they have been born and within the argument that I think you put forward well, that is a qualitative analysis that should not be left out.

I ask myself finally, can I be an advocate for the local community? Maybe my conscience will allow me to be one in part, in proxy, but we do need to consult extensively with people in marginalised settings what is intrinsically a women and families issue. We are currently in the process of discussing ways to do this. Once we have got a clear line on what the issues are and not the proposals. Thank you Chair.

Question: What effect will centralising the service have on young people, on the mums and babies of Brackenhall and Deighton?

Denise Campbell: I think what will probably happen is that we will get more increase, a higher rate of non-attendance for appointments and there will probably an increased rate of babies born at home. That's an assumption I'm making because people won't want to travel and I would say conversely the same would happen if you live in Todmorden and the services are put in Huddersfield. I have a serious concern about the issues of rural poverty which haven't necessarily been raised, certainly not this morning. The distance they will have to travel there. You have low pockets of concentrated deprivation it doesn't actually clearly come out when you are looking at maps of the area.

Question: One of the pieces of information we tried to get from the Trust was information about the socio-economic background of their customers. What we wanted to know is how many users of the special care baby unit and NNICU fall into the socio-economic categories?

Denise Campbell: Two concerns, I think the numbers are so low that if you actually got that evidence it would be breaching confidentiality. So that is one of the issues which is why you won't get HIV and AIDS, information so specific. The other thing is that if there is any information that should go out or is available to go out into the public domain the Health Authority will have that information.

Question: How do you maintain bonding links with babies in special care when nobody is paying proper attention to how you maintain the relationship with that baby?

Statement by a previous witness: In my business life I'm a consultant and one of the things that you note is that women from excluded groups are treated extremely differently in the inter-personal remit, so even if you get over the exclusion of them because of travel, the way they are welcomed and made part of their babies' care will be significantly different from women who can afford to go to the canteen for lunch, and this is just further evidence of exclusion. I would suggest that there would be an increase to the in-patient take-up for those particular reasons. If the provision had been moved away from Huddersfield and was in Halifax bearing in mind that intervention can sometimes be required very quickly people would err on the side of caution so they would be in hospital for longer periods of time.

Statement by a previous witness: I've served on the Adoption Panel for about eight year until quite recently, and many of the mothers of these children seem to me to leave it very late before they go to hospital. They have no ante-natal care at all. Now if the facilities were moved to Halifax I think a lot of those women wouldn't even know and they would still turn up at Huddersfield and find that they were in completely the wrong place and a lot of these women have problems. Many of them come from very, very dysfunctional backgrounds and would find it very difficult. They don't have the sort of inner resources to keep going to the hospital and to keep contact with the baby.

Chair: Local Authorities have spent a lot of time and effort trying to overcome the impact upon children of social deprivation - one of the key responsibilities we have surely is to try to make it so that it isn't any worse than it is?

Statement by a previous witness: I think within Huddersfield there are pockets of excellence, where we have midwives who communicate with women extremely well and others who manage women and the care that they offer. I remember particularly the debate where midwives suggested that women have access to their own beds which would mean that they could admit women, help deliver the babies, discharge them and then continue with peri natal care. This has just not happened in Huddersfield, and it could well have improved morale between consultants who felt that their role was the decision making and midwives.

In Huddersfield the medical profession the key specialists are driving the debate, and other issues around women's choice, about needs about maternity care have actually been lost along the way.

Denise Campbell: I think that what I would say is that there is a ground swell at the moment of developing the profession at interface with clients in community settings. Around engaging with them. The whole issue like Deighton DBI initiative is to try and get people much more empowered so that they can lift themselves out of this social exclusion by being much more informed and enabled to do so. I think a lot of work needs to go on to get some of the clinicians in the traditional professional roles to take that on board. An acknowledgement of being a powered partnership.

One of the two things that I haven't mentioned - I am deeply concerned about using areas and definitions of social exclusion to further stigmatise individuals. I think its insensitive and its wrong, because there are very little differences in the needs of people just in what they suffer. So that's a particular issue that I've got. What I would like to say to supplement what I've said before is the issue about paediatrics and child protection. Because they cover everybody and to use Deighton as an example would be wrong. It happens just as much in Golcar, it happens in Honley, Holmfirth, wherever.

It's probably not as overt but the issue of paediatrics for me is that if the women's services go on to one site then the paediatrics specialist will move as well - I just do not see how we can avoid that. If that happens, what is going to happen to people who fall outside the Primary Care services? Either as chronically sick or as emergency or impending crisis situation in paediatric care and it's no different for coronary heart disease issues and all the rest but we are focusing on young children of course. We're struggling in terms of being able to deliver services in a joined up way with and for people when we are looking at spanning two Local Authorities.

The bureaucracy and the cultures of different organisations are phenomenal to understand. What are we doing engaging with another organisation, Calderdale Local Authority, I'm not saying that there are any better, any worse, but its yet a different organisation to be in partnership with when issues such as child protection, people fall between two stools constantly and this is why we have child death enquiries. Please God it never happens that we need to consider that in the long-term and with hindsight we could say actually that was a red herring, but I don't believe it is. And we do have different standards, different emphasis, different manner for delivering services.

We don't have effective communication systems. We don't between departments in the Local Authority. We don't have effective communication systems within different departments of the Trust, I'm sure its just the same with the Health Authorities, so what chance have we got therefore when we want partnership between different organisational settings. And each one of those issues impact on creating further and further divides within the health equality. It's no solution, I'm not giving you a solution, but these are probably other considerations that need to be taken.

Chair: The Health Authority do say they have information by post codes of their patients, customers going back for a few years.

Denise Campbell: They have geographic information which has been produced, information on patient flows relating to post code.

Chair: Thank you ever so much for coming.

KIRKLEES METROPOLITAN COUNCIL

SCRUTINY COMMISSION ON CHILDREN'S AND WOMEN'S SERVICES

PHILIP WEBBER, HEAD OF THE ENVIRONMENT UNIT, KIRKLEES METROPOLITAN COUNCIL

Thursday 11 November 1999

Philip Webber: First I would like to say what sustainability means. It means looking at economic, social and environmental impacts. It also means having a local process so that people can see what decisions are based on, and obviously involve the widest number of people. Taking that as a starting point for your criteria then reading the Health Authority report they do not take this approach. There is no clear information, there is no clear structure. Although they do give a list of criteria, you can't see how one weighs against the other.

It is really impossible to judge whether the decisions being made will work. If there was somebody who was going to build an airport in Halifax or Huddersfield, we would have to have an environmental impact statement. All new public bodies now are being given a duty of care to consider sustainable development and sustainability in all their decision making and that is what I have just referred to. They have an open process where they consider all the factors so that they can say what information was used to make a decision. There has not been an environmental impact assessment done for this new hospital. There certainly has not been a sustainability impact assessment on these proposals - so on that basis alone the Health Authority has been deficient in its duty to the public. In other areas of work in the public sector you couldn't get away with taking a decision on that basis.

I have to say you can't really do a proper analysis of the proposals if you don't consider the catchment areas of hospitals. You don't really know where people are coming from and at what times. I was only able to get limited information. So that information simply isn't there.

How should it be done? Well, first of all, there needs to be an initial scoping exercise to determine what the relevant factors are, so in other words you look at what all the impacts are or could be and you ask various people to actually determine what the impacts are and then, using that group of people and some of their expertise, you then come up with an overall decision based framework based on costs, benefits of what these people thought and professionals thought, and those

costs and benefits are not just the economic costs, they can be social costs and environmental costs and benefits. There might be psychological costs and benefits, there are all those sorts of things which are normally not considered, and they certainly aren't considered in the report. Issues such as social exclusion.

What the report is talking about is centralisation and this is a dominant factor in many areas. The proposal is that when people arrive at the centralised point they get a better service and better choice. I do think we have to recognise there are pressures due to the fact that doctors aren't allowed to work as many hours as they used to do , so you have got less cover and the defence against higher litigation. So, using the results of this scrutiny, you need to evaluate what the various impacts are and then try and evaluate these factors, so that is the way the Commission would present its findings. I would suggest you say "these are the factors you can consider" and you say "we haven't considered this set of factors" and the Commission could say on balance these are the factors for and these are agreed, and then take a judgement on what options we could come up with as a result of a properly based, comprehensive, qualitative stakeholder view.

So what you have to know is the numbers not just of patients but of the numbers of relatives, how many trips are being made for whatever reason. We need to know what mode of transport visitors go by. There are impacts on other people as well on the transport. We also know that traffic can get blocked up between Huddersfield and Halifax, let alone get through Huddersfield to Halifax. We don't know what the catchment area is and as I think you have said you would expect people in the south west to defect, as it were, to Barnsley or Oldham where the access might be somewhat better, that is if they have a car and they have got a choice. If somebody relies on public transport or a taxi then that is also a high stress. You are also talking about not just them but their partners and children.

What is a reasonable cost estimate for additional journeys for 5,000 patients and their families? If the answer is that the average cost per patient, family, relatives is more than £48, it would actually be cheaper overall for if all Health Authorities to spend £250,000 more on doctors in net terms. If the Health Authority say okay, we will centralise this service and anybody who hasn't got bus provision we will pay for a taxi, then that would be a reasonable part of the analysis which they could take. It is probably not going to result in litigation because if you are travelling in an ambulance or a taxi and something goes wrong it is obviously not the hospital's fault. Once you **are** in the hospital then it **is** their fault. So, in other words, by centralisation you are casting off a larger amount of potential litigation costs. If the Health Authority say okay, we will

centralise the services and take full responsibility for an incident happening en route, then in litigation terms it would not be sensible to do that.

That is the type of thing that can be done and the other things that should be looked and we are talking separately as a Council about public transport.

That I think summarises what I want to say. I would suggest the Commission draws up a framework, then looks at the work that needs to be done to do this type of balancing exercise and do basically what I would do, which is a sustainability 'in house' assessment.

Question: Basically, what you underline is a total lack of information.

Answer: It would seem that this decision is based on what I would call economic thinking and professionalism. Professionalisation combined with dominant economic thinking. Clearly a new hospital is already being built by private finance in Halifax.

You should expect that the public and all these particular public bodies dealing with these issues to be provided with information when dealing with issues as fundamental as health. The Health Authority should be able to make available the information on which they make decisions and be open and honest about that.

Question: Do you want to add anything from a highways point of view?

Stuart Clewlow: (Highways Service) We don't have the information to hand, but we've seen a copy of a previous study to assess transport impacts. It is quite interesting to look at some of the figures they have got - the Wards with the highest birth rates, the Wards with the highest population of over 60s. People who would suffer are those least able to cope with it financially, those who would be unable to afford transport costs. In terms of the impact on transport, we don't have any information. We have no idea of the number of patients.

Statement: I think the responsibility lies very clearly with the Health Authority, particularly in relation to planning. They need to take proper evidence before they make their minds up. As a Local Authority we may chose to do something the responsibility on them as a public body spending large amounts of public funding is immense in the impact on the local people its their responsibility to consider these issues.

Philip Webber: It isn't strictly speaking their duty to do this yet, but new public bodies, for example, the new Scottish Assembly, and various other bodies like that, are required to. I don't think that it's actually a duty of Health Authorities at the moment and it's not actually a duty of Local Authorities yet.

Statement: Quite apart from the sustainability issues, we as Councillors have a responsibility to make sure decisions we make are reasoned and informed and I do not feel that the Health Authority is making reasoned and informed decisions.

Question: Do you know of any other Health Authorities who are carrying out this sort of exercise in other parts of the country? Do you know if any of the others have done any assessments?

Philip Webber: I don't know about any Health Authorities but, for example, the Regional Economic Strategy and the Regional Planning Guidance were subjected to sustainability by a firm of consultants.

Chair: Thank you very much for coming here this morning.

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KIRKLEES METROPOLITAN COUNCIL

SCRUTINY COMMISSION ON CHILDREN'S AND WOMEN'S SERVICES

DR A BRYAN GILL, CONSULTANT NEONATOLOGIST, LEEDS GENERAL INFIRMARY

Wednesday 17 November 1999

Dr Bryan Gill: What I thought I'd try and do is to give some kind of regional perspective on neonatal services. In order to do that I would like to set some definitions within neonatal care because I think there is some confusion amongst many people who are outside of the field between what represents intensive care and the presumption that when planning all you need to plan for is intensive care cots, whereas in reality, the neonatal care is a whole package of different what we call patterns of care which is based on primarily the patients needs. Intensive care is clearly easy to define for example any baby who requires ventilation because of breathing difficulties will be deemed to be receiving intensive care and that requires a certain level of nursing care so there is a certain nurse to patient ratio with each band of level of care. High dependency care are those patients who have recovered from intensive care but require for example continual option therapy so they are actually off a ventilator but they need background oxygen to maintain their breathing and maintain their clinical status. They are often in incubators and they are often very small. Special care is babies who are being established on feeding. The pre-term infant is often unable to suck and establish on full breast or bottle feeding. This requires a nasogastric feeding tube to be placed in the stomach, and continuous feeds of small amounts of milk every hour are provided. As the infant matures they are then gradually weaned onto full bottle/breast feeding.

In the last ten years there has been the development in terms of a care package called transitional care. Not all hospitals have transitional care, in Leeds there is a Transitional Care Unit on both sites. What that development has done is allowed the mothers of babies who are not extremely pre-term to remain in hospital with their babies by the bedside with a higher level of midwifery input to both the babies and the mother to help them establish the infant or infants, often twins, on feeding prior to going home. What used to happen in the past was that the babies were admitted to the neonatal unit and the mothers went home and visited. Many pre-term babies born two or three weeks early will only be in hospital for a couple of weeks the mothers like the opportunity of being able to stay with their baby or babies before going home. When planning the neonatal services you've got to plan for all aspects of care so not just intensive care; for example, in Bradford they have no

transitional care unit. Their neonatal unit is often full, with intensive care beds blocked by special care patients, who would have been capable of going to transitional care. So it's all a continuum of care but the care is delivered normally within the same unit. The patients move from one level to another, and not infrequently if they become poorly, they can go from special care back to intensive care having previously gone from intensive care to special care. Once out of intensive care does not necessarily mean you are going to stay out of intensive care, so I hope that sort of sets the scene of how neonatal services tend to run.

Your nursing staff are part of that whole package so you plan your daily nursing numbers on the basis of how many babies you have in each of your care package. So either intensive care high dependency or special care. If a unit has a large number of high dependency, and special care patients then your ability to do intensive care is dramatically reduced. So even though you may nominally have three intensive care cots for example you might not be able to run at that level because of the demand for high dependency and special care. So its important that when planning for the service you plan each unit's capacity on the basis of the flexibility between each of the levels of care. I'll talk about St James' because Leeds General Infirmary has a surgical neonatal unit as well as part of the body but at St James' they have a capacity for 30 cots, nominally 10 of those should be intensive care but on occasions they can only run at 5 intensive care patients because they've got 25 other babies on the Unit and they can't go anywhere else they are local babies they have to stay or they have been transferred in for special services. So I just wanted to set the scene for that.

Now, to summarise what's happening in Yorkshire, which has taken quite a while to fathom out in terms of how care is delivered for neonates, there are two nominated regional units one at Leeds General Infirmary and one at St James'. We are now one service but still two separate units and the proposal is that we will become one neonatal unit on the LGI site, if it all comes off, and we'll have to go through exactly the same exercise that you are doing now.

There are seven what I would term District General Hospital Units undertaking neonatal intensive care. Obviously Halifax and Huddersfield have an intensive care component to their care. Bradford Royal Infirmary and Hull Maternity Units are sub-regional intensive care units. Pontefract and Harrogate carry out short-term ventilation, whereas York, Airedale and Dewsbury try and meet their local needs, and have on average one/two intensive care cots. Wakefield and Scarborough do not undertake any long-term intensive care at all, so any baby born there who could not have been transferred out before the baby was born (by moving the mother) would be stabilised, and that baby would then be collected either by the Leeds Team or by wherever that baby could go. If it doesn't go to Leeds it needs to be collected by the Unit to which that baby is going to go, so that could be further afield and I'll talk

about some of that shortly. You then have places like Castlehill and Bridlington who have a maternity unit and special care baby unit, but are affiliated to paediatric services provided from another hospital base, for example, Castlehill is affiliated to Hull Maternity in terms of provision of support for paediatric services and Bridlington is affiliated to Scarborough Hospital.

The problems within the region I believe are that the pattern of intensive care cots are too diluted throughout the whole region. Why is that so? Well, for example, there is a critical mass of intensive care cots to develop a number of areas. Firstly, to provide flexibility for being able to admit all your local population - for example, if one of your intensive care cots is full (it is taken up by a baby) and you only have one other cot available, if a lady comes in at 30 weeks with twins then she will have to be transferred because they would not want to keep one twin in the hospital and move the other twin somewhere else for obvious reasons, so the mother has to be transferred. If you have two hospitals like that 10 miles apart, for example, where intensive care cot in one hospital has got a patient in and the other intensive care cot in the other hospital has got a patient in, then if you pull them together you've got four cots. You can see you've suddenly got two extra cots side by side so if that lady comes in again with twins you can put those twins in those cots.

There is a critical mass of intensive care for flexibility of care for your own local population. We've found this in Leeds even though we seem to have a massive amount as a regional unit we are often full by the highly specialised work that Leeds does and we have discovered that we've had to transfer twins because we've only had one intensive care cot in Leeds to places like Liverpool, Newcastle, Sheffield, Nottingham in order so that can be together. It doesn't happen very often but its happened more frequently over the last few years than it used to when I first came to Leeds and from areas where I was before. That I believe is a reflection on a number of issues. Firstly as there is a rise in twin deliveries, IVF has resulted in an increased number of twin pregnancies. The triplet number has dropped due to changes in the way it's actually being dealt with, that people are only putting two eggs in rather than three, so the triplet rate has fallen back to the background spontaneous triplet rate, but the twin pregnancy rate has risen and is continuing to rise with the success of IVF and the problem with twins is they always invariably deliver early so they require neonatal services.

The additional factors is that obstetricians are making decisions to deliver women earlier in their pregnancy on the basis of the fact that neonatal care has improved dramatically so survival has gone up exponentially over the years, I'm not talking about four months pre-term but for the three months and upwards pre-term population. Survival has risen now to nearly 90-95%. Whereas in the past obstetricians may have made a decision to wait because of the lack of neonatal service. Now they are delivering them at 30 weeks and 32, 34 and they are filling up the neonatal service. So we have a

very close inter-link between the early delivery, the increased twin rate and the actual background demand for neonatal services as a whole. So there are two solutions to that as I see it, one is that you increase the number of neonatal cots you have be it intensive care or whatever and you do that throughout across board. The cost of that is enormous because in order to introduce an intensive care cot and staff it appropriately costs somewhere between £100,000 and £200,000 to meet the nursing need, the doctor need etc. So what we have in Yorkshire is not the same as in many other regions, for example, in the Northern Region and Trent you have a very dilute intensive care provision. I personally believe there is insufficient intensive care cots available because of the changes in neonatal services, but I also believe that we are only likely to obtain the necessary funding and development of that by looking at how efficiently we run that bed base. If we carry on putting them in all units around the region we're going to find it very difficult to get nursing staff, we are going to find it very difficult to get medical staff and this leads me on to some of the significant problems.

