Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Plant a Phobl Ifanc
The Children and Young People Committee

Dydd Iau, 7 Mawrth 2013
Thurssday, 7 March 2013

Cynnwys
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Cynnig o dan Reol Sefydlog Rhif 17.42 i Benderfynu Gwahardd y Cyhoedd o'r Cyfarfod
Motion under Standing Order No. 17.42 to Resolve to Exclude the Public from the Meeting

Cofnodir y trafodion hyn yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir trawsgrifiad o'r cyfieithu ar y pryd.

These proceedings are reported in the language in which they were spoken in the committee. In addition, a transcription of the simultaneous interpretation is included.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Christine Chapman	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Bethan Jenkins	Plaid Cymru The Party of Wales
Suzy Davies	Ceidwadwyr Cymreig Welsh Conservatives
Rebecca Evans	Llafur Labour

Julie Morgan	Llafur Labour
Lynne Neagle	Llafur Labour
Jenny Rathbone	Llafur Labour
Aled Roberts	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Simon Thomas	Plaid Cymru The Party of Wales

Eraill yn bresennol
Others in attendance

Dr Mark Drayton	Neonatolegydd Ymgynghorol ac Arweinydd Clinigol, Rhwydwaith Newyddenedigol Cymru Consultant Neonatologist and Clinical Lead, Wales Neonatal Network
Lesley Griffiths	Aelod Cynulliad, Llafur (y Gweinidog Iechyd a Gwasanaethau Cymdeithasol) Assembly Member, Labour (Minister for Health and Social Services)
Dr Chris Jones	Dirprwy Brif Swyddog Meddygol Cymru Deputy Chief Medical Officer
Mark Partridge	Dirprwy Gyfarwyddwr, Legal Services Deputy Director, Gwasanaethau Cyfreithiol
Dr Heather Payne	Uwch Swyddog Meddygol, Iechyd Mamau a Plant Senior Medical Officer, Maternal and Child Health
Daniel Phillips	Cyfarwyddwr Gweithredol Cynllunio ar gyfer Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru Executive Director of Planning for the Welsh Health Specialised Service Committee

Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance

Ffion Emyr Bourton	Dirprwy Glerc Deputy Clerk
Claire Morris	Clerc Clerk
Victoria Paris	Y Gwasanaeth Ymchwil Research Service

Dechreuodd y cyfarfod am 9.15 a.m.
The meeting began at 9.15 a.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **Christine Chapman:** Good morning and welcome to the Children and Young People Committee. I remind Members that if they have any mobile phones or BlackBerrys they should be switched off as they affect the transmission. We have had apologies this morning from Angela Burns. The first item on the agenda is neonatal care.

Ymchwiliad i Ofal Newyddenedigol
Inquiry into Neonatal Care

[2] **Christine Chapman:** By way of background, this committee published the findings of its inquiry into neonatal care last September. We recognise that local health boards were at different stages in updating their neonatal action plans, and we wanted to continue to monitor progress in this area. For this session, I welcome Lesley Griffiths, the Minister for Health and Social Services, Chris Jones, the deputy chief medical officer, Heather Payne, the senior medical officer for maternal and child health and Mark Partridge, the deputy director of legal services. I welcome you all this morning for this update. We have had your paper, Minister, and Members will have read it, so if you are happy, we will go straight into questions.

[3] I will start with the first question. You gave oral evidence to us last May and you stated that the local health board action plans were not as robust as you would like them to be and that the plans were being monitored by your officials. What improvements have been made with regard to the action plans and what is their delivery status?

[4] **The Minister for Health and Social Services (Lesley Griffiths):** Every health board had to submit updated action plans to the neonatal network back in the summer of last year. We have just had the 2013 capacity review, which is obviously for 2012, and it provides clear evidence that these revised plans have been strengthened. For example—I am sure we will come on to the workforce later—there has been a 50% fall in the nursing shortfall across units in Wales. The action plans are live documents and they are monitored, evaluated and refined by both the health boards and the neonatal network, which is professionally and clinically led, and we are very plugged in to that. As I said, we have just had the latest capacity review, so the plans will be revised in light of that review and I expect the neonatal network to review them within six months.

[5] **Christine Chapman:** You say that they are being monitored, but obviously there are some shortfalls there. How are you holding the local health boards to account in areas where the action plans have not been delivered?