Nurse staffing in neonates is becoming an ever increasing problem as it is for all nursing throughout the NHS. It's not seen as a very attractive specialty any more because its due to Midwives who used to move into neonatal care now stay in midwifery because of the changes to their training stay within midwifery because they have to keep their training up to date to be registered. Paediatrics has developed with the development of paediatric intensive care which has taken away those nurses who want to be at the intensive care end of their practice, so the growth in paediatric intensive care in Leeds, for example, has taken away a lot of the experienced nurses, so the pool that is left is decreasing. It hasn't reached the bottom yet and I think we will discover over the next year or two that the numbers coming in and the numbers moving out starts to equalise out, but that will leave us with a significant problem, in that many units presently undertaking intensive care will simply not be able to do it. Leeds is struggling to meet its need for the region which is why many babies from Halifax and Huddersfield and other district hospitals can't always get into Leeds if need be. So that’s one end of it.

The significant transfer of neonates around not only the region but to other regions is a problem that we are trying to address by development of a unified transport team for the whole of Yorkshire not just for neonates, for new born infants but also for children who require intensive care, and it is possible that, within the background of the development of paediatric intensive care, we can build a transport service that would move those patients that needed to move.

We have just heard yesterday that there is going to be a reduction in the number of middle grade doctors training in paediatrics. The numbers are being clearly set at the number of consultant posts so that all those in training will have access to a consultant post. Obstetrics and gynaecology have three times as many middle

grade doctors who are qualified than there are consultant posts as you have probably gathered from the press and from the colleges, so they can't get jobs. We train these people for eight years and they have no job to go to. So we are now in the business of trying to match up the training numbers with the number of consultant posts.

Now, if there is a rise in consultant posts, then you're going to have a rise in the number of trainees, but there has been a recommendation that there will a significant reduction in middle grade doctors in Yorkshire, not as bad as some other regions, but certainly there is going to be a reduction. Junior doctors' training has changed dramatically since I did it, for the good I would say, because of the number of hours we used to have to do, but what it's demonstrated is that the experience of people coming through at the end of their training is not as great as it was under the old scheme where you stayed a lot longer in the training. So the abilities of consultants to provide the whole range of paediatric services from neonatal services through to specialist paediatric services in all hospitals is diminishing, so you have consultants who will be coming through who will need to specialise or sub-specialise within each of the different specialist areas within paediatrics, neonatology being one of them, diabetes being another or asthma being an addition.

I think the profession wants to do it but also the public want to see somebody who is a specialist in that area if they have been referred into hospital, and that's a demand we are seeing across the board. That has resulted in consultants often working in the community who have been asked to be on call for a neonatal intensive care unit. So they work in community service all day looking after disability, child protection and doing an excellent job and then at night they are expected to look after a 24 week gestation case. They cannot maintain the necessary skills, and see this as a long-term problem. So again, planning wise, you're all being pushed into trying to get core team of specialised consultants to look after the patients appropriately. If you are going to do any neonatal intensive care, any highly specialised work, I believe you have got to have the right people doing it. It's not acceptable to have it two days a week and then on the third day somebody who says "well, I don't know really what to do, we'll have to wait till the following day before the treatment is appropriate". This is reality, this is what we face throughout Yorkshire.

There has been also a rise in new practices, new different modes of care being offered, for example, different types of ventilation, different neonatal surgery. Surgery on a new born infant has risen exponentially over the last ten years due to improved techniques and improved understanding, so more and more patients are requiring surgical procedures, new born infants requiring surgical procedures that ten years ago we wouldn't have operated on because we didn't have the understanding. That also applies to the heart patients, the new born babies with heart conditions, and

congenital heart conditions that, ten years ago, would not have been offered treatment. They are now being offered treatment and their care starts off within the neonatal service. They are born in the maternity unit and then they are admitted to neonatal units. They fill intensive care beds. There is not one thing that has changed. I suppose what I am trying to do is give a summary of all the problems. Now that sounds very depressing but where is the solution?

The solutions in Yorkshire are being helped by the drive towards planning and commissioning services on a region wide basis. Because of the interlink between all district hospitals and regional units within any region, planning is now taking place or commissioning of services throughout the region. I am Chairman of what's called a Neonatal Forum, which is a group of lead consultants from each district hospital and myself and a couple of colleagues in Leeds who have met twice now to talk about the issues I've referred to and the problems that we are facing. M6 Commissioners have Calderdale and Kirklees leading on neonatal services, with Philip Sands as Chair, and we've had a number of meetings now about the issues related to planning for services within the region. We've developed a framework for commissioning that we are all signing up to or we hope we are signing up to.

One of the key elements of that framework is to, wherever possible, deliver neonatal intensive care in the patients own locality. That is a key framework, that Leeds has never been signed up to before, because one of the problems we've had down the years is the perception that Leeds wants to take all the patients. I don't want them. I would much prefer that any neonate needing intensive care, that isn't needing the highly specialised support like surgery or cardiology or the really extremely pre-term infant, should have that care delivered as close to home as possible, because if you do that it is fundamental to the whole package of recovery and support to the family. It's absolutely essential. Dealing with the baby is the easy bit, dealing with the family and the problems they face with trying to get to hospitals and the distances they sometimes have to travel is a major issue, and that's an issue that I can see from the framework, and the document that you have put together is a big problem that you are trying to address. However, given the problems before, I actually think that we are left with little option but to develop geographically located neonatal services that deliver intensive care. Now I don't know the number of those because that would depend on how things pan out. In the northern region, for example, they have only got four so there are only four units in the whole of the northern region that do any intensive care. So any baby born in a maternity unit and needing intensive care is automatically collected by a transport team and taken to the nearest intensive care centre. Now, by planning their service on that basis, it is very rare that patients in South Tees who deliver in one of the local maternity units have to go to Newcastle, instead they go to

Middlesborough. Okay, it is a distance to travel, but it is not as bad as it could be, as is often the case in Yorkshire.

At present, babies can be born in Huddersfield who have to be transferred to Liverpool or Nottingham because there is not either a facility within the Yorkshire region to transfer them to a more locally based hospital or put them in a unit of an appropriate size, but more locality based. I will come back to the options within the document. We need a single transport team and as I said earlier we are developing one. We need to maintain maternity units that have paediatric departments on site and obstetric departments on site to provide the necessary stabilisation of any neonate born there who either unexpectedly comes in and the mother cannot be transferred, which happens commonly or following delivery develops a complication. Now they might not necessarily undertake their ongoing intensive care in that hospital but my vision would be that if they were delivered in a unit such as this, and the nearest hospital that had intensive care facilities is five miles away, the baby would be transferred to this hospital by a single transport team who come out, collect the baby and take it back to that hospital.

It is important to recognise that you need the throughput, for want of a better phrase, of patients through any intensive care units to maintain your skills. If you only get one intensive care patient every three or four weeks, you will not maintain your skills. There have been debates, and I'm not sure I fully sign up to the fact, that people say you should do at least 500 days of intensive care in any unit undertaking intensive care to maintain the necessary skill base. If you don't do that then the consultants will not keep up to speed on latest techniques, management of the patients, the junior doctors will not get training, and therefore you will not be able to maintain the training for them within that hospital. The nurses will not maintain their skills and you get on a downward spiral. That is one of my biggest areas of fear that why potentially the service is not attractive for that reason because we are not maintaining the skills of all concerned and the support networks.

If I can refer to the report that obviously I have seen - I have previously seen and commented on the drafts that were put together initially in Calderdale and Kirklees. My view, and I would like to think that it's Leeds view, although I can't always speak for my colleagues, but I think my view, as lead Clinician, is that I would fully support wholeheartedly the centralisation and the development of the neonatal service on one site. I would also go as far as to say that I would fully support any expansion of neonatal intensive care in Calderdale and Kirklees if the demand was there. I am about to start a project in the new year to look at the movement of neonates both before birth, in utero and after birth, around the region and that will include Halifax and Huddersfield to actually find out how many are moving, how far they are moving, so we can get an accurate assessment of the problems that are faced within each of the district hospitals as well as the regional hospitals.

It is important I think to recognise that in order to staff, in order to educate, in order to train doctors you need to have a paediatric service with a neonatal service. You will not be able to have (easily) two separate teams of people unless there is a massive expansion in the numbers of staff that you have. Now, if that was the case, you could re-visit it, but on the basis of a level transfer, which is often what planning undertakes, then what we are faced with, and we recognised in Leeds when we were planning our reconfiguration of services, that you need access to all specialist services within paediatrics to deliver a neonatal service. You need access to specialist chemical pathology to do all the specialist blood work on small samples. You need access to radiology, paediatric radiology, because they are undertaking investigations on newborns as they are on children. You need access to other specialists where the neonate develops a condition that will require ongoing support by a consultant who has a specialist interest, for example, neurology, and for any surgery that is required that doesn't always necessarily have to be carried out in Leeds. Future plans for paediatric surgery are that it will be a hub and spoke model so that you have a major highly specialised service in Leeds with spokes around providing the necessary level of support to areas like Calderdale and Kirklees so that they can deliver care.

Within the report my biggest area of concern, and you would expect me to say this, is the option of a low risk maternity unit. I just want to talk through what that means, how I see it meaning, because I think it is important that I get across what I see as an important issue. If you are going to run a low-risk maternity unit where you can pre-determine women who would not be expected to have any complications during their delivery. Well, I need to point out to you that there are a number of studies that have demonstrated that 10% of so called low risk women who go into labour require the urgent assistance of either an obstetrician with anaesthetist or a paediatric resuscitation, where the baby required paediatric resuscitation immediately after birth. So that is up to 10% completely unexpected, sudden loss of foetal heartbeat, sudden bleeding, sudden complication in the mother, it happens and you can't anticipate it. Unfortunately, obstetrics don't have the wherewithal. Obstetricians don't like me for saying this but we don't necessarily have the wherewithal to predict exactly what's going to happen during that critical phase of labour, and it is a critical phase not just from a maternal perspective but also from a baby perspective and that these studies have demonstrated you've got to have, and I could not sign up for anything that would provide, a unit where the level of specialist cover to meet that need would be below acceptable standards.

Castlehill in Hull have tried to resolve this issue by developing what is called neonatal nurse practitioners who are neonatal nurses who receive training in resuscitation and ongoing stabilisation of a baby. What they have discovered in Hull is that it's not sustainable. They can't get the necessary level of the number of nurses to go through the training when they start. Within six months they are burnt out

because of the stress, due to isolation on a separate unit, consultant staff, middle grade staff and, on occasion, senior obstetric staff. That is my big area of concern in that there is a significant risk associated with having a low risk type maternity. It would be an about turn for us to start developing low risk maternity units anywhere because they have been changed over the last 15-20 years within any region, every region has started to move away from them.

In the Northern Region where they do not do intensive care they have a special care and they have nursing staff but they have a paediatric department, so have the consultant staff and the junior doctors on site. If you have a low risk maternity you've got to provide, 24 hour, 365 days of the year, appropriately trained staff on site. You've effectively split up your teams already. You've got to have consultants who have some input. You really need to have a special care unit so that goes very much against what you are trying to deliver, and that is why we have rejected this in Leeds because you could say "well, why not put it on the St James' site and have a low risk delivery suite". For the reasons I have eluded, we have not opted for this approach.

I hope I have not sounded too depressing about the services in Yorkshire. I think there is great potential for us to make the service much more efficient so that in every geographical area hospitals would be able to deliver the bulk of their neonatal intensive care in their locality.

Question: One of the things we have tried to do all along is get some sort of regional perspective on the issues that have been brought up here and so far you are the first person who has actually given us one. I'm really grateful for your presentation which has allowed us to understand the whole situation.

We have had evidence given to us by people who have said we need to centralise the NNIC services because otherwise your babies are going to have to go to Leeds, which I always thought was a bit scaremongerish myself, and now you're saying you don't want them.

Dr Bryan Gill: Yes it is. We don't want them, but unless you get together you're going to have to send them. I think that's the problem.

Question: But its planning, isn't it, that's important?

Dr Bryan Gill: Absolutely.

Chair: It would be fascinating to know the results of your survey to see where babies are going because our experience of talking to people is that we've got babies going all over the place.

Dr Bryan Gill: Yes, and that's our experience.

Question: It causes incredible distress to people, and I think that that is something that concerns us a great deal. It feels like there are people in hospitals, consultants or health authorities planning for things and the rest of the community is cut off that it feels very technical the planning that's going on and we've been missed out. People have said that their concerns are about the broader issues about caring, about how families respond, about how the relationships between mothers and children are supported. We find it very difficult to get hold of the experience to validate the experience of people, of the services, because it's a sort of technical design. I think you've raised some really interesting issues.

Question: If neonatal intensive care moves from Huddersfield across to Halifax, with in-patient paediatrics in Halifax, that will have all sorts of knock-on effects for Huddersfield such as the level of care, staffing issues.

Dr Bryan Gill: The short answer is yes, you could improve things by having a massive expansion in the numbers of staff if you could get agreement to do that, and there was a pool out there. I think the problem that we face within the hospitals is that we are at the sharp end and must recognise that the requirement for neonatal services is actually a small portion of the total number of deliveries, it's only about 5%. That is a very small portion but it requires a lot of finance and a lot of resource to meet its needs. We debated in Leeds whether to leave the neonatal and maternity unit over on the St James' site, to leave it there and just move paediatrics, because we felt we had to get paediatrics onto one site because of the need for access to paediatric intensive care, access to other specialist services. A lot of these children (ignoring neo nates for a minute) have multiple problems under different areas of expertise and you have got to get the people there to cover that.

What we recognised was that the knock-on effect would be that the unit standing alone would have to have its own team isolated day in day out. Even though we are two miles apart, the movement would not happen because you've got to have somebody there - you've got to have consultants there, you've got to have junior staff there. If they are not getting access to general paediatric training, because you don't just train in neonates you train in the whole of paediatrics, then that would be a complete death knell. The unit would go down, you wouldn't be able to get the nurses to go and work there as they wouldn't have access to the rest of paediatrics, and you wouldn't have access to other neonatal services. If you just move intensive care the experience of units that have just done that is that the unit that's left, that's just delivering special care, is not an attractive place for people to want to work, because the neonatal nurse wants to work in all the different aspects of care. If you've just got a unit that stabilises patients and just offers special care, whilst five or ten miles down the road they do it all, staff will gravitate across site.

Question: Can I explore that a bit more, the idea of transitional care? What would happen if you were to have special care and transitional care on one site and intensive care on the other site, but having one team of professionals doing the care? Would that be an efficient way of delivering services from your point of view?

Dr Bryan Gill: I would have to say no because if you have effectively got two special care and two transitional care, and one unit has the intensive care, which ever unit it is there will be patients delivering because you won't be able to predict the ones that accurately need intensive care. There will be babies delivering in the unit where there is no intensive care facility other than stabilisation, you will still need effectively the same number of middle grade or junior doctor staff covering both sites because you've got to have somebody on the other site for the unexpected. You just can't get away with it if you want to minimise risk associated with that. It's not impossible to do, none of these things are impossible but if the pool of middle grade junior SHOs, consultants is at a certain level then the most efficient way is to have it all localised.

The through-put of the units, both maternity wise and obstetrically, also relates to the level of training received. If you are only going to have 2,500 deliveries on one site and 2,500 on the other, if you put them together you've got 5,000 - you've suddenly got a more appropriate core of patients for which all the doctors, nurses, midwives can receive necessary training. Because maternity is not separate from neonates, the two are very closely linked, and you've seen that you plan neonatal services, you then enter the debate about what you do about maternity services and then into the debate about what you do about paediatrics.

Question: It all seems to depend upon whether you can get the doctors or whether you can get the nurses who patient is actually going to meet.

Dr Bryan Gill: I'm not sure that's true actually.

Question: Stays in intensive care tend to be quite a long drawn out process. What is the average sort of stay do you think?

Dr Bryan Gill: The average length of stay in intensive care is eight days.

Question: Then after that in the transition and special care units.

Dr Bryan Gill: The average length of stay depends on the gestation. A general rule of thumb is whatever gestation you are born, you will go home at a corrected gestation of 38 weeks, so if you are born at 30 weeks you will be in eight weeks. You will need intensive care for about a week, high dependency care about a week to two weeks and then special care.

Question: My tentative understanding is that people from low socio economic groups tend to need intensive care more than others. That might be wrong.

Dr Bryan Gill: Not exactly. They tend to need the special care more than the intensive care.

Question: But that also can last for weeks.

Dr Bryan Gill: That can last until the patient has fully recovered.

Question: What we tend to have then is demands upon mothers to travel distances and spend time with the baby when there are demands at home, problems with transport and problems with money, and yet we know that actually making that initial bond with the baby is crucial and yet we plan services that do not take it into account.

Dr Bryan Gill: That's because it is the way the service structure is. If you started with a blank sheet of paper and it was a limitless pot, and there was a limitless number of nurses and a limitless number of doctors, you could run a service where every maternity site could have a special care unit, you have a core or neonatal intensive care. What hospital doctors are faced with doing is, as they are battered into doing almost, to use a phrase is, to work from within the structure that you've got not to work from a blank sheet of paper.

Whilst I fully recognise what you say, it is very difficult to separate out the neonatal intensive care component from the high dependency, special care, and transitional care. Patients in special care can become sick, they don't necessarily have a completely smooth transition once they are in special care, and they need intensive care again. So its not unusual, the figures I would say in Leeds are approximate - 5-10% of all those that get into special care then jump back needing intensive care. I know exactly what you are saying and it causes me angst that patients have to travel an unacceptable distance. We face this every day in Leeds because mothers have to travel long distances for the specialist services that Leeds offers like neonatal surgery, specialist ventilation, the more extreme pre-term, a 24 week gestation baby for example. The mother is going to be with us for months and she could live out in Scarborough.

Question: You were also talking about the special care babies blocking the intensive care cots and if we developed a service that catered for babies with less acute needs and their families as a speciality you may find the intensive care cots would be better used.

Dr Bryan Gill: I don't know that they would be better used because they would be more accessible. If you went down the line of saying "we will have two special care and transitional care units on both sites, with intensive care on one site", you would have more flexibility in intensive care. There is no doubt about that, the chances are you would be able to keep more of your patients that need intensive

care within Calderdale and Kirklees, but you're still faced with the problem of staffing both units because separate they're fairly small, together is a better care, flexibility of staffing. You've still got the problems of the interface between that and the maternity set up, so you've got a need to provide 24 hour obstetric and paediatric cover. You've got a need to train those doctors as part of their on-going training, you'd have to have an on-call at both sites that would have to swap. You would have to rotate them so that they spend a period of time on the low dependency special care site or some period of time at the higher intensive care site.

Now junior doctor training is such that you need to be exposed to neonatal intensive care for at least six months to get the necessary junior doctors skills. The number of junior doctors is falling. The actual core to be able to put them on both sites, you're going to find extremely difficult to do. You're going to find it less attractive to doctors who want to come and work there. You are going to have to spend 3-6 months over on the special care baby unit, possibly without any form of senior support. Now you are going to ask them to work split sites, so they have to travel between the two. If there is a disaster on one site, they are going to have to try and get over there in appropriate time if there is a problem with any of the babies or any other complications during delivery.

Question: So you need consultant obstetric cover and a consultant paediatrician on both sites?

Dr Bryan Gill: You would. If you could design that team it would actually be quite an exciting development from a service delivery point of view.

It might solve some of the problems over maintaining the locality issues, maintaining patients as local, as close to their home. If you're being hypothetical then you know all things are achievable but where I come from is that I'm facing day to day reality and I suppose that's the problem we face.

Question: We have been told that up to 10% of low risk babies births become high risk. Have you got the numbers of how many are high risk?

Dr Bryan Gill: You would have to determine what are high risk already or would be deemed high risk. It depends on your definition obviously but you are talking of about 30-40%. Now prima-gravida is considered high risk in the sense of it's your first baby, you don't know what is going to happen. Multi-gravida, those that have had more than three, are considered high risk, so you can see already that you are taking up a large bulk just by those two, and then you've got all the other complications that occur -blood pressure problems, poor growth of babies, that kind of thing. So I would say probably about 30-40%, but I'm not an obstetrician. They would be able to give you a much better answer. It depends where your definition starts, but that would be a ball-park figure, so you are left with 50-60%.

Question: 30%/40% seems a high base figure.

Dr Bryan Gill: Well, they are deemed high risk for potential problems they have not necessarily got problems during their pregnancy but they could run into potential problems where obstetricians and midwives believe that they need access or availability of the highly specialised back-up support that is needed. If you talk about high risk in terms of high risk to the mother's health and high risk to the foetal health, you know, during the pregnancy, then that number is very small. You know that's probably only 5-10%, so if you are talking about women who have got very high blood pressure and they need close monitoring, or where the baby isn't growing or where they have twins or triplets, then that number is small.

From a planning, where you're going to deliver, point of view, you need to make sure that you plan your service so that if a complication occurs you can get that mother into the theatre to deliver within 30 minutes. That's the recommendations from a risk management point of view. If you can't achieve that then you're not only placing the mother at risk you are placing the baby at risk. Life-long disability, we mustn't lose sight of this, it is a small number but you are placing that baby at risk you only need one and the uproar is enormous.

No hospital is perfect and people don't always meet that standard and we know that all the time but the drive to meet that standard is ever increasing. The drive from obstetricians point of view is to have an obstetrician covering delivery suites, in the long-term, 24 hours a day, a consultant making the decisions. Now, hypothetically, if you could put that on both sides, if you had a massive amount of money and people agreed to the expansion and so on but in reality the links between obstetrics staff and what they do the rest of the time, whether they do gynaecology, whether they just specialise, who covers the holidays, annual leave, you know, all the things that go with any post really.

Question: Are there any statistics which demonstrate that once you have achieved a centralised hospital, increased your throughputs of patients, that this has actually resulted in the better outcomes?

Dr Bryan Gill: There was evidence from the late 80's that in the Trent region where they compared the outcome of babies delivered in what they classified as regional units versus the outcome of those babies cared for in smaller district general hospitals and the end result of that paper demonstrated that there was improved outcome being cared for in the regional unit both in mortality, survival and in morbidity, in terms of disability. There was then, in the early 90's, an expansion in the number of consultants in the smaller hospitals in recognition of the problems - I'm talking about paediatricians with a specialist interest in neonates, and they repeated the survey at a later date and did not demonstrate the same difference, so by putting in more staff into the units that delivered intensive care appeared to suggest that it made a difference.

The problem with that information is the size of the unit, the so called smaller units they were working on 4/5 intensive care cots versus the regional units working on 10. What you are comparing in Yorkshire is a regional unit that works on 10 intensive care versus a district general that has two. Huddersfield never runs at three because it can't staff three most of the time, that's the problem. Although they say they have got three, in reality they have only got two. There is reality and what you believe you are paying for, or what you believe you are commissioning. Every now and again they'll go up to three but most of the time they run at one/two babies because of nurse staffing, because of cover.

Question: So if you put them together would you need more staff?

Dr Bryan Gill: No. If you put them together you have a core of at least four because you have got two in Halifax. If you put them together you've got four intensive care cots all the time. You could keep more of your patients in the locality.

In terms of regional planning you would be able to say well, you've now got core in that hospital of intensive care cots and this is the need for Calderdale and Kirklees. We'll do a transport survey, this transport study of movement of the patients that we are looking at will tell us that, it will tell us where patients are going, where the demands are. It would move towards Calderdale and Kirklees and, say it's Halifax for a debate point of view, it would become what we term a sub-regional unit like Bradford, so there would actually be a net gain, so patients in Dewsbury or patients in Bradford who are on the border, not sure whether they would get into Bradford for their needs because they have a different population, a more complex congenital problem, would come into Halifax for example. So you're keeping the patients as close as possible for their neonatal care.

Now I fully accept problems about special care patients living in other areas, we face this day in day out. In Leeds what we try and do is that when a patient finishes their intensive care on the Unit they go back to their referral hospital. Commonly what blocks that referral back is that the Unit they are sent back to are full or their intensive care capacity is full. They just don't have enough nurses - even though they've got some special care beds they can't take the baby back because you're diluted between two sites. You come together and you're going to have a great deal more flexibility between what you can deliver for your special care local population. I know its not local if it's in Halifax, and I know its not local if it’s the reverse, but you will instantaneously improve your flexibility for the bulk of patients needing neonatal services. It will remain within this district, Calderdale and Kirklees. Now I accept that doesn't necessarily solve all the problems about how far you have got to travel and such.

Question: Can you explain to us the hierarchy of doctors? You're saying that we haven't got enough middle management of doctors to cover the consultant posts. Why are there not more middle grades, why do they have to be consultants?

Dr Bryan Gill: They didn't have to be before, in the old days so to speak. The training for junior doctors is when you qualify you make a decision to specialise. You become what is called a senior house officer and spend up to three years normally, rotating through the different specialist area. Now this is what is called a senior house officer. During that time you pass or attempt to pass what is called your membership exams which allow you to move into specialist training, what is called specialist registrar training. Now the Government and the previous medical, Chief Medical Officer developed a scheme - this was four or five years ago, because of pressures by the European community to shorten the training for junior doctors because it could take you ten to fifteen years once you enter the registrar grade before you became a consultant, and there are all sorts of reasons that I don't understand about why we've developed it, but it occurred.

So we were forced into developing a five year training programme and it was clearly set out that you could only have as many trainees as there were predicted to be consultant posts, because the drive seems to be towards having specialists delivering hospital care and full training of those specialists. So I don't fully understand all the politics behind it all and what drove it, all I know is that we have about 50 specialist registrars in Yorkshire and that number is going to drop by approximately 10-20% on the basis of the fact that there aren't enough consultant posts being created to meet that need. Now the problem is that, if you don't offer people at the end of that training the ability to progress in that speciality, you've just trained them for nothing. People in training, doctors in training, don't want to go into a sub-consultant grade, they are striving to become a consultant and what goes with that.

Question: Can I ask you to explain why all doctors training at middle grade level in hospital need to become a consultant? This is similar to saying that all school teachers need to become the Head Teacher.

Dr Bryan Gill: You have two different groups - you have hospital consultants and you've got general practitioners, and the vast bulk of doctors are GPs. Now that's your teachers, you know, the classroom teachers. That's the primary care end, that's where most care takes place. Hospital care is at the specialist end and you will not attract people into hospital if you ask them to stay in exactly the same grade. You can't ask somebody to be on call every fourth night, to live in the hospital when they are 55 years of age or 50 years of age. You can't ask a junior doctor to come in at 9.00 a.m. in the morning and work for the next 24 hours, and ask them to do that for the next 25 years. You can't ask them to do that. There are not enough of them to do things like shifts like nurses.

You get people staying at a particular grade of nursing, which is the example that you know in terms of school teachers. In hospital medicine you make a sacrifice for ten years where you work an average of 72, or in my day 96, hours a week. I'm not blowing this up, that's reality. Now if I didn't become a consultant there's nothing left for me. I couldn't then go and re-train as a GP because people simply would not accept me as somebody who is a hospital consultant suddenly packing in and becoming a General Practitioner because they couldn't make the grade. So you've got this within medicine, its history. Now if you develop a grade and there are some grades called staff grades etc. that are non-specialist. They receive a certain level of training, they will only stay in that grade for four or five years because of the demands you place on them. Unless you change the whole fundamental structure you will not be able to alter that.

You're talking about the top 5% of all those qualifying in medicine going into become hospital consultants. The rest become General Practitioners. Now there is nothing wrong with that, that's absolute, but they drive themselves to be hospital specialists and they want the consultant's position and the job that goes with that. They want the responsibility that goes with that, they want to take that on.

Question: You mention regional hospitals that don't have intensive care. Could you inform us of the paediatric and maternity services they have?

Dr Bryan Gill: The difference in the Northern region is that they historically had quite big maternity centres, 4,000-5,000 deliveries each, in addition to quit small maternity centres with paediatric departments of 1,000-1,500 deliveries. So it was actually easier to plan their service. Most district general hospitals in Yorkshire have around 2,500-3,000 deliveries so you have a bigger core. The impact in the Northern region, which I do not like, is the total model of all patients receiving intensive care, being done so in huge units and nowhere else. However, what this has allowed them to do is provide special care/high dependency care facilities within their local hospital as they have continued to provide a paediatric service with all the attendant middle grade and consultants available on site 24 hours per day.

What they have been able to do is, by having improved flexibility in the way that they have done it, by only having four units, they have been able to keep the bulk of their patients within their region or within their local geography, so it is a compromise. The big compromise is made for the babies needing neonatal care. They have been able to deliver special care in the locality with a paediatric department by having consultants and junior doctors based in that hospital who are on rotation. It was part of your five year training as a specialist registrar that you spent two years within the district hospital and then three years in the teaching hospitals. I would think that it would be better for a 28 week gestation infant to

stay in Halifax or Huddersfield rather than come to Leeds. You know that must be better for the local population.

Question: The proposals seem to be for the few rather than the many, so many women and children will in fact face increased travel difficulties.

Dr Bryan Gill: But that's the decision you make in health care all the time. Where you've got a clear need, the needs for the so called majority are not clearly defined, you can't actually quantify accurately what the difference would be if they had to travel five miles rather than one mile. You can't define that clearly. What you can say is that for some it will be difficult, for others it would be easy. It depends on which groups or who you were talking about, but what you can say is that for those that need intensive care you cannot deliver it all in this area by having split sites. That's the bottom line isn't it, and you can define that population, that's the problem you face with it. On the clinical level you can clearly define the needs of that population. You know they need intensive care, you know they need the backup of the middle grade doctor and the consultant who has specialist interest. For the special care patient you would like, wherever possible, to have it on the doorstep.

I came here today to discuss the proposal on the basis of what the Health Authority have put forward. I am here to present the regional perspective, not a local perspective, and that's the most important thing. But what I would say that is that in Leeds what we have planned to do is to provide out-patient services in different clinical areas away from the main hospital base, so actually you know it is a trade-off. You might have to travel while the baby is in hospital but once you get home you do not have to go back to that hospital, and actually the bulk of the ongoing care is once they have gone home. That is when you need the support, that is where you need the Outreach Teams, that is where you need the doctors and GPs, hospital doctors working in tandem with Health Visitors, midwifery when they first go home. To get that support when they take their pre-term baby home having been in the neonatal unit, that is where it can fall down. It does not fall down because they have to travel to hospital, it falls down when they go home and do not have the level of back-up.

Chair: Thank you ever so much for coming today.

D4K080

KIRKLEES METROPOLITAN COUNCIL

SCRUTINY COMMISSION ON CHILDREN'S AND WOMEN'S SERVICES

Wednesday 17 November 1999

Local Midwives

We are here representing the local branch of the Royal College of Midwives, which has over 100 members in the Huddersfield area. We are not here to represent the Huddersfield NHS Trust.

Over the last few months we have been engaged in various meetings, think tanks and workshops about the reconfiguration of hospital services in Huddersfield and Calderdale. Our aims over the last few months have been to explore options put forward by the Health Authority, to provide a high quality, safe and equitable service for the women and children of Huddersfield and indeed Halifax.

As you know three options have been put forward in the report to the Health Authority. They are now being looked at by various project groups within the Trusts of Huddersfield and Calderdale. We were asked last week to look at these options as a multi-disciplinary group including intensive care nurses, paediatricians and obstetricians. We have looked at whether the options are workable or not. The options are:-

1. Centralise Children and Women's Services in Calderdale (gynaecology and paediatric services with neonatal intensive care) with an optional "low risk" obstetric unit in Huddersfield.

2. Gynaecology centralised in Calderdale, paediatric services centralised in Huddersfield and an optional "low risk" obstetric unit in Huddersfield.

3. Gynaecology centralised in Huddersfield and paediatrics centralised in Calderdale.

As a group of midwives we have looked at the advantages and disadvantages of all the options.

The advantages of option 1 are:-

- There is a possibility of meeting the accreditation criteria but we don't know what the criteria is at the moment.

- There is a possibility of increasing clinical specialisms that the obstetricians and paediatricians can specialise in.

- There is a possibility of reducing transfers to regional tertiary units depending on the number of neonatal intensive care cots provided (there may be less need to transfer babies to Leeds although that is not common now).

- There is the possibility of achieving critical mass i.e. the numbers required to sustain services at a population of around 450,000. In Calderdale and Kirklees the population is about 400,000.

- There is a possibility of strengthening community teams. We have been told a merger will mean an increase in community care.

- The benefits of a new purpose built unit.

The weaknesses of Option 1 are perceived as:-

- There will be a reduction in choice for women if there is a "low risk" unit without any medical cover.

- Poor accessibility for the majority i.e. increased travelling times etc.

- Lack of safety on optional "low risk" unit and difficulty in defining "low risk" care. "Low risk" means different things to different people. It is different to the medical profession and the midwives. There is an argument that you are "low risk" until proved otherwise and an argument you are only "low risk" in retrospect. Therefore there is a difficulty in choosing the place of delivery. There may be some inappropriate choices made by women.

- Increased travelling times, women travelling further will be going into hospital earlier, will there be more medical intervention?

- Higher numbers of unnecessary admissions from standard or "low risk" unit to centralised unit, for things that could be deemed to be abnormal you would be transferring them at an earlier time.

- Would the "low risk" unit survive? We have seen in Huddersfield the closure of many of our maternity units over the years.

- There would be increased rates of transfer with the stand-alone unit.

- Inaccessibility for disadvantaged groups visiting sick children, some of these babies are in hospital a very long time and a lot are born to women who are already disadvantaged.

- Child protection issues.

- Decreased continuity of carer. We try at the moment for the same midwife to see the same mothers before and after birth and if at all possible during the labour as well.

- There is no public support for it and we are very worried about what will happen to Huddersfield Royal Infirmary if we take away all these services i.e. paediatrics, gynaecology. What happens to the Anaesthetics department? A lot of their work is concerned with obstetrics. What happens to the Accident and Emergency department? The overall integrity of Huddersfield Royal Infirmary may well be at risk.

Looking at the options in turn, here are some of the problems which we, as midwives, have with the clinical workability of them.

Option 1

We feel the safety of mother and baby are compromised. Emergencies occur totally out of the blue and they need immediate medical attention e.g. haemorrhaging. This may be medical attendance for 25-30 minutes but they need it just when called. Emergencies occur with the baby which are totally unexpected when we need paediatric input straight away e.g. the ones that are born shocked and need resuscitation, it may be ventilation with paediatric input. The comfort and confidence of the mother may be affected when the site of delivery or site of ante-natal care could be changed at any point during their ante-natal period or during the labour. Transfers could frequently occur in this option to Halifax for minimal risk. If we anticipate any problems we would have to transfer them over rather than wait and see what happened.

Option 2

On site paediatric cover would be available for use in "low risk" unit for any emergency with the baby. However we would not look to deliver by caesarean section or any instrumental delivery. Women would have to be transferred in labour if they needed that. That is approximately 20-25% of women.

Option 3

There are benefits from having gynaecology on site in that we would have obstetric cover but again we couldn't deliver by caesarean section or forceps if women needed it. If there were problems with the baby we wouldn't have the medical input necessary for resuscitation.

All the options as they stand are to some extent unsafe and therefore we feel are unworkable.

We think that by perhaps further developing Option 2 or 3, by giving 24 hour obstetric, paediatric, anaesthetic medical cover there will be definite advantages. If we had obstetric theatre provision for 24 hours we could deliver on site. There would be no need to transfer women for any intervention. If we had an epidural service we wouldn't have to transfer them just for pain relief. In a lot of midwifery led units or "low risk" units around the country we have to transfer for pain relief, we don't think that this is the way forward. We also feel that a special baby care unit, if we are losing neonatal intensive care, is a necessity because for a baby shocked at birth we need the facility to stabilise them, then safely transfer them to Calderdale.

In the last twelve months we have had four unexpectedly "flat" babies in Huddersfield. These were monitored ante-natally, were classed as "low risk" women, the babies heartbeat had been recorded throughout labour and there were no anticipated problems with them, but they still needed resuscitation at birth and major paediatric input.

If we had a special baby care unit we would then have facilities for babies to be transferred back to Huddersfield when their neonatal intensive care period is finished i.e. when the ventilation period is over. The mother would not then have to go to Halifax to feed the baby two or three times a day. We need facilities for safe transfer of any mothers that come into Huddersfield and are in suspected premature labour. We also advise development of advanced neonatal nurse practitioners. In areas where paediatricians cover more than one site there are advanced neonatal nurse practitioners who support paediatricians in their work. Also midwifes could maintain and develop midwifery skills and high risk midwifery and paediatric care, again in the hope of supporting the obstetricians should they be required to cover two sites.

With this provision we anticipate that we could deliver 95% of women from Huddersfield in Huddersfield. Less than 2% of women delivered in Huddersfield last year had babies who were at risk of needing neonatal intensive care. The advantages of providing the above would mean safe local accessible services for the majority of women. We would give them real choices of where to deliver and appropriate care and reduce the unnecessary transfers for the minimal risk options and admissions to the high risk unit. In doing this we think there would be minimal disruption to the general fit with the other hospital services. Halifax would be able to keep the majority of services and Huddersfield the range of services it wants to serve the local population. We also think it would increase the long-term viability of the maternity unit in Huddersfield. "Low risk" units around the country are constantly under threat because of efficiency and various other things. We think it will use other resources efficiently. We already have a very good delivery suite and neonatal intensive care and special care baby unit, a good ante-natal and post-natal ward.

We also think that these options could be used in reverse i.e. it would be workable with neonatal intensive care unit and high risk obstetrics being maintained at Huddersfield.

I will illustrate the difficulties with the options as they stand. Of three deliveries this week, I had one lady whose labour was not progressing. It needed a little Doctor input to set up a drip. She delivered normally and both mother and baby are doing well.

The second delivery was a lady that came in normal labour then had spontaneous ruptured membranes. It needed a paediatrician there at delivery. The paediatrician was there and mother and baby are doing well.

The third lady had previously had a normal delivery and just had pethidine but on this occasion she wanted an epidural. An anaesthetist put the epidural in, 20 minutes later it worked and she had a normal delivery.

All three ladies would have been transferred to Halifax if we had a "low risk" unit at Huddersfield. All three would have problems being "low risk" when they came into hospital but developed into "high risk". Are we really going to disrupt them to go to Halifax in the middle of labour in an ambulance to progress normally and have a normal delivery along with all the anxiety that goes with it? Their care was continuous. Women are going to wonder why in the 21st century we are offering them care that is substandard to that offered in the 20th century.

We think that medical cover for emergency is therefore necessary. By developing the options only the women at risk of having a baby needing neonatal intensive care would have to be transferred to Halifax. We think that this development model could be achieved by rotating staff across two sites. Although we appreciate there may be a need to centralise the neonatal intensive care unit we are disappointed that the results of certain studies have not been awaited for example the neonatal services review, specifically for accreditation criteria and neonatal study which may have influenced the decision making happening at present. The SEPTA report was not based as far as we see it on any clinical evidence, proven outcomes, geographical accessibility or usage. It was just based on bricks and mortar. We think that a state of the art unit could be provided on either site.

I would like to state the case for maintaining the neonatal intensive care unit in Huddersfield or at the very least having one neonatal intensive care unit and two special baby care units. The Huddersfield unit provides care for up to 18 babies its 3 intensive care cots and one high dependency cot. These are generally Huddersfield babies but we do take cases from other units including Leeds, York, Bradford, Wakefield and any surrounding areas when these units are full. We transfer out only when absolutely necessary, for example, complex procedures surgery, and specialised ventilation. The SEPTA report says that we can save babies from being transferred out but that is not the case in Huddersfield, only in Halifax. In Halifax they have only been ventilating for two years. In Huddersfield we have been ventilating since 1976 for babies up to age one year if necessary. 75% of the staff have worked on the unit for over 10 years and have formed a team built upon friendship, trust and loyalty. It is always covered by experienced members of staff and at times of sickness and staff shortage staff will give up holiday and time off to cover. We feel that this core of highly skilled nursing staff is central to the unit's successful outcomes as demonstrated by statistical evidence. We also feel that this good will and team spirit is unlikely to be transferable.

Huddersfield has a number of additional innovative projects initiated and set up by the staff that are now an integral part of the service that we offer. This includes the Breast Milk Bank. These are post-natal ladies who give their milk to feed premature babies and is the only one between Birmingham and Glasgow. We offer the milk to other units for very ill and sick babies. We have an infant massage service which is offered to all post-natal women and their babies and is also an integral part of special care. There is a parent led support group and well established bereavement group which offers care to bereaved parents of infants and children. We have a well established outreach service which takes care of the mothers and babies when they go home. It allows the mothers to go home a little earlier because they have more support at home. On the unit we have a specialist breast feeding advisor, free loan of electric breast pumps and we have just employed a development care co-ordinator who actually looks at the care of neonatal intensive care babies and makes sure that we are doing the most up to date and research based care. We are part of the North Eastern benchmarking group which has set standards for practice and for initiating audit programmes.

The people of Huddersfield have always supported and raised money for the intensive care unit and they are still doing so. The Special Care Baby Unit Trust Fund has received over £10,000 from the general public in the last five years. The Huddersfield Medical Trust Fund which is for special care has received over £161,000 in the last 8 years. The purchases that we have made are £110,000. Some money is also used for staff education and for providing books on the unit,

providing clothes for babies, prams and some of the luxury items we require. Some equipment is also bought by other charities such as BLISS. Without charitable donations from the people of Huddersfield we may not have been able to achieve the level of care and expertise we now enjoy.

Finally I would like to put to you a typical scenario which would happen in either town if there were no intensive care facilities and no special care facilities. Assume that the facilities are in Halifax. A young unsupported mother, of a low socio economic group, of a 26 week old baby requiring neonatal intensive care may face the following problems. The baby may be in intensive care for a number of weeks and then in special care at the extreme for up to three, four or five months. Visiting would be a great problem particularly if relying upon public transport. There is the time and cost, particularly if other children are involved in visiting. Transportation of maternal breast milk is essential for the health of the baby and the establishment of breast feeding. There is a need to encourage the bonding process. It is research proven that neonatal intensive care babies are more likely to have an increased chance of handicap, have behavioural problems or learning difficulty. If parents are unable to build up a relationship in the early stages of life there is potential for big problems. From our point of view the child protection issues begin as soon as the baby is born and if there are added problems it doesn't enhance that. There is also the drug abuse scenario. To take children of drug abusers to another town is not satisfactory. If we can only have an intensive care unit on one site there should be a special baby care unit on both sites.

Question:

Thank you very much. You say that you have three neonatal cots in Huddersfield. Dr Gill said this morning that you could only use two of them because you have not got enough staff.

Midwife:

Yes we do have a problem with staffing. If we have three neonatal babies then staff work overtime to manage them. Part of our staffing problem we feel at the moment is due to the reconfiguration process. We have advertised in the last six months three times. We have had interested people look round the unit but because of the uncertain future we have not been able to recruit anyone.

Question:

This was a central part of Dr Gill's evidence this morning. There is a great difficulty in recruiting nursing staff and doctors and centralisation of services is more likely to attract staff than the more diverse service here. Can you tell us a bit more about training and what other staff problems there are?

Midwife:

The speciality is difficult to recruit into anyway. There has been a nursing shortage nationally and the more specialised you become the more difficult it is to recruit staff. Leeds and some of the bigger units also have difficulty. One or two people have come from Leeds because they want to work in a less stressful environment and a smaller unit. It is a national problem compounded by the reconfiguration process.

Question:

So the basic problems is not being able to attract people to the job as a whole?

Midwife:

Retention of staff is generally better in smaller units. 75% of Huddersfield staff have been there for over 10 years.

Question:

Do you have any advanced practitioners?

Midwife:

The handout we gave you does demonstrate that the neonatal nurse in Huddersfield undertakes a lot of procedures to support paediatric staff that they don't do in other units. None of us have actually trained as neonatal practitioners but it is something we would be looking to do if it is felt as necessary.

Question:

Would it increase the possibility of recruitment or not?

Midwife:

I wouldn't like to say.

Question:

It seems to me that most nurses and midwives don't like centralisation ideas and most doctors do. Would you say that is a fair assessment?

Midwife:

I think it is more to do with the doctors training. We do not have those problems. In fact midwives have more areas to train in, more areas open and working well. We do not have the recruitment problems that the doctors feel they may have in the foreseeable future. We would like to see them addressing those rather than looking to centralise services.

Midwife:

Paediatricians do say that in a few years time they are not going to have a lot of middle grade cover which is what they need to have the SHOs trained up. Centralisation will pre-empt that rather than looking at the problems.

Question:

It feels like services are being designed to fit the system not the needs of people.

Midwife:

As a whole we tend to see families as a unit and the problems they have, we can see the knock-on problems. Also because of the reduction in their hours the medical staff are not actually addressing their training needs.

Question:

If two Trusts amalgamated and you became part of one obstetric and neonatal team what impact would that have on the way you work now. Even if you kept the services as they are now.

Midwife:

If we have to lose neonatal intensive care and manage to keep 95% of the deliveries we have now in Huddersfield it would not have many implications on our working lives. If they kept a special baby care unit in one area and an intensive care unit in another it may well mean that staff have to rotate between the two. That would be essential and the majority of staff would be willing to do that.

Question:

Would it have advantages for nursing staff to have a bigger opportunity for moving to two sites?

Midwife:

They would be seeing what they are seeing now in two different areas and in bigger numbers. You wouldn't necessarily be getting any more experience unless they anticipate doing surgery or looking at cardiac problems in the future, which is unlikely.

Question:

How realistic is it to have two high risk units on two sites?

Midwife:

We don't think it would have huge implications because we are doing that already with the same amount of people, resources and facilities. It is only neonatal intensive care that they are saying there is a real need to centralise. Even with high risk cases if the babies are delivered at 36-37 weeks they do not need neonatal intensive care. There is no reason why they should not stay in Huddersfield.

Question:

We hear a lot about what consultants say about junior doctors and travelling etc.

Midwife:

We feel it is easier for one consultant to travel between Huddersfield and Halifax than however many women. At the moment all consultants on each site are covering 24 hours paediatric, obstetric and anaesthetic cover. Why that can't

continue with a larger rotation between the two sites we don't know. They will still have to cover on two sites if the proposals go forward because of an increase in community care. Also at one point they were talking about have a paediatric assessment unit which was going to run until 10.00 p.m. in both towns. So the majority of time even if there was a low risk unit they would have to be covering on two sites. There would still be a day care unit for gynaecology. If the problem is consultant time why don't they just employ an extra consultant?

Question:

Would rotation help you to get accreditation?

Midwife:

Anything to do with obstetrics we are meeting and going beyond. If this goes ahead we will be depleting what we are already achieving. We do not have accreditation criteria as such but we will have some guidelines to do with our training. Into the future with a bit of juggling around we could probably meet them because we deal a lot with normal midwifery care. We can meet them in the community as well. It is easier for us to have two sites to meet them but we could meet them on one site. The accreditation criteria for neonatal intensive care unit and obstetrics would be driven by recommendations from the Royal Colleges. They are recommending the 40 hours obstetric input on delivery suites so the rotation would have to fit that in on two sites which will be slightly more difficult than covering it on one site. But there are advantages to covering two sites. Two consultants will be seeing a number of people rather than one consultant seeing a large number of people. We think it is advantageous to retain two sites for general care really.

The other option is to have one site that has all the consultant care and the other site has none. We don't think that is acceptable.

From the midwifery point of view the accreditation they are looking at is the number of ventilator days not intensive care days. Again we do not yet know what that criteria is going to be. As far as looking after intensive care babies the methods we now use to keep respirations going is not just a ventilator. Another innovation has come out in the last few years and hasn't been accounted for, the CPACK machine. Our figures for ventilator days in Huddersfield have gone down because we are giving a better service.

Question:

Dr Gill said that in Leeds they not only have intensive care and special care but something called transitional care. Do we have it and if we had a situation where neonatal intensive care was in one place and special care on both sites would it inhibit the development of certain special areas?

Midwife:

We see special care and transitional care as being one. Special care is for poorly babies and small babies who don't feed well. Transitional care is for those babies who need short-term medical input but can stay with their mothers. They may need an odd feed or some antibiotics. They tend to be well babies that need some form of intervention.

Question:

So if we lost special care, that would make transitional care very difficult.

Midwife:

And if we had a "low risk" unit some of the transitional care stuff would have been "high risk" anyway.

Question:

So if services were centralised improvements in service in Huddersfield would be inhibited.

Question:

With regard to staff rotation between Huddersfield and Halifax, Dr Gill said it would be difficult or impossible to keep staff if there was only one special care baby unit.

Midwife:

Certain members of staff would be very happy just to stay on a special care baby unit, rotating to a neonatal intensive care unit to keep up with the skills but primarily focus on special care and mums/families. Conversely there are people that like the intensive care aspect of it.

Question:

If you had a magic want to wave, what you like to see happen?

Midwife:

Neonatal intensive care centralised in Huddersfield. The next best thing would be to keep as many deliveries in Huddersfield as we possibly can, only losing a very small number requiring neonatal care and to have a special care baby unit/transitional unit.

Councillor Smith:

Thank you very much for attending today.

D4K079

KIRKLEES METROPOLITAN COUNCIL

SCRUTINY COMMISSION ON CHILDREN'S AND WOMEN'S SERVICES

JEAN WILLIAMSON, SAVE OUR HOSPITAL SERVICES CAMPAIGN

Wednesday 17 November 1999

Jean Williamson: During the past few months, during sessions of petition signings, vigils and protest marches, I've had the opportunity to meet ordinary people with very grave concerns, in particular over the siting of maternity services, neonatal intensive care and special baby care units which they feel intensively proud of and with good reason, having provided a great deal of the equipment by their own generosity.

I have attended Area Health Authority meetings, listening to idealistic plans for the future health care of Huddersfield's women and children. At no point have any substantial reasons been given for why these proposals are necessary, or the difficulties to local people acknowledged or addressed since there is only one route from Huddersfield to Halifax. Even now that route is often blocked by traffic jams.

It has been said by the Health Authority that fear of litigation is a valid reason for moving maternity services to Halifax. I suggest that indeed they should fear litigation if such a move is made.

I understand that Huddersfield can boast of being the largest town in the country, but apparently not large enough to support or sustain its own maternity services, which are working extremely well. We have much to be grateful for in the dedication, care and skill of the midwives.

We were told at the last Health Authority meeting, rather patronisingly, that it was difficult even for them to sometimes understand the need for these changes so how we ordinary members of the public could be expected to understand was quite a problem, but one that must be addressed. What it is to be educated, clever and smart!

The only problem we mere mortals have is how do we get to Halifax if we have no car and little money? What happens to our other children if one of them has to be admitted to hospital in another town several miles away? How do we visit, who will pay, how much time will we be involved in travelling? But of course these are minor practicalities to be dismissed in favour of a state of the art hospital where

trained medical staff will be waiting for us all to arrive, whatever time we can manage to get there.

We, the people of Huddersfield, are not opposed to change. We are all for making things better and improving services, but does progress have to mean transporting patients miles from their home town? I do wonder what the knock-on effect will be to other services at the Huddersfield Royal Infirmary, for example, Accident and Emergency.

The Save Our Hospital Services Campaign have collected thousands of signatures. The people of Huddersfield are making their voices heard but who is listening? Not the Area Health Authority, not the National Health Service Trust nor the consultants. But then why should they, what inconveniences will it cause them? Admittedly, they will face the same journey to Halifax but presumably in a comfortable, warm car, arrive at a brand new, beautifully appointed hospital and wait for the sick and travel fatigued patients to arrive. I think the people of Huddersfield deserve answers to serious questions of transport, possible delays and risk to human life.

Is the new hospital the real reason for the change? The mood of the people in the street is that a building has become more important than themselves.

The Save Our Hospital Services Campaign has written to the Area Health Authority asking for answers to twenty questions which are upper most in our minds. They are as follows:-

1. Why, when Huddersfield Royal Infirmary has twenty years experience of neonatal intensive care and incubating sick and premature babies, and Calderdale has only two years experience is it proposed to move these units?

2. What assessment has been made of the risk to patients in urgent need of medical attention, and in particular maternity cases, involved in the extra travelling time to get to either Halifax or Huddersfield? If there is a report, can we have a copy please? This appears to contravene one aspect of the reasons for centralisation i.e. fears of litigation. The proposals appear to increase the risk to health by delaying arrival at hospital, so increasing the possibility of litigation.

3. How can a "low risk" obstetrics unit operate in Huddersfield?

4. What is the criteria for classifying patients as "low risk"?

5. What assessment has been made of the effect on Asian women who prefer to see a doctor in addition to the midwives during their pregnancy?

6. SEPTA undertook some limited public consultation about whole hospital modelling prior to preparing their report to the Area Health Authority. How were their findings reflected in the report the Area Health Authority received on 21 October?

7. When will full public consultation begin in both Huddersfield and Halifax on the proposals? Can we please have a list of dates, times and venues. Consultation meetings need to be heard at a range of different times enabling local people to attend if they are working or not.

8. How much weight will the Area Health Authority give to public opinion in its decision in March 2000?

9. Transport was acknowledged by Philip Sands at the last Area Health Authority meeting as in need of review. Can we please have details of the transport structure you have in mind together with the review process and timescales.

10. What consideration has been given to the effects on family life if a child is in hospital in one town whilst siblings and parents live in the other? How has this been considered when the family rely on public transport?

11. What consideration has been given to the mental health of children in a hospital in a different town to their parents, who can only make the journey to visit them infrequently?

12. Has thought been given to the mother who is breast feeding a premature baby in Halifax and her other children live in Huddersfield?

13. Is the building of the PFI Hospital in Halifax the prime reason for these proposals?

14. What is the average number of applicants for medical posts in each specialism in Calderdale and Huddersfield?

15. How can Accident and Emergency provide a full range of services in both Calderdale and Halifax, or will certain types of injuries and illnesses be routed to Halifax and others to Huddersfield?

16. If the latter is the case which cases will go where and how will the public know where to go?

17. How was travel time by blue light ambulance calculated as 12 minutes increased journey time between Halifax and Huddersfield? Note - this is not a realistic amount of time for the majority of journeys to hospital which are made by private car or public transport.

18. What has the increased journey time between Halifax and Huddersfield been calculated as for private cars and public transport?

19. If neonatal intensive care is in Halifax who gets priority if a Leeds baby and a Huddersfield baby need the last cot available?

20. How much extra cost will have to be met by the Ambulance Service in respect of the additional mileage and who will meet this cost?

The people of both Huddersfield and Halifax have grave concerns about these and many more questions. They are concerned for the future of their local hospital services and the health and welfare of their families.

The letter was sent on 8 November. We have not received a reply yet but hope to hear from them very soon. I am willing to let you have a copy of the reply.

Councillor Smith: We are in the process of setting up focus groups to get people's experiences. We would be grateful if you would write down stories that you hear about how the proposals will affect people. Thank you very much for coming today.

D5K005

KIRKLEES METROPOLITAN COUNCIL

SCRUTINY COMMISSION - CHILDREN'S AND WOMEN'S SERVICES

NEIL HOLT, BUS SERVICES CO-ORDINATOR, WEST YORKSHIRE PTA

Monday 10 January 2000

Cllr A Smith: This Scrutiny Commission has been set up to look at the implications for Kirklees of the proposed changes in health services, hospital services for women and children. There are proposals that maternity and paediatric services should move from Huddersfield into Halifax and that would be the worst case scenario. What we are interested in getting from you is the impact of moving those services, on public transport. We have been over to Halifax on the bus - we went over on the Express Bus. Do you want to tell us about the services that serve the Infirmary now.

Neil Holt: I did a little bit of homework over the week-end just to remind myself about what actually existed at the present time. I think it is probably worth starting off by talking about what our involvement would be. Clearly we were aware from the planning application for the Halifax site that something was happening way back in 1997 when the first planning application went in. At that stage we were concerned to make sure that there was adequate provision for buses on the Halifax site. So we made representations as far as the planning application was concerned to ensure that buses could access and egress from that site effectively.

The plans as far as I can work out at this stage and unfortunately I have not had time to get back to the developers of the site are supposed to make provisions on the Halifax site for a bus turnround adjacent to the main entrance to the hospital. Buses should be able to get into and out of the Halifax site and drop off somewhere near the front door. Other than making representations on that planning application we were then approached by the Health Authority by Philip Sands in May time of last year, and three meetings took place between May and September at which the implications for public transport were considered.

There were a number of ideas suggested I think the main thrust of those ideas was actually trying to provide some link between the two hospital sites and the consensus that came from the meeting was that the X36, which you rode on direct to Halifax, would actually divert, run out of Huddersfield via Manchester Road, calling at the Huddersfield Royal Infirmary site and then would drop down onto Halifax Road and run direct into Halifax, but divert via the bus provision that is being made at the Halifax site. So there would be a fast link between the two hospital sites. There are two problems

with that - one is that the bus access to the existing Huddersfield hospital isn't very good or not on site. The buses stop close by the hospital but the buses can't actually get onto the site and one of the things that Philip was going to go away and look at was actually trying to get bus access onto the Huddersfield site as well as ensuring that provision was being made in the plans for the Halifax site.

The half-hourly service that the X36 currently runs at wasn't considered to be sufficiently frequent and so the operator who also attended the last meeting in September went away and came back with the cost for increasing the frequency on X36 so that it ran every quarter of an hour rather than every half an hour during the day time and also ran half hourly in the evenings and on Sundays. There would be a significant cost associated with that. It would need at least two additional peak vehicles to provide the service. The operator came back with the costs which unfortunately I haven't got but that cost was subsequently relayed onto Philip Sands at the Area Health Authority at the end of September/beginning of October.

Since then we have heard nothing from the Health Authority at all. It was only the note to attend this meeting that prompted me to realise it has been three or four months since we have heard anything from the Health Authority about the ongoing discussions that were taking place regarding public transport. So effectively it would mean that people would continue to go to the existing Huddersfield site either that or come into Huddersfield and then change from whichever bus they were on to catch the X36 to go through to the Halifax site. The discussions seemed to be centred around the customers, the patients, actually paying the fares on the bus so there would be a fare penalty as far as they were concerned in having to pay twice if they had to go through to Halifax.

That is the way the discussions were going - basically to provide an enhanced X36 that would divert and provide a fast link - journey time would be something like about 20 minutes. Generally speaking, the service is reliable. It experiences problems in the peak period up at Ainley Top and at the Calder and Hebble junction and certainly was some comment passed onto your Council as Highway Authority to look at possible measures for improving or providing some form of bus priority to help buses through the Ainley Top junction.

Statement: Both those routes are within Calderdale?

Neil Holt: The Calder and Hebble one was passed onto Calderdale. It is bad coming up to Ainley Top out of Huddersfield and out of Halifax, and Calder and Hebble is just a disaster area in the morning peak. That is the honest truth. I just wish we could find some solution, although it has got better. That is the background. The other thing that I did do at the weekend was to actually have a look at the existing Huddersfield site which I think is what Councillor Smith was

asking - how accessible it actually is for people within the existing Huddersfield area?

Not only are there the links out of Huddersfield Bus Station up to the hospital site but a lot of the services that do run up and past the hospital actually run on a cross town basis so there is already fairly good links from the Brackenhall/Birkby area using service 360 from the whole of the eastern area the Rawthorpe, Dalton, Upper Heaton area with 370, 371 and 369. Almondbury has got the 372, 373 and we have got Newsome and Berry Brow on the 319 and then you have got the 392, 394 etc. that provide a little circular service that actually gets as far as Milnsbridge in the Colne Valley, but the rest of the Colne Valley and Holme Valley I think are the two areas that don't particularly have good links through to the hospital at the present time, but the rest of Huddersfield really have a direct link. People do have one bus that they can catch, one through fare that they can pay without having to ride into Huddersfield and pay again.

The 360 from Brackenhall and Birkby is half-hourly. The 369, 370, 371 - those three buses which are doing the Rawthorpe, Dalton, Upper Heaton area, they all operate at a 20 minute frequency each, that is 9 buses an hour from that general area. The 372 and 373 they operate every 20 minutes. Newsome and Berry Brow and the 319 have got an hourly service and then, as I say, the 392, 393, 394 and 395, which is, in effect, a big circle that covers Almondbury, Newsome, Milnsbridge, Lindley, Weatherhill - they operate at an hourly frequency.

Question: Are these all commercial?

Neil Holt: All of these are commercial during the day time which I think is the time you are bothered about. Nights as well for visiting.

Question: So that means that most of the bus services that are provided are provided on a commercial basis without public subsidy? Dalton, Rawthorpe, Brackenhall and Newsome have all got direct access through to the Infirmary during the day time at least, one fare to be paid not two, and it is all provided on a commercial basis with no public subsidy. What happens at night?

Neil Holt: Some of the services don't run - the 360 link - so the only way that people from Birkby and Brackenhall can get through is by Huddersfield. In Birkby a link remains there with the 394 and 395 but it doesn't go as far as Brackenhall. Rawthorpe, Dalton area still has a half-hourly service on an evening which continues to run through. Almondbury goes to half-hourly. Newsome and Berry Brow can use the 392 and 393 which is there as an hourly service.

Everywhere other than Brackenhall still has a direct link through to the hospital. The frequency of that direct link is a lot less than during the day time. Some of that is subsidised and some of that is commercial. It is a mix of the two. The majority of it is subsidised. Evening starts at about 6.30 p.m./7.00 p.m. The watershed is

between about 6.30/7.00 p.m. It is a bit earlier on some and a bit later on others broadly speaking.

Question: We heard that the way the Health Authority was thinking about providing their connections with Huddersfield was that people would have to go the Infirmary in order to get to Halifax. They would have to go the hospital they didn't want before they went to the hospital they did want. They are more or less on the same bus route - it isn't as if they are on different bus routes to get there - so I can see that in some ways the X36 changes would be beneficial.

What concerns me is at the moment you have got a whole network of commercially viable services that go to the Infirmary. There are two issues - number one is the socio economic issue about getting 'through' buses like people from Brackenhall instead of having to pay one bus fare they will have to pay two now. The other issue is commercial sustainability of the existing services through to the Infirmary. Now if you took some of the people who visit the Infirmary off the buses you have just said because they go to Halifax and they are going to choose to go a different way, maybe will that threaten the rest of the services going through to the Infirmary? Will they become less financially viable?

Neil Holt: I think one of the things that the Bus Company has done is to recognise that the Infirmary is a cross town destination that people actually want to get to, and within the local Huddersfield area most routes are provided on a cross town basis so the operator actually looks for destinations beyond the town centre where he thinks people might actually want to make cross town trips. They have actually tried, in a positive way, to create links through to the Infirmary because people wanted to go there. If the number of people that do want to go there decreases and people do find different ways of going, then the operator will look at different patterns on which he can run his buses because there is no point in continuing to run buses past somewhere that people no longer want to go to. What he wants to do is to maximise the number of passengers on his buses so that he can make as much money as he can do.

Question: People using these cross town buses, particularly during the day, will be going to out-patient clinics or they will be visiting. People who have got to visit on a night might have to go to Halifax. Why would they take the X36 to Huddersfield Royal Infirmary? They want to go direct to Halifax. Why does the bus need to go to Huddersfield Royal and increase the fare for those people to get to Halifax?

Neil Holt: I haven't been involved in the discussions but the view that has been expressed to me was that the Health Authority was looking to try and provide a link between the two hospital sites. It will slow the service slightly but the operator does still think that he can make the total trip in the 25 minutes running time that we have got at the present time.

New Voice: All that those proposals are going to do is actually make the trip between the town centre and the Infirmary better. You are going to have more trips - it doesn't make actual sense for the people who are going to have to go to the Halifax General.

Neil Holt: The X36 is the quick bus. There is the 502 and 503 that is reasonably direct, but it doesn't stay on the by-pass - it goes off via Elland and then you have got the 343 and 344 - but that one meanders down the back way to Elland and if you really want to go round the houses you could try the 537 and 538.

Question: It would seem that, in making their plans, the Health Authority have fallen into the trap of looking at it only from their point of view rather than their customers point of view.

Neil Holt: To be fair to the Health Authority, I think there is an issue regarding staff movements as well. There seems to be a suggestion that staff will need to be relocated from one site to the other site and providing them with some form of transport between those two sites. Essentially we can try and work with the operators to provide whatever people want. At the end of the day we are not in a position to fund. I think that is something that needs to be funded by the Health Authority and not ourselves.

Question: There is no possibility, I am sure, of providing a direct service from Brackenhall, Rawthorpe, Dalton, Almondbury, Newsome direct through to Halifax is there?

Neil Holt: No. The existing level of service between Huddersfield and Halifax - you have got basically a half-hourly service on express direct and you have got the half-hourly one via Elland which is still fairly quick. I think you have got a pretty good service there. It is not capable of sustaining a service at any higher frequency than that. While you can put the cross town links in, within an urban area, because you have got lots and lots of services that are designed to come into Huddersfield centre then you have got to send them somewhere else. So whilst you can put those links in within an urban area, you can't then look to providing the cross town links onto what become inter-urban services. It just never works.

Question: How much does it cost to go from Brackenhall to the Infirmary now?

Neil Holt: I think the off peak fare is 80p, but I stand to be corrected - it might be 90p. If it is 80p maximum off peak, they are going to have to pay two 80p rather than one 80p. Essentially, if they do what they say they are going to do and centralise various services on one or other of the hospitals, then there is a cost penalty that is going to be incurred by their customers effectively. In the off peak it is going to add nearly £2.00 onto the cost of a return journey to hospital for the majority of travellers.

Question: You talked about the buses getting stuck in traffic. What about the buses going from Huddersfield to Halifax?

Neil Holt: It is in the morning and afternoon peak periods.

At the present time the services that we are talking about are commercially provided. If we were talking about the increase in providing some sort of service and the Health Authority came to us and said we will pay for 'x', then we would tender - it would be open to any operator to actually submit a bid to run that service. The reality is that X36 at the present time is run by First Huddersfield and First Calder Line and they are about the only operators that are likely to bid for the running of a service like that.

Question: If the Health Authority says it will pay for a bus to go to such and such a place, with a view to going out to tender and pay for that, first of all, is that legal? My understanding is that you can't put tender services on commercial routes. Would they be able to do that? If they were able to do that, what impact do you think it would have on the commercial network?

Neil Holt: If the Health Authority was going to do, all you could actually do would be to provide something between the two hospital sites.

Question: You said the Health Authority were proposing that the X36 divert half-hourly at night.

Neil Holt: No, it is not financially viable. There would be a cut and it would need to be met by the Health Authority.

Question: Extra costs will be incurred to run frequent services at night and week-ends, when commercial services don't run. Extra costs would be incurred by patients going into Halifax having to pay two sets of bus fares instead of one.

Neil Holt: Potentially extra costs during the day time if you felt that the existing level of service wasn't sufficient - you have only got an half-hourly link between the two centres. A quarterly hour would only come about if somebody provided some money to improve the service. There is not a hope of the Bus Companies providing any higher frequency service than they currently operate without somebody paying for those extra costs. Those extra costs would be for two peak vehicles, a lot of mileage and a lot of staff - we are talking big money.

Question: Can't we do a survey to see who is using public transport what the usage would be?

Neil Holt: That is one of the things that we asked the Health Authority for - some indication of the likely demand for the service, even if it was just existing levels of out-patients attendance that there was at the existing Huddersfield site. We have got nothing back from them as yet.

It is always incredibly difficult to provide "new services" because if you go and ask people if they are going to use the bus then 90% will say yes. But then they will use the bus maybe once a year or something like that. So your base level of usage is always a lot less. You end up getting the best information that you can do and running on a trial basis to see if people are going to use the bus or not use the bus. If it doesn't work on a trial basis you maybe try something slightly different but eventually you give it up at the end of the day.

Are patients themselves going to need to move from one site to another?

Question: How much input has there been from the Health Authority into the Local Transport Plan, bearing in mind that the Salter Hebble junction is over-capacity?

Neil Holt I honestly don't know. I am not involved in the local planning process itself, but I understand that the Health Authority has been invited to comment and been involved in the consultation process.

Chair: Thank you very much for coming. It has been very interesting.

D5K007

KIRKLEES METROPOLITAN COUNCIL

SCRUTINY COMMISSION ON CHILDREN'S AND WOMEN'S SERVICES

TONY KEIGHLEY, CHIEF EXECUTIVE
CHRIS VEAL, MEDICAL DIRECTOR
PHILIP SANDS, EXECUTIVE OFFICER
all representing
CALDERDALE AND KIRKLEES HEALTH AUTHORITY

Monday 10 January 2000

Tony Keighley: Obviously we are now almost a month into the consultation process. We have many meetings still to hold - we have quite a number of public meetings that are still to begin, but we have already had some preliminary ones and I think a lot of ad hoc meetings have also been arranged by request that you will be getting involved in. I am heartened actually on the response to the consultation document so far, particularly from professionals and people in the wider NHS who were familiar with the issues that we are talking about and the way they have been presented. I feel reasonably comfortable that it has caught many of the issues that is facing the wider NHS in the country, but clearly we have to localise this and look at the impacts of the proposals. You have put a series of questions and Chris (Veal) is going to do a presentation which is probably the standard presentation that we are doing across the board. We will try to respond to the questions that you put.

I found out about this meeting on Friday so, unfortunately, I had a previous commitment and I have to leave after an hour. Some of my colleagues will stay. Some of the questions it may be difficult to provide some of the details that you are looking for. It may be worth a discussion on the thinking behind some of them - we will do our best and if we can't respond today we would be happy to follow up with further work or it may require progress further down the consultation process because some of this is about testing proposals and receiving feedback in some cases. Some of the questions I think might need some further discussion. This is the second meeting we have attended. I hope that many of the issues are beginning to make some sense. We have a long way to go yet. I want to stress that we haven't made any decisions as a Health Authority. We have no intention of making any decisions on the proposals until the final outcome of the meeting on 23 March 2000. If the proposals that are coming forward clearly do allow us to deliver some clear objectives for the future then that is what we want to get into a position for. It is about developing a future strategy, not immediate solutions but clearly we are looking some years ahead in some cases.

Chris Veal: You will have had the option document and I am sure spent quite a lot of time with that document. I think it is important for us to try and emphasise what it is that we actually want out of our Local Health Services. I think it is important that we maintain the widest range of hospital services that we can within the locality. That obviously includes Huddersfield and Calderdale. We are aware that there are a number of pressures which would push services into the larger teaching centres, particularly with Leeds and Manchester being only 25 miles away from us.

We are looking for two strong hospitals and I think this provides us with an opportunity to consolidate and produce services which would take us forwards into the future and maintain two hospitals. I think a lot of other places have gone down the route of closing a hospital, producing a hot and cold hospital, our intention is to produce two acute hospitals and to maintain two acute hospitals. But we need them to work together in order to provide a full range of services. I think it is important that we maintain two 24 hour A&E services. The A&E services are critical to hospitals in terms of providing that front door for patients to come into the hospitals, to act as the power house in many ways - to look at the problems that come out. They are the distribution centres within the hospital from our point of view and we need to maintain our A&E Departments.

We need to actually improve how they are performing at the present time. Where we see there are particular problems in terms of critical mass for services, within terms of specialisms, we want to create local centres of excellence. We want to be able to maintain specialist services. We would like to be able to develop those specialist services and you will know that some of the work that has already been done around oncology, haematology - a range of areas where we can actually strengthen our existing services. There are areas we have already talked about such as neonatal intensive care, where there are risks of losing services if we can't achieve centres of excellence. We want to meet national quality standards. Increasingly, the Health Service is coming under scrutiny. There are obviously the exceptional cases like Bristol but in terms of day to day performance it is very important that we actually provide services which meet and can be shown to be at least average or better than average from that point of view.

There are a range of pressures coming through and we are seeing them increasingly being wound up. We started with cancer services, with the Calman-Hine report. We are seeing National Service frameworks. The new one for mental health has recently come out. We are looking for one for heart disease, there is elderly, there is a whole range of drivers and there are mechanisms in terms of some of those services where our local trusts, our local health services will be visited and inspected, similar to Local Authorities who have experienced the

arrival of organisations like OFSTED. We are going to have the Commission for Health Improvement visiting our hospitals on a regular basis, assessing the levels of quality and the standards of care that we are providing. So we have to meet the national standards.

We have to be able to provide services which are of good quality. We would want to do that anyway as a health authority but this puts a perspective on it which means that we have to keep up to national standards. There is a changing pattern of delivery of health services which is trying to put more services closer to patients homes so that children in the past, who have spent long periods of time in hospital would find far more of those services in the community and we are looking to increase that. Children used to stay in hospital when they were of low birth weight, often for months on end. We get them home earlier, we send in teams to help the parents look after them at home. We can do a lot more in relationships to this.

Why do we need to change? Disease is changing. I can show you a graph of haemophilus influenzae which was one of the common causes of meningitis in young children, particularly under the age of one, which shows a continuous decline in cases since we immunised against that infection. The number of children coming into hospital has just crashed. You will know recently that we have been starting to immunise children against one of the forms of meningacocoli infection which produces meningitis. That is likely to have a significant effect on the number of very ill children coming into hospital. So we are seeing changes in diseases, we are seeing people living longer, so we are seeing more cases of cancer, we are seeing more heart disease.

Treatments have evolved. When you came in and had your cataract operation, in the past you probably stayed in hospital for two weeks. You went home being able to see partially, you got your glasses at three months. We now have people coming in for cataract operations that walk out of hospital able to see. Their final refraction isn't done until a little later, but there are some very major changes in the way in which we manage cases, more cases being done as day patients, less length of time in terms of in patient care. We are seeing a greater degree of specialisation in terms of consultant staff, nursing staff, right the way across the board, and it is no longer appropriate for people to be generalists in the way in which they were in the past. They have to show their competence in a sub-specialist area by doing a certain number of cases - it is not adequate to do two or three cases a year and to be able to say that you are competent to provide that level of service.

If we look, particularly in relationship to children, we should not have surgeons who are operating infrequently on children. We need anaesthetists who are competent, who are working with children on a regular basis. We have seen repeated recommendations that this infrequent form of surgery is changed. There is increasing specialisation, we are seeing it across the field whether it be in terms of general surgeons, we have vascular surgeons, we have gastro intestinal surgeons - there is much more specialism and it is difficult to provide all those specialisms in the smaller district general hospitals. We also have requirements for training. Training is an important part of the health service to produce obviously the next generation of doctors and nurses.

While the requirements for training are being increased, we have to show that we have the sub-specialists, we have to be able to show and attract the junior hospital doctors into our hospitals. Without junior hospital doctors we lose a significant service approach to local hospitals. We also lose a lot of the enthusiasm for consultants to come to our hospital. We have to maintain our teaching and our training facilities to produce the next generation of nurses, senior nurses and doctors. We have pressures for change of providing a 24 hour service and that relates partly to the reduction in things like junior hospital doctors hours, that is coming down to around 50 hours a week. We can't ask consultants to be on call every night and if you look in the past we have two neonatal intensive care units of which we have one consultant working in Huddersfield and we have two consultants working in Halifax dealing with children who are small and sometimes critically ill, needing a very high level of skill and care.

I think we are seeing a move gradually away from what could be considered a consultant led service to one which becomes a much more consultant delivered service. In other words, the consultant is doing more of the work so that the hours they are on call become more critical in terms of the time they are there and are working in hospitals. So we've got shorter working hours, everybody else accepts that it has taken a long time for the medical profession to come to terms with the fact that long hours are not good for patient care. But we have shortages, particularly of junior hospital doctors - the recommendations are that we need to be qualifying several thousand more junior hospital doctors a year.

Even the current increases to produce an extra thousand junior hospital doctors will take five years before those doctors come through the system and they have still to continue their post-graduate training. We are talking about 10-12 years before action that we are taking at the present time will result in consultants arriving at the end of the scheme who are able to provide the level of care that we are looking for. We are going to see significant decreases in the number of junior hospital

doctors in a number of specialities and we are talking around 600 in both obstetrics and paediatrics. That has to do with equating the number of specialist registrar posts with the number of consultant posts that are going to become available.

I think it would be useful to say at this stage that SHOs are a very junior grade of doctor within the hospital service. They are not on the specialist training programmes at that particular stage in their career and although we rely on them to do quite a considerable amount of work you have to accept that it's the Registrar grade who are specialising and have a high level of knowledge and skills. National standards in the terms of quality of care and the National Service frameworks we have mentioned. We have talked about the changes that are occurring across the whole of the speciality - all the specialties having to meet national standards in the future.

We obviously need hospitals that are going to work together. We would expect our local hospitals to have to work together particularly to provide some of the services. We also expect our local hospitals to work with Leeds, particularly, but also with other teaching hospitals as well. There are one or two national centres for particular diseases that you would expect to be sent to as a patient, such as Birmingham or to London. In terms of the proposals, we are still looking for 90% of services to be provided in both hospitals and we are talking here about out patients, day patients, in patients. 90% will stay locally. People will not have to travel any further and in fact they may have to travel less.

We are talking about hoping to be able to establish normal deliveries and having a normal delivery unit in both hospitals. We are talking around 10% of services that would be provided as an in patient service, not an out patient service in one or other of the two hospitals. We are talking about services that are maintained, 24 hour A&E for both adults and children. We are talking about intensive care for adults in both hospitals, you will know that we don't have intensive care for children, the paediatric intensive care beds are in Leeds.

We are talking about coronary care services, coronary care units being provided in both hospitals. We are also talking about general medical admissions and general surgical admissions, in other words the strokes, the pneumonias, the hernias, going into both hospitals. We are talking about most breast and bowel cancer surgery staying in both hospitals, we are talking about care of the elderly and rehabilitation staying in both hospitals, and we are talking about mental health being provided in both hospitals with in patient beds.

As far as possible we will provide an out-patients day case, ante-natal and diagnostic tests, full range of services in both hospitals. There are three potential options for the low risk delivery unit and they are at three different levels. One would involve a midwife-led unit with some form of specialist doctor on site, some form of obstetrician; a midwife-led unit with a specialist doctor on call; and a midwife-led unit which would be able to have advice with admissions and problems being sent to the more specialised centre. In terms of centres of excellence we talk very much around the complicated deliveries and care of sick new born babies being in Calderdale, together with in-patient specialist head and neck surgery and also hand surgery.

There is not a lot of in patient hand surgery so it wouldn't make a major difference where that went, but there is access to a specialist hand surgeon for Halifax. In patient cancer care and the treatment of blood disorders (oncology) brought a tremendous number of patients back from Cookridge at Leeds. Obviously things like radio therapy will continue to be provided in a large centre, currently Cookridge, but moving to Leeds General Hospital shortly. There would be specialist in-patient surgery for adults in Huddersfield, with special investigations on arteries and veins, so the vascular laboratory would come here.

The proposals mean that 90% of services will continue to be provided both in Calderdale and Huddersfield. We will have facilities for normal deliveries in both sites. There are three sub options and very quickly to try and highlight them, where we mentioned in patient children and in patient gynaecology the first option puts both of those in Calderdale. The second option puts in patient children in Huddersfield and keeps the in patient services for gynaecology in Calderdale. The third option basically has in patient children in Calderdale but the in patient specialised surgery in gynaecology in Huddersfield.

I think I will stop at this particular stage.

Question: How many children receive in patient care on a repeating or regular basis? I think all along our concern has been to reconcile the social factors with your requirements.

Answer: We have in Huddersfield 116 children in a year who have had two or more admissions. We have some figures in relationship to the length of stay for the different groups of children. 76% of children are only staying in a day.

Question: What are the sort of illnesses that these 116 children have?

Answer: They can be recurrent. A child that comes in with an asthma attack. Some of the chronic illnesses from that point of view and children with diabetes. There will be a few children with long term congenital conditions amongst that group of children. Amongst those 116, I suspect that most of those will be for acute conditions.

Question: We would appreciate a better breakdown - further information on that because it would seem to us from a lay persons point of view there are a cohort of children who come in and out on a regular basis.

Answer: I think we would want to do further research because it is necessary for us to understand whether the surgery led to an unstable condition which led to another admission to hospital or whether it was a stable condition but the family had problems with coping.

The other thing we are able to do is break it down through super profiling. We have got ten levels and there is one around disadvantaged children. We are talking about 20 children from the disadvantaged group that will have had two or more admissions in a year.

Question: Have you any figures for children who are repeat attenders at Halifax?

Answer: We can get those figures for you. I think there is a move to provide a different style of care - we discussed this last time that hospitals are not the appropriate place to provide respite care. It is the wrong sort of environment.

Question: Are there any figures for in patient coronary care?

New Voice: I haven't got the exact figures but we are talking around 400 admissions to the coronary care unit a year in Huddersfield.

Question: The thinking behind this question is that we felt that if 90% of services stay put that the children's services were seen to be regarded as more "disposable".

Answer: It is important to look at what skills are needed in the coronary care unit as opposed to those needed in a special care unit. What is the level of complication we are talking about. Paediatricians will tell you that dealing with children requires very different systems of treatment. There are some areas within coronary care which are very complex. Chris has done a lot over the last few years on the protocols on treatment in coronary care work where you monitor people who have a heart attack and, while it is complicated, it is relatively much more simpler than trying to look after a very small infant.

The other thing as well that we have tried to get across in the consultation is that looking after children isn't just looking after a single set of problems for children - you are looking after neo-nates, babies, toddlers, adolescents - all of which will require different styles of care - but within that you have got a wide range of diseases and conditions as well. So when you break it down whilst the number of children repeat admissions may be large, if you broke those down into age groups by diagnosis then the numbers would be much smaller.

Question: There is an issue about having women-centred maternity services - I have a feeling that, because a small percentage of women need intensive intervention, everybody else is having to go where they are going. I have a feeling there is a tension between the hi-tech skills and the women's-centred services.

Answer: The commitment around the normal delivery is a commitment to work with your other colleagues. How can we maximise the number of women who can be comfortable within that women centred care when they need that medical intervention how is it best provided. I don't think what we are looking for is a single massive unit which is 'bossed' by doctors. In Halifax, at the moment, they have what is a GP led unit but is, in fact, more midwifery led. If there are problems there then the mother would be transferred quickly to the place where the consultants are. However, I fully agree with you - it isn't about turning delivering babies into a high tech specialisation, but how best to provide both of these.

Question: I think there are other questions around the midwifery unit. I think the feeling here is that we would not want to have a midwifery unit without consultant support. That is not acceptable. I think the consultants we spoke to feel that the midwives feel that it would lead to an unacceptable level of risk and would result in a downward spiral of the service.

Answer: We can show you and provide you with information on a number of units across the country which work very much to that model (low-tech midwifery led) that achieve good outcomes in terms of the deliveries. They are not potentially any more risky. Admittedly, we have to argue with our colleagues in relation to these areas, but the successful units have a very high degree of local support and enthusiasm on the part of people who deliver in them. Even the women who are transferred out of those units because of complications still want to go back to that form of care. I think we have to look at the situation where we can show that there are very successful units running on that particular model.

Question: What obstetrics and paediatric cover will be available to a midwife led unit? There are three options aren't there?

Answer: Three options laid out. One level would be a midwifery-led unit which wouldn't have medical cover. The midwives could work with an anaesthetist on site but there wouldn't be involvement in that other than advice over the telephone from an obstetrician or a paediatrician.

Question: And that would mean that on a practical level the women would be able to have an epidural?

Answer: I think that would need to be decided because you obviously need an anaesthetist involved. There are units where the anaesthetist supervise from a distance - the midwives give the epidurals, but it is a change of practice and we would need to look more closely at how that was actually delivered. The other problem with epidurals is that you potentially increase the number of lift-out deliveries that are required.

It is difficult to sort out because sometimes epidurals are given to women who are already having problems or prolonged labours, so you would expect a high degree of obstetric intervention in terms of forceps and caesarean sections. However, there is evidence of the fact that epidurals can limit the number of normal deliveries in which you get more opportune interventions - it is debatable as to what the actual reasons for that are. It is something you have to bear in mind when you decide to set up an epidural service, that you might need a higher level of intervention.

Question: Would a woman in the midwifery-led unit without any backup who needed an emergency caesarean have to go over in ambulance to Halifax?

Answer: We are unusual in that the unit will be on a site which will have paediatricians covering A&E, covering the admissions area, and the day assessment area. You will have anaesthetists on site at all times - it does differ from the sort of stand alone small isolated unit.

The next option was where there would be an obstetrician on call. There wouldn't be resident obstetricians in the hospital but they would be available on call. If a woman was getting into problems during labour, then an obstetrician could be called and would be available within 30 minutes to assist the delivery or to carry out a caesarean.

Those could be in the form of specialist registrars or consultants and, again, we have a situation where at least during the day you would have clinics in both hospitals with people who could be called on. Being on call doesn't always mean that people are far away. At night you would be calling people in from home or from the other hospital.

Question: How does that differ from the situation now?

Answer: The situation now is nearer the third option where there is obstetrician doctors on site, so there is a 24 hour rota which might be made up of consultants or registrars or SHOs. We are, however, seeing the number of SHOs reducing.

Question: If the two hospitals operate as one team would you have specialists to cover for 24 hours?

Answer: Not as it is currently, particularly as there is an expectation that consultants will be available for 40 hours as a starting point which we don't achieve at either hospital at the current time.

Question: So that option is not achievable unless you increase the number of obstetricians?

Answer: Yes. The other element to understand as well is that when a women gets into difficulties on delivery it could be around problems that an obstetrician could solve, but my understanding is that often a paediatrician would be called to look after and monitor the baby's condition. If it is a problem during delivery, which is just a problem for the mother and not the child, then the availability of obstetricians can solve that. If it is a problem which then results in difficulties with the baby then it is better if paediatricians are available as well.

Question: The Commission have received evidence about the need for team working within different specialties. Will team working affect services being provided across the two sites?

Answer: If we look at the present situation we have a limited number of obstetricians and paediatricians, and for them to work together as a single team across both sites they would have to provide day care and out patient care, cover for the A&E department on one site and the in patient care on the other site. It is being able to put more specialists together and being able to sub-specialise in particular areas.

You could not provide the 40 hours cover on the labour ward currently with four obstetricians.

Question: Is it an option to employ more obstetricians?

Answer: It is certainly an option. I am sure we are going to see a change in service where more obstetricians and consultants are on call to actually deliver the services.

Some of the basic services that we are talking about with doctors covering 24 hours could be provided by employing more staff. It will depend on whether those staff are available. At the moment within obstetrics an individual consultants costs the service in the order of about £100,000 so if we took on two or

three we are talking about a £¼m needed. But the added difficulty is in terms of the specialist services that we have talked about. We would neither attract people from the other specialist services, nor would they retain their competence to deliver specialist services, because there are insufficient problems coming through. Whilst you could provide the normal delivery unit with more medical cover, those people serving the delivery unit that doesn't have the complex deliveries will not gain or maintain their skills as the other one unless they rotate.

Question: Is that what they would do?

Answer: Well, they could do. In paediatrics that is more complex because there aren't enough paediatricians, and also it is not just team working across the doctors, it is team working with other staff as well. Therefore, if you take something like youngsters with cystic fibrosis, which is a medical specialism, then they actually need to build up a team with specialist physiotherapy and other therapy groups. It is not just the doctors within the team, within each of the medical conditions that children might well be subject to, you need other members of the team, nursing staff and therapy staff building up their expertise in that area.

Question: One of our concerns about that is that hospital staff also learn to build up partnerships with non-hospital based staff such as health visitors, specialist nurses etc. We need to develop protocols, particularly around child protection, that work and we feel that there will be added complexities in concentrating in patient paediatric services in one place which will give added complications for other professionals working in the area, such as around child protection.

Answer: I started Ellersley many years ago and the principle there was to develop paediatric services in a community environment, it wasn't actually to centre on hospitals. There is a centralisation and decentralisation factor in this. Most paediatricians now and in the future will work in community environments, what we are talking about is a diminishing number of children who will require in patient hospital care and most paediatricians will tell you that the numbers have diminished because of change in clinical policies, but also because of strengthened ways of keeping children out of hospital. That will continue and that is what we want.

We can't say irrevocably that staff numbers won't change in certain of these areas, but it isn't as straight forward as just putting more money in. It is a matter of recruitment and retention in the right specialties. Some specialties have a proliferation of doctors coming through training, others are very scarce and difficult to recruit. Whatever specialty we look at, this will apply in the future. Chris talked about junior doctors' hours in quite a small way. The impact actually of staffing in-

patient services across all specialties is going to become increasingly difficult. The European directive on junior doctors' hours, if implemented, and there are debates going on about the time it will take, requires 6,000 initial doctors in training and, quite frankly, it is going to take years to get the impact of that through. We will not be able to sustain some of these services even if we wanted to.

It is getting a balance between those who focus on hospital care, but we also expect paediatricians to be working increasingly in a community environment and developing the networks that you suggested.

Question: We have heard a lot about that but have seen little evidence on how it is working. No evidence has come forward. Our concerns are that the protocols that have been built up between Ellersley and Huddersfield Royal Infirmary are contributing to keeping those children out of hospitals. How will we ensure then that those particular protocols will be developed in the new service that has a much wider area and will have to develop those very local relationships on a much broader scale? To be hard nosed with you, the General Practitioners have come to us and said that they have not been involved in your planning for this - we have not had evidence from the nurses to say that they have been involved in the planning of this, so all this talk about taking local services out into the community is actually talk.

I cannot gauge how it will actually affect the children, in fact I worry because we have spoken to parents of children in particularly vulnerable areas who say that they are not getting proper access now. The danger is then that by changing things it will make it worse for them. We need to see that all these things have been taken into account and measured up and given as much importance as your consultants. I understand in some ways what you are saying but there are other things to consider as well.

Answer: I think part of the process for consultation is for us to listen to you and for other bodies feeding into the process. We are looking at a strategic development which won't happen immediately in certain circumstances. We don't want to implement any service that actually deteriorates from what we have now. But the reality is that change is inevitable. We are not looking at the convenience of consultants in this. The first reaction I had when consultants wanted to centralised the whole service was "is this really to make life easier for you". Human nature is human nature and some will clearly want to develop services that suit them.

I think what we are trying to do is separate ourselves from that and look at the difficulties sustaining services in the future and to do that whether we like it or not we have to recruit medical staff. We have to recruit medical staff into a working environment that

they are prepared to come to. There is a balance here, isn't there. We can have all the principles we wish, but if you can't recruit the doctors to provide the service then you don't provide that service, and that equally applies to nurses and midwives and clearly the other supporting professionals that are essential in getting the team working. None of this will work without proper team working.

We are talking about two NHS organisations that are relatively separate at the moment. There are very encouraging signs of them coming together and the most encouraging are around children's and women's services. Clearly we are looking at wider issues than women's services, but it is quite unique to get the amount of clinical support so far that has come forward. We have got to exploit that, but none of this will work unless there is proper team working.

Question: The Pinderfields Hospital at Wakefield - do they have obstetric cover and the only thing they lack is neo-natal intensive care?

Answer: They are wanting to combine their obstetric services onto a single site by 2002. Obviously they would like to go to a single hospital, but the intention is to centralise services on either of the two sites from that point of view - moving away from having two separate obstetric and paediatric in patients.

Question: At the moment they send their neonatal intensive care babies to Leeds.

Answer: To Bradford or wherever they can find.

The Wakefield HA consultation document recognises that those two separate hospitals in Pontefract and Pinderfields cannot sustain obstetrics and paediatrics in the future, therefore the proposal is to bring paediatrics and obstetrics together in the same service on a single site.

Leeds are in the process of moving obstetric services onto a single site.

I think the main messages which are being put out are around the specialist medical work. You are right in saying that there needs to be a counter-balance in ensuring that the community based normal services are not distorted because of that focus, and that is what the consultation is about - to achieve that balance.

Question: The question was about how does the unit operate without neonatal intensive care?

Answer: It is better to transfer in utero a proportion of patients directly to a centre in which women will be delivering, so a number of women will go to Leeds for their pregnancy and delivery when they are known to be of high risk. That can have an effect on the obstetric services in terms of recruitment because that is where the women will deliver because that is where the neonatal intensive care unit is.

Elsewhere around the country there are delivery units in maternity services which will have obstetrics and paediatrics on site but they won't have neonatal intensive care. What they do then is either transfer out, as Chris has said, on assessment of the mother before the birth, and with the level of negligence claims rising that is becoming more and more of a defensive decision, so that many of the patients who will be referred to a specialist centre actually will end up having a normal delivery, but they are referred because of the possibility of complications. Alternatively, the baby would be delivered and would be resuscitated at that hospital and then mother and baby transferred as soon as possible to a neonatal intensive care unit. The worst option is the third one where the mother is transferred in labour to deliver where there is a neonatal intensive care unit and that is when more of the tragedies occur.

If you have a unit where they have to resuscitate and transfer then you have to make sure that the resuscitation skills are provided by the doctors there. What is developing now is through the midwives developing resuscitation skills. Their skills are sufficient - they have sufficient numbers coming through to keep those skills up to date. They would then transfer out. For example, over at Castle Hill, in the east of the county, there are midwives there who would resuscitate babies and transfer them to Hull. They have about 2,500 babies a year. In our proposals we are not solely arguing for the coming together of paediatrics and obstetrics simply around the neonatal intensive care. There are other reasons why the paediatric team needs to come together on the site, particularly around the decreasing number of in patients and also about support of paediatric surgery.

Question: Does Wakefield at the moment have a special care baby unit?

Answer: Yes it does.

Question: Can you envisage a midwifery led unit in Huddersfield with a Special Care Baby Unit for the transfer of babies?

Answer: They would be transferred to the special care baby unit in the hospital that has the neonatal intensive care, but you wouldn't envisage having a special care baby unit attached to a midwife-led unit.

Each of the options provide a different sort of decision being made by the women and partner as to where they would want to deliver and why. Some would say they would rather stay local and take the risk of transfer - others would say I would rather go to Leeds where there is every facility. The issue I guess for yourselves is the starting point of saying here in Huddersfield we have a service which has both paediatric and obstetrics and neonatal intensive care - why does that need to change when all the options seem to have more risks in and that is because, behind low risk secondary units, there are risks at the present time because of the paediatricians that cover that service only one has a special interest and special training in the care of neonates, so if you deliver and there are problems then one of the other consultants will come in and do the best job that they can but there is a risk around that in as much that they don't have all the skills around that particular area of speciality. What we are saying is that one of the reasons for moving forward is that the present system has weaknesses and we want to improve them.

These services will be subject to greater scrutiny in the future. I think Chris's comments about quality of care will end accreditation issues and will be more pertinent in the future. If you look around the country, the amount of litigation that takes place in terms of obstetrics is phenomenal and these are areas that we have to address for the future.

If you have got a comprehensive range of clinical skills in the unit then that is bound to reduce the risk.

Question: Is it a known fact that where decisions are made by people other than obstetricians, then that is where you will get more problems?

Answer: Certainly if you look at the confidential inquiries that are conducted into maternal deaths and infant deaths you find that the lack of involvement of the consultant is one of the major feature - they came in late or they weren't there - the right decisions weren't taken and the feeling is that the consultant involved would have changed the decisions. In fact they talk around 17% of deaths in children, young children, neonates as being preventable. The next criticism is that the consultant wasn't involved in those cases to the level that they should have been.

I think we must say that for neonatal intensive care cases the consultant for that case would come and attend in virtually all situations but can you ask that consultant to continue to do what is equivalent to a one to one on call. How often would you work your normal day, how often would you expect to be on call at night as well coming in to resuscitate babies? How often would you expect to come in as a consultant over week-ends as well? I think you would agree that if you are one on one you may rely

on your colleagues to do the less serious things, but if they are critical and complex and you are going to be called in for that then you are then the equivalent of being on continuous call.

We couldn't allow a service to be sustained under those circumstances.

Question: Is that a reason for merging the two units together?

Answer: It would give us, in the early stages, three consultants covering that unit. That unit (at Huddersfield) is not sustainable as a neonatal intensive care unit locally without the two units coming together. If that doesn't happen that service must move to Leeds as it has done for Wakefield and Pontefract.

Question: Would the transfer of the NICU to one site reduce cases of litigation - what about the transfer of women and babies?

Answer: You need to have good clear protocols of transfer. This is where we may have disagreement with the consultants who would obviously like to see everything centralised on one site for the very reasons that you actually say. We can actually point to other units which achieve good results because they have got good criteria, they are well sorted, the midwives continue to rotate and receive high levels of training. You can't set up that sort of unit without a significant level of input in terms of making sure that things are identified earlier, that you do the transfers at an early enough stage, and that you know when to call people.

The medical leaderships around that would need a very clearly agreed assessment criteria. If it was clear that there were very few risks, then the woman would be offered the opportunity of delivering on that site so that would be one issue. The second one would be that when problems arose during delivery, there would be very clear agreements on when the midwives contacted doctors for advice or when there would be a transfer. If the baby was born and needed resuscitation then again the requirement would be that we would have to demonstrate that there were properly trained midwives available at all times on that unit. If we fail to do any of those things then the issues that you have raised would be problematic.

So as long as we do those things within very clear operating guidelines, then the legal requirements are solved, but in talking to a woman about whether or not she wishes to deliver in a unit like that as opposed to one which has medical support attached to it, then there are different levels of risk upon which she has to decide. Just in the same way now as women decide on home delivery as opposed to delivery in a hospital. But the answer - shouldn't we have high tech units in both towns - if it was at all possible to provide all this range of service in both towns that would be clearly one of the proposals we would put down. The reality is we can't - not for lack of money because in one of our

earlier documents we assessed it would cost about £5m - it is the lack of doctors, but more importantly the lack of through-puts of problems that will keep those skills.

One of the major reports to come out from the Joint Colleges is that you need a population of a certain size to support these services, and for a population of around ¼m we can only support services up to a certain range. What the proposals are talking about is do we combine some of those services across Huddersfield and Halifax and get a larger population, or do we like in other areas simply say we don't provide that service locally, we will buy that from Leeds or Bradford. The problem we have about that direction of travel is that it would erode the local service even further because you haven't got those specialisms.

We have got one of the best cancer services in the country in Huddersfield and that is because we have got Richard Sainsbury and Jonathan Joff, Medical Oncologist, who are here and remain here because we have developed a good local service and also because we have now developed that service across Huddersfield and Halifax. If we hadn't done that then certain areas of cancer treatment wouldn't have been able to be provided locally and those people would have left because there wouldn't have been the work that they are interested in.

Question: Can we come back to the special care baby unit - there is another issue about that. This is one of the areas where we have looked acutely into the social factors. Why would it not be possible to have special care for sick babies, not intensive care but special care on both sites? This follows on from a presentation from Brian Gill who talked to us about extending services, issues around transitional care. Why can't we have a special care unit with transitional care development?

Answer: There is still a considerable amount of medical input and you would really require a doctor to be on call and present in the hospital - possibly to attend a baby that suddenly requires to be resuscitated. I think the other thing that we are wanting to move away from is keeping babies in hospital. One of the anxieties I have about some of the concepts around transitional care is that it still retains the hospital end of looking after children. We should be developing those services in the community.

We have had babies transferred from special care back into a neonatal care in a matter of hours. But let us assume that the babies we are talking about are relatively stable, but for whatever reason it is premature to send them home because of the level of skill or support or whatever from that family. My understanding of transitional care is an opportunity where parents and child can become more confident with each other in a supervised setting.

I think what that does do and taking up Chris's point about 'at home' - then if we extend our thinking I think we should not see it as a hospital service it would be exciting to see it as a community based service which may start its life in a hospital but actually as soon as possible transfer that support to the person's home. If we have a home where we are not confident about a new baby going back in those early stages then we have also got a responsibility to work with those parents and that seems to be really providing us with a good focus on community problems that we should be tackling.

Question: You can add paediatrics to that because of similar sorts of issues. The major concern we have about paediatric services is that it is the hiatus between hospital and home. The worry we have is that moving paediatric patients to the other site and the in-patient SCBU to the other site, the social factors, the 'soft' health issues, will be lost.

Answer: I think it could certainly do more interesting and exciting things in the community. Like we have said, there may be one or two more examples over in Calderdale which we need to learn from and from other parts of the country. What we would say to you is that in covering the work within hospitals around consultants, staffing 24 hours and junior doctors one of the messages we are putting on the table in this consultation is that in order to release more of that time into the community there are advantages in centralising the specialist areas. If we attempt to carry on both of those services in both hospitals then we would not release resources in time to be active in the community. In saying that, I fully agree with concerns that this document could be read as just centralising services and going back into the shell of high tech services. We need strong messages from yourselves and others to make sure we retain the balance and commitment to that community service.

Question: We have been talking earlier today about the transport issues. We have talked to two communities listening to evidence about transport, we have heard very clearly the messages from parents with children in special care and in paediatric wards about getting to hospital and maintaining the bonding links. The impact of parent/child relationships - these types of issues have a crucial impact not just on health services but on other services as well and I think that to concentrate in-patient paediatric services on one site without considering these implications will lead to a serious disintegration of services in Kirklees and Calderdale.

Answer: In those discussions have you received a clear message or advice on what services in the community would assist that. Even if things were to stay the same what would assist things in the community because as you have said the feeling is that there are certain communities within Huddersfield that are not getting the right level of access to hospital services.

Question: Isn't this part of the Primary Care Group remit?

Answer: With these proposals coming together, the Primary Care Groups are now leading on what community based services they would like to see. From you own work did you come away with any ideas of those services.?

Chair: We came away with the idea - correct me if I am wrong - that where children are in hospital, they need to maintain relationships with their parents, which can be difficult, particularly if they are on special care units where parents have been having to go backwards and forwards to maintain relationships with special care babies for a long time.

I think the message comes over that ante-natal care in the community is very important. We have heard from parents of children that need to go in and out of in patient care particularly those from rural areas where transport can be a problem. One of the issues has been around A&E - it is very clear that people of a low socio-economic status use Accident and Emergency for their children because they have not got very good access to primary health care.

There is still going to be this hard core of children who are going to need in patient care.

Answer: What we need to balance is making sure they get the quality of care that is required and are not separated from the community and family, and it is how to pull those two together. One of the issues that the Health Authority is having to consider is rather than simply falling back on the ambulance service as a transport solution we have to promote much wider transport solutions.

Question: Have you actually looked at transport and come to any decisions?

Answer: The short answer is not at this stage. What we have done is commissioned a piece of work from a Transport Consultancy who will report to us prior to the March meeting so that we will have information on options dependent upon which proposal is taken forward at that stage. We will have firm information to make sure that we have an holistic set of proposals in March not only about services but about transport as well.

Question: What do people do to get to hospital very quickly, for example, where a child is having a severe asthma attack?

Answer: They would need use of the emergency ambulance service - West Yorkshire Ambulance Service has very good delivery times of getting people into hospital from a range of areas. The service meets all the national standards in terms of time.

If a family in a rural area want to get into a hospital then, if they have a car, they will use that or they will ring an ambulance. Ambulances now are not garaged only in WYMAS garages, they actually sit on sites that are more easily accessible. The average call out time for a blue light ambulance arriving is less than 10 minutes and they will have the oxygen and often paramedic skills to be able to provide immediate treatment. That to some people is the quickest access to medical treatment. There is an expectation for the ambulance service to bring it down to 8 minutes. There is a national target that A&E ambulances will attend in 8 minutes.

Question: We understand that in Calderdale taxis are provided for people on income support who are unable to get transport home.

Answer: There are services funded through the Health Authority for access to transport for families who receive income support where they can claim back travelling expenses.

I think it is an area we need to look into more. I know that we provide through the Trusts patient transport services which is not only ambulances and minibuses but also ambulance cars. There are a number of mainly elderly people who are capable of travelling on public transport who themselves and their GP feel that it is more appropriate ordering a car. I think what we are looking at in areas of children's services is that there may well be social and other conditions which make it right that ease of transport is part of the care package. The Health Authority need to think about that very carefully.

I think it also applies not just in coming and using hospital services but also in terms of having access to public transport services in general. The Access Bus that comes and stops outside your door and takes you to do your shopping, we should be thinking about an integrated transport policy not just around trying to do something around hospital services.

I think there is a place for the Health Authority to lobby the Local Authority in terms of improving the transport. A public transport service is needed that people can rely on, not just for hospitals but for a range of services.

Question: There is a general feeling amongst the public that the proposals will result in a second class service for the people of Huddersfield because they not going to have everything on site that they now have. You must be aware of these comments. How do you respond to them?

Answer: I think the first thing is that in order to provide a safe service into the future we need to create a critical mass. I think there are problems with the services that we have at the present time, I think without changes you will continue to see those problems highlighted as time moves on. I think it is important to say 'yes'.

The low risk option presents us with more problems in relation to the provision of that service and we have got to work hard to make sure that we can provide that low risk option within Huddersfield. In terms of providing the service overall, a centralisation particularly of the high risk areas will provide a much better service.

Question: So what you are saying is that women and children in Kirklees and Calderdale get a second class service at the moment?

Answer: I think there is a lot that can be done to improve the service at the present time - we have quoted the figures in relationship to litigation over the last 10 years for the Health Authority which is the tip of the iceberg and it is a national problem as well.

When it comes to team work there will be a single service across Huddersfield and Calderdale where parts of that service are delivered, some at different times, but all the people are getting access to the same service, the same specialist skills, the same individuals, but where you may have to go for some of these services may differ. It isn't about women in Halifax getting access to better quality services and specialist consultants than Huddersfield, it is a single group and all the women and their families in Huddersfield and Halifax will have access to that group of expertise and that is the important side of it. At the moment, if you take something gynaecological cancers, that is now dealt with by a specialist consultant based in Halifax but he is accessible to Huddersfield women for that very specialist work.

Question: Would there be 24 hour Accident and Emergency cover on both sites - children as well?

Answer: Yes.

Question: Would that have paediatric cover?

Answer: It currently doesn't have paediatric cover - at the present time it relies on the services being provided by the in patient service. I think we have to see that changes have to occur in terms of the recommendations that are coming down in relationship to A&E.

Question: What do the recommendations say?

Answer: The recommendations requires that we should have a significant level of paediatric cover and work within the A&E department. At the moment we have got mostly 'adult' doctors who are looking after children.

Question: So part of the skills of the A&E doctors would be a background in paediatrics?

Answer: What we also need to do when we talk about A&E is to be very clear about what the aim of the service is. The A&E service is open 24 hours a day to respond to what comes in on a there and then basis. If a person is in a serious state then obviously resuscitate them, stabilise them and assess them and then decide where the best treatment is provided. For a number of people that is then provided within the hospital where the A&E Service is. They will then be transferred into the care of the paediatric staff or into the beds in the hospital.

At the present time there will be people coming into the A&E in Huddersfield where that assessment will say the person needs transferring to another hospital where the skills are better. If you come into A&E at HRI at the moment with a bad head injury you will get transferred to Leeds or with a bad burn you will get transferred to Wakefield. But the A&E service is one of resuscitation, stabilisation and assessment with the skills to do that and then to decide where best those youngsters or adults are treated.

Question: Would it be true to say that most children attending A&E are actually discharged home after treatment?

Answer: Yes. About 9½ - 10% of children seen at A&E are admitted because there aren't the facilities in A&E to sort things out. If you look at the number of children who only stay overnight a lot of that reflects the fact that most children might have been managed in a different type of way if we had a different service.

Question: If you need a paediatric doctor and nurse on both sites how are you going to do it?

Answer: What we would have there is A&E doctors who are not paediatricians but have been through training and spent some time in paediatrics, so they will have some of those skills. They won't be paediatricians but they will have those skills to do the assessing that is needed. Again, it is being honest about the level of service they currently get. People go into A&E and believe that when you see a doctor that doctor is sufficiently skilled in everything that is wrong with you and that is sometimes not the case, and that is why Chris has made reference to expectations to improve our aims in terms of services locally as well.

Question: Would we see a need for more specialist training for all doctors and nurses?

Answer: When you look at the provision around junior medical staff, housemen, SHO's, specialist registrars, you notice that we are relatively proficient in the most senior grades of staff in those areas at the present time between the two hospitals. There is no doubt that a larger department would be able to provide a high level of specialism - we have already seen this in

ophthalmology - it would attract more staff in but also we would have a better opportunity to maintain our trends. The problem at the moment is that there are significant planned reductions in terms of the number of junior hospital doctors that are going to be available both at registrar and SHO level over the next few years so we are going to have to fight to even maintain what is an inadequate level.

I need to explain the system which is much more managed than it first appears. The number of doctors in training and the specialists in training is decided centrally so that sets the number of overall parameters and, as Chris has said, in certain specialty areas the number of training posts will be reduced In other areas the numbers of training posts will increase, but in paediatrics and obstetrics the numbers are coming down and that is related, certainly in obstetrics, to the fall in birth rates.

Also, the number of training posts which take you through to become a consultant, and so you have to create a number of training posts to meet the requirements for the consultants. If you don't need a lot of consultants nationally you don't train them.

We are also the outer rim of the universe in some senses in that the attractive jobs for trainees are going to be in the larger teaching centres. If we look at this, because it is important, there is a negative side. It feels at worst like a closed shop of making sure that there aren't any more people in post. There is a good number (in excess of 100) of Senior Registrars who have been trained up in obstetrics and gynaecology where there isn't a consultants job for them. The issue then is do you create more jobs when there isn't a need for them, or do you retrain in other areas which is very difficult because they have been trained as specialists, or do you not train them in the first place.

Question: Why can't they just stay at that level, people in other professions will reach a level and cannot progress.

Answer: Because they are in training posts. The training posts for specialist registrars run for five years. You can possibly get an extension for another six months or so at the end of that period of time but after that there isn't the money for the post because it is funded centrally.

Chair: I appreciate that it isn't a local issue, it is a national issue.

Answer: The other issue is that the training post exists. The training posts are divided out into places where essentially they can provide the best form of training. A service in Huddersfield may well be designated as having two posts for specialist registrars or, if that service is felt not to provide a wide enough range of experience, they may actually reduce that number or take it away altogether.

The Royal Colleges come and visit and approve the training posts effectively, and the other person who approves the training posts who has access to the money from a training point of view is the Post Graduate Dean Rosemary McDonald who sits in Leeds.

Chair: That makes it a very autocratically provided service which essentially stops us providing the services we want because of the rigidity of the closed shop training issue.

Question: Have the proposals outlined in the Consultation Document been discussed with GPs?

Answer: GPs have been involved from the outset - this debate about change in the Hospital Service has been going on for three years. That was prior to Primary Care Groups but at that stage we had GP commissioning groups, GPs report back at that stage. As the discussions have continued GPs have been involved in understanding that process. It is only now that we have actually put proposals on the table that there is something firm to respond to and each of the Primary Care Groups have there own formal process of responding to the proposals. They have been involved. Already indications coming back from GPs is that they have a range of views about the proposals and certainly it would be wrong to say that we have the agreement of GPs, but there has been consultations with the Primary Care Groups.

Question: Will child protection issues be fully considered before any merger between the two hospitals takes place?

Answer: On child protection the ACPC's are separate consultees within the process. The short answer is yes and we have to be very confident that a robust process is set up in that area. What is interesting is, in the latest guidance that we have received on child protection, one of the issues raised in various questions is around whether the ACPC should be coterminous with local authority areas.

There may be some advantage in them working together because the tendency is for the parent to take the child to the next hospital out of the district, and use a range of different organisations and A&E departments in the hope that they don't actually come to attention. There does need to be some co-ordination between what actually happens across boundaries and not just think in terms of pure boundaries.

Question: Do larger wards increase the risk of infection?

Answer: I think we are looking for the majority of services to remain on both sites. We are talking about some concentration of specialised surgery in one site or another. We are not talking about increasing in total the number of patients who are in hospital in either of the centres particularly, but it is likely to present a major problem from that point of view and we have obviously got to look at the issues of infection control in each of those hospitals at any time.

There are some problems associated with bigger hospitals from that point of view, although most of the infection control procedures allow you to isolate particular areas of a hospital and deal with problems in isolation.

I think one of the interesting changes that have happened over the last number of years is that people were admitted to hospital who had picked up infection in their own homes and for many people that has actually switched now. Where we have got issues is around relatively small groups of families who can't provide reasonable conditions within there own home but to me that is not an argument for providing better hospital services.

Chair: Thank you for attending the meeting for a second time and discussing the issue with us.

D5K045

KIRKLEES METROPOLITAN COUNCIL

SCRUTINY COMMISSION ON CHILDREN'S AND WOMEN'S SERVICES

LYNNE GOMERSAL, DIRECTOR OF COMMUNICATIONS
ANDREW CRATCHLEY, DIRECTOR OF OPERATIONS
MAGGIE HARRIS, PUBLIC RELATIONS

all representatives of

WEST YORKSHIRE METROPOLITAN AMBULANCE SERVICE

Wednesday 26 January 2000

Chair: As you are probably aware the Scrutiny Commission is convened in response to the Health Authority's proposals to reconfigure the children's and women's hospital services. We have been taking evidence from various people, we have had evidence from the Health Authority, Huddersfield NHS Trust, and we have talked to individual groups of people about their concerns.

We thought it rather important to ask you to come and give your evidence about how you think the proposals will affect your services.

Andrew Cratchley: With anything like this, when there are a number of proposals or various options it is difficult to actually quantify the different things until we actually know what we are going to quantify. We did a similar exercise in Wakefield. We have actually modelled, on their behalf, what the reconfiguration of their services would mean to us as a service. That is quite a costly exercise and we had to do it by engaging consultants who are currently looking at the whole modernisation of the Ambulance Service. So what we are going to try to do this morning is put together a brief presentation for you, not specifically on every detail of the proposals, but what the proposals would mean to us in general terms, and then if there are any questions that you want to ask us we will try and answer them in the best way.

Question: How long has the Group been working to look at these reconfigurations?

Andrew Cratchley: Since October.

Lynne Gomersal: We have actively been involved in discussions with the Trusts and Health Authorities in the past and we have been doing that for a couple of years, but I think it is important for us to understand the other issues that concern yourselves

and other agencies. It is important that we look at the collaborative working and also the quality of this means in terms of the community and the patients. We have certainly had opportunity to look at the reconfiguration document and what that really means but, as Andrew has explained, because there are a number of models it is quite difficult for us to be able to say this is how we can respond and what resources will be needed.

We don't want you to think that we are sitting on the fence in anyway but obviously it is quite difficult to say what this really will mean until we get something specific. It is important to us that we maintain the relationships we have already got and we aim to do that. We will maintain quality that we are already achieving and look as to how we can improve that in the future. As Andrew said earlier, we have had quite a bit of experience with other Health Authorities and Trusts in terms of reconfiguration.

We have had a lot of in-house experience in doing that both with Wakefield and Pontefract, and also with Wharfedale and the Leeds experience - we have developed principles of how to respond and how to put our own agenda together and what that means in resources and costs. Clearly the effect of this does have cost implications, so we have had quite a bit of experience. Something we did do at the end of last year was commission an independent study that would look at the effects of modernisation agenda because that clearly has a big implication for us as well and the sort of consortium that we work alongside with.

For those of you who are unfamiliar with what this means for the Ambulance Service, we have to work towards what is the Department's health agenda. In future we have to respond to 75% of emergencies within 8 minutes and 95% in 14 minutes. We have to look at our efficiencies and how we will respond to that in future, and what that means in terms of resources. Clearly, to have a reconfiguration now comes before that and we have to look at what that means.

I think one of the important things for us is in terms of this agenda today is what that means in terms of training and development for our paramedics and staff. I am sure you are aware we have both trained paramedics and ambulance technicians, and also support PTS people. To look at extending journey times and what that means, we have to look at designated crews possibly developing additional training skills.

Chair: Could you explain this further as we know nothing about the Ambulance Service.

Lynne Gomersal: Paramedics are members of staff who have undertaken specific training modules which involves in-house training within the organisation and that is worked along a recognised course which is the IHCD, which is the Institute for Development, and that is the recognised course. With that they also work in hospital settings in terms of experience that they can gain in certain procedures. That actually takes about two years and eight weeks to complete. We have that level of staff who can administer drugs, can incubate patients who have respiratory difficulties, cardiac arrest patients and manage major trauma and major paediatrics and obstetrics emergencies. Then we have a level of staff who have not had that sort of expertise, they don't administer drugs, but have all the other basic support information and are quite skilled in their own right.

We have recently developed support crews who transport low dependency patients and we go through quite an explicit criteria to determine that they are the right level of staff with the skills to match the needs of the patients. We have used that quite successfully in a number of areas. We have patient transport services who have the ability to move patients around again probably those with low priority needs. What we are suggesting is that to actually reconfigure we need to look at those resources to marry those appropriately and what will be needed with the new configuration.

Clearly some of the issues are very much about transportation in terms of mother, etc. moving but clearly there are also some indications about obstetric emergencies being moved from A-B and what that brings with it. We have to look at the resources, but we clearly have to look at the training and development needs of our staff. Currently paramedics have a limited experience in obstetrics because the need has never been there because of the "flying squads" etc. With the withdrawal of those collectively throughout West Yorkshire and other areas, that has an implication and we have been striving for some time to look at the consortium in terms of getting support for training and development in that area.

Again, the reconfiguration has quite an implication and it is something we would clearly want to pursue in terms of training and developing those staff more appropriately to meet those needs. We see that as a key area that we need to collaborate on with the Health Authority. I think one of the other main areas is the extended journey times and what this means in terms of hospital transfers. Having read the consultation document it is very difficult for us to plan those times because it is not explicit in terms of which model will be agreed, so we are not in a position to respond, but it doesn't take a lot to understand that there will be a number of extended journeys from patients moving out of the area

across what was seen as the boundaries in the past and also the increasing inter-hospital transfers and the skills that are needed for those transfers because stabilisation is an issue at one site to another that does dictate what sort of skill levels are required.

We are very conscious of the fact that we need to do work in this area. As I said earlier, what we have done in the past is work with other agencies. We have had quite a lot of experience in the framework that was put together for some of the early consultation documents in terms of how to communicate that to the community. We have had experience of working and clearly we need to pursue that in the future.

We have got two agendas - one is responding to the immediate needs of the reconfiguration and, secondly, the Ambulance Service responding to the modernisation agenda which does have implications on how quickly we respond and what timescales we respond, and these obviously dovetail together in terms of matching those appropriately to the community service and maintaining standards. It is quite difficult to say we would need to do this and this X amount of costs because we haven't been asked anything specific at this time. What we have tried to do is look at the document and look at the implications and the key areas of these particular points and the training and development needs of the staff that we have currently.

Andrew Cratchley: At the moment we currently carry around 4,000 out patients a day across West Yorkshire, that is patient transport services. We respond to between 450 and 500 emergencies a day throughout West Yorkshire and, on top of that, we have in the region of 200 urgent jobs daily, that is where a GP will ring in and say "we need a patient to go into hospital in the next hour or two hours".

Question: Are those daily figures?

Andrew Cratchley: Yes. These are daily figures. That just gives you some idea of the size of the operation that we currently undertake and a lot of the reasons why we can't quantify at the moment is because if we are doing additional work, for example, let's say we extend journey times or we utilise a crew to do things differently, then it will have a knock on those 450 emergencies or 200 doctors urgent cases. It is all about where we put our resources to respond more appropriately so there would be some issues around that area. Quite clearly there would be issues around training.

Question: When you are called out to emergencies like a road traffic accident, and the ambulance picks up the injured person, do you take them to nearest A&E? Is that the standard procedure?

Lynne Gomersal: There are a number of occasions when that may not apply, but they are very, very specific and that would be in consultations such as a major burns, but the rule is generally we would go to the nearest appropriate A&E and, if a secondary transfer was involved, that would be dictated by the physicians at the hospital when that patient has been stabilised.

Question: Would a woman who is going to have a baby very quickly be dealt with in the same way?

Lynne Gomersal: If a woman is actually in labour then we establish very quickly where she is booked in, and we would always endeavour to take her to that facility. Clearly, if time is of the essence, we would go to the nearest facility so that we have got patients to definitive care where you have got the medical support, etc. to be able to support the patient's needs.

Question: If a woman is categorised as high risk and an emergency occurs, would you take her to the nearest hospital or the one with intensive care?

Lynne Gomersal: I think there is a point there. If a mother is high risk then that should have been identified previous to getting to the latter stages of pregnancy anyway. I would anticipate that some dialogue will have taken place as to where that lady would go if it became an urgent admission as opposed to a planned admission with the appropriate timing. We would expect to have to deliver them to that facility, but all high risk patients should have been identified before and obviously that doesn't involve the Ambulance Service. We would be governed by what arrangements had been made previously. Clearly, if she became a true emergency, then we would have to look at taking the patient to the nearest facility. It is very difficult for us to say because it depends on the models and what discussions take place. As it stands, currently we would take them to the nearest facility.

The only thing I can say in all fairness here is that at all times for us the patients' needs is the priority. From the Ambulance point of view, the quality of the patient care that we give, and ensuring that the patient reaches the appropriate facility to match their needs is our major consideration.

Question: You talked about the withdrawal of the flying squad. Can you explain what you meant about that?

Answer: Traditionally, the obstetric departments in most hospitals had a "flying squad", and that was made up of a midwife and maybe a couple of other support staff, nursing qualified midwives and they would respond to community births. They still do have some of those facilities but, unfortunately, they are a little bit ad hoc now, and it depends on where you live as to whether that facility is still in place. We have experienced a decline in that which has alerted us to the needs for our paramedics to be more skilful and more prepared for what used to be historically not seen as a level of care that fell into our remit. Because of that withdrawal, babies born in the community, and possibly some of the more complicated births, have started to increase. We have responded obviously to ensure that the patients are protected and our crews have the skills to manage those situations but that is something that wouldn't be driven by us at all. We are just trying to respond to the changes.

Question: One of the other big questions is about transferring mothers who have may be gone to low risk maternity services and then become an emergency. Presumably, you will be called upon to transport (or could be) women in advanced stages of labour, or babies that have been born, that need intensive care. Are you equipped to do that now and what would you need to do to make that possible?

Andrew Cratchley: Two things on that. Number one is to try and expect that and, secondly, I would also expect in that situation that someone with appropriate skills at the correct level, such as a qualified midwife, doctor or whatever, to accompany the crew. That is the expectation.

Lynne Gomersal: I think, given the looseness of the model, if we were transferring a mother and baby whose conditions were compromised, we would expect to have a physician of some description with us. Again, that is something that we need to work through when we talk to the hospital.

Question: So you would feel the same as us that a maternity unit with no emergency obstetric facilities was not an option?

Lynne Gomersal: My understanding from the models that I have worked through is that in the A&E department there will always be someone with obstetric experience who is in a position to help with that transfer. That is very different to having a designated obstetric department that deals with unusual emergencies. There are senior people in the A&E who have got obstetric backgrounds as well, they will have gone through that training. It depends how they anticipate that to work really and it is not within our remit at all.

Question: I am not sure how the relationship works between the Health Authority and the Ambulance Service.

Lynne Gomersal: There is no doubt from experience we have had with other similar exercises that they have ideals as to how they would like it to work and they proposed those and respond with what we think those implications are on resources and, as Andrew said earlier, we have used an independent organisation, commissioned them to identify what some of those resources would be, both for the modernisation agenda and also for the reconfigurations. Clearly, there is a lot going and we have to be careful that we identify the resources that are really needed to match the changes in the service facility. We look at how to work through those and respond to what would be needed.

Question: Where does your money come from?

Andrew Cratchley: We are funded from the A&E service funded by the various Health Authorities under the guise of a purchasing consortium, and the patient transport service is funded by the various Hospital Trusts, who are in turn funded by the Health Authority.

Question: The Health Authority pass their money to the Hospital Trust and the Hospital Trust pass their money to you?

Andrew Cratchley: That is right. They then decide what we are going to use on the out patient journeys that we make, transfers, whatever would come under that, dependent upon their needs.

Question: So whichever option is agreed, would the Trusts provide more money and, if not, would you have to say that you could not provide the service?

Andrew Cratchley: We would indicate what we would expect it to cost us in terms of additional resource should that be the case - that could include staffing levels, the number of vehicles and also types of vehicles and equipment that they carry.

Lynne Gomersal: In previous experience when we have been involved in this type of work we have actually worked it through to come up with what is seen as a maintenance of the quality of the service and what those cost implications have, and we haven't really encountered problems in the past with the exercises we have done. It may take some time to work through and for everyone to clearly understand what those implications are in terms of real resources, real ambulances, etc, but we have successfully done it in the past.

I think from our point of view obviously the Health Authority has acknowledged that professionally we are putting in recommendations to maintain the standards for the community, and it is in everyone's interest to be able to see that through so that we do provide what we should provide for the people.

Question: But so far you have not been involved in drawing up the models for Halifax?

Lynne Gomersal: No. We were involved in the early days in terms of what some of the consultation issues were because we are directly involved in that, and we have had some discussions regarding the transport initiative and we have had discussions over the phone with key members, but I think to take it a step forward what we need to do now is look at what the implications of the models are. It is quite difficult when we don't say this is what the model and work through the cost and resources of that. We have to look at it quite generally and laterally as to what that means at the moment.

Question: Have you any idea how many women in labour are transported by the Ambulance Service during a day?

Lynne Gomersal: To be perfectly honest I don't actually know at the moment. Most journeys are triggered by the midwife or the GP, or the mothers themselves phone the Delivery Suite and initiate that it is the appropriate time to come in. If they haven't got transport of their own then they will ring us, particularly if they are progressing in their labour.

Question: So it might be a few?

Lynne Gomersal: It is something we will have to look at. We are able to do it, but we haven't actually done it for this exercise today.

Question: Of the home births, how many of those do you have to transfer to hospital?

Lynne Gomersal: We don't have that many babies born where we are present. The numbers are very small. I wouldn't like to say without looking at some clear statistics about it.

Question: Can you tell us about transporting babies that need neonatal intensive care? We have heard from other people who have given evidence that there are two ways of transporting babies who need neonatal intensive care - one is while it is still in the womb and one is when they have been born and need this care. We also have evidence that it is quite difficult to find intensive care cots and you might end up going all over the place. What is the procedures for transporting these babies?

Lynne Gomersal: We have a number of designated vehicles currently in service that have the capabilities to carry a range of specialised incubators because throughout West Yorkshire different Trusts have bought different incubators to suit their needs. We actually developed some specialised vehicles that can accommodate these. Obviously they have to be secured into the vehicle because they are cumbersome facilities in terms of the oxygen supply, etc, so we do have designated vehicles to do that. The method of activating that currently is that the hospital will telephone our communications centre and arrange for a transfer and, if it was paediatric neonatal, then we would respond with the appropriate vehicle and currently that would get transported with a clinician of some description.

Question: You would expect a doctor or a midwife to travel with the ambulance?

Lynne Gomersal: If they are coming from a hospital facility I would expect there to be a clinician.

Question: Do you feel there is pressure on that particular service? Is it as easy to find the Ambulance than it is to find the neonatal intensive care cot?

Lynne Gomersal: I don't think there is any more pressure for specialised bed facilities than there is in any other area. I mean adult intensive care obviously at certain times of the year are very difficult to maintain because of the changing climate and the medical needs, so it isn't any more difficult in my opinion but, again, it is only a feeling at the moment. It is not statistically led.

Question: If someone phoned up needing your special ambulance, it is there to go?

Lynne Gomersal: Even if we couldn't have that vehicle, we do have a number of other vehicles who can transport the incubator, but these are easier because they have a special mechanical device (a winch) that prevents them having to do a lot of lifting. Some of these incubators are very heavy so it involves both hospital personnel and ambulance personnel to lift them. These new ambulances actually prevent that so everybody is not having to do additional lifting.

Question: Do you think that transferring babies is an additional risk, or do you think that they are totally stable? Is being in an incubator in an ambulance the same as being in an incubator in hospital?

Andrew Cratchley: To answer that really you have to say that it would be a clinical decision which is made on the basis of the varying risks, and decisions will have to be taken to decide whether it is more appropriate to have a specialist centre in one location and non-specialist facilities in another or to split the amount of available resources. I don't know the answer to that.

Question: Is the Ambulance Service subject to accreditation?

Lynne Gomersal: The criteria is laid down by the Institute of Care and Development, and we meet that criteria in terms of the quality standard. What we recognise is with the changing environment we need to respond to make sure that we offer a quality service as things change and that is what we have acknowledged and so has the Institute. From next year the module for obstetrics is being extended and obviously that has an implication in terms of the funding aspects, and that is just with no reconfiguration. With reconfiguration as well clearly there are implications for that also. We are trying to take those on board and ensure that our staff are prepared and in a position to respond to what they could be faced with, for the benefit of everyone.

Question: Are you having to provide training in obstetrics because you feel that the paramedics are becoming more vulnerable?

Lynne Gomersal: We would not anticipate being placed in any vulnerable position. We would anticipate that whatever risks, whatever implications that had for the mother or the child had been undertaken by someone with much more skill levels than ourselves, and that if that baby were deemed to move or the mother was to move, then that was within the range of skills that we could offer at this time and that they were of a standard that were appropriate to the patient's needs. We wouldn't anticipate being placed in a vulnerable position by anyone.

Question: If Huddersfield and Halifax Trusts combine - two major hospital sites - would that mean a huge increase in terms of inter-service transport?

Andrew Cratchley: Yes, that is another implication with a separate brief. If you have different services on different sites, then that may have implications in that if a person is admitted to one hospital, they may have to be transferred to another to receive appropriate treatment, so that would increase the demand on our service in the area of the urgent work that we spoke about. That is what it would be more than likely be classed as.

What we would be asking for is additional funding to support that. Clearly, if it is an increase in the quantum of activity that we do and it is recognised as such and will put an increased burden on the service, then we wouldn't want it to be detrimental to the service we currently provide. When someone says this is what we are going to do, or this is what we plan to do, we can turn round and say if you do that we would anticipate that the number of transfers between X and Y would increase by 10% on this area, and then we would be costing against that in terms of additional resources and also appropriate.

Question: Can you explain to us - is there any special training or special skills required if you need to transport paediatric patients?

Lynne Gomersal: For paediatric trauma there are a range of skills that our staff are currently trained in. If you are going to extend journey times you need to look at training and develop additional skills. Again, we would enter into that with the Health Authority but we are trying to manage paediatric emergencies currently.

Question: In relation to the Huddersfield and Halifax merger, if you had a major trauma incident and both facilities offered the same standard of care in terms of physicians, etc, where would you take the patients?

Lynne Gomersal: By the most appropriate fastest route probably. Distance and time are quite different aren't they? Barnsley is particularly one - Barnsley Road to get to Huddersfield or to get to Barnsley, the time/distance don't always equate so I would say with my experience, having been a paramedic, I would use what would be the easiest and quickest route.

Question: If you had information about where the major trauma site is?

Lynne Gomersal: We would expect to have been informed about change of facilities in terms of what a hospital could offer because we would never just change our working practice. We would work through what this meant in terms of transportation for patients and where one would go. Again, that isn't something we would just decide on our own. Currently, and we are just talking about currently, we would go to nearest facility for the patient.

Question: By major trauma do you mean if there was a train crash?

Andrew Cratchley: We would probably go everywhere because of the amount of resources that would be available, and we would deploy all our resources and put into place our emergency plan.

Lynne Gomersal: We have links in terms of how that protocol rolls out so that each hospital isn't saturated and that appropriate needs go to appropriate facilities in a major accident, and that is quite different to a normal everyday practice.

Chair: Thank you ever so much for coming.