[6] **Lesley Griffiths:** I go back to the neonatal network. As I said, it is the clinically and professionally-led process that we have. It identifies for us whether insufficient progress is being made. There is an escalation process that we would put into place, which holds health boards to account. Last summer, all health boards were visited by senior Welsh Government officials and follow-up discussions took place in November and December of last year to ensure that the health boards maintain the focus that we want them to. Since last year, we have also included the neonatal cot status in the daily executive conference calls because that enables pressures to be managed much better.

[7] **Christine Chapman:** Aled wants to come in on this point.

[8] **Aled Roberts:** Just picking up on the neonatal network's evidence—and we will be hearing from it later—in its written papers, it states that

[9] 'Whilst Health Boards are all making progress with plans to reconfigure services, on the ground there is little evidence of immediate action to develop robust medical workforce plans to meet medical staffing standards for units in accordance with BAPM'.

[10] So, the network itself appears to be dissatisfied with the status of the workforce plans that you referred to a minute ago.

[11] **Lesley Griffiths:** Clearly, there are still issues relating to workforce. I referred to

those in my paper. Many of their plans are linked into reconfiguration plans.

[12] **Jenny Rathbone:** I would just like to say that I think that BadgerNet and the neonatal steering group are giving us a clear idea of the situation that we are in and of the issues that we still have to face. So, it is good to know that we have some very detailed data on which you will be able to make your policy decisions. Could you tell us what action is required to achieve full compliance on the nursing standards? We are going in the right direction, but there are still around 46 full-time equivalents to recruit.

[13] **Lesley Griffiths:** You are right about the BadgerNet information technology system. It has provided us with dramatic improvements in the availability of the information that we have. On compliance, south Wales is around 96% compliant, but it may be a little bit higher now. North Wales is around 83% compliant. It is very hard to put a date on when it will be fully compliant, but it very much links into reconfiguration plans.

[14] **Jenny Rathbone:** That leads on to the next question on the shortfall in neonatologists. It is stark that we have 26 neonatologists in south Wales, but only one and a half in north Wales. Somewhere in the papers, it says that the only qualified neonatologist has moved to employment elsewhere. Clearly, there is a major issue in north Wales.

[15] **Lesley Griffiths:** Yes, absolutely. I have to be very careful about what I say on this because of my quasi-judicial position, but the shortfall in neonatologists in north Wales is very well documented. It is difficult to recruit neonatologists to units that are not attractive for them. Again, that fits into reconfiguration plans.

[16] **Jenny Rathbone:** There are one or two places—and I will not mention them—where it would appear that there are insufficient junior staff, who do the initial analysis, to assure mothers that they and their babies will get the service that they need. At what point will you feel the need to move that service elsewhere?

[17] **Dr Jones:** There is a well-documented need to look at service configuration for paediatrics as well as neonatology. We know that we are trying to sustain a lot of services and we know that some of those rotas are under great strain. We also know that a sustainable solution probably requires some service reconfiguration.

[18] **Christine Chapman:** There are supplementary questions from Rebecca and Aled.

[19] **Rebecca Evans:** The committee heard in a previous inquiry that there was an over-reliance by LHBs on bank nurses to cover the shortfall. To what extent are LHBs still relying on bank nurses and what kind of extra support and training is available for those bank nurses so that they can do their job safely?

[20] **Lesley Griffiths:** I will ask Heather to answer that question.

[21] **Dr Payne:** The figures that you have seen in terms of the increased establishment have naturally reduced the reliance on bank nurses because if the work is there, it has to be done. Bank nurses were brought in previously, so the reduction that the Minister mentioned will naturally reduce that need.

[22] **Rebecca Evans:** Do we know to what extent the bank nurses have the kind of extra training that is necessary for them to have the skills and confidence to deal with these situations?

[23] **Dr Payne:** With any nurse who is brought into a situation from a bank-nursing background, there is a quality standard that requires them to be sufficiently skilled to deal

with the shift that they are working on. That holds and will not be any different. So, the main improvement will be in having a better establishment.

[24] **Aled Roberts:** You referred to the difficulty in recruiting neonatologists. Can you confirm that north Wales and its predecessor authorities have only attempted to recruit on two occasions in the last seven years?

[25] **Lesley Griffiths:** No, I cannot confirm that.

[26] **Aled Roberts:** There is movement on the establishment figures—overall, there is a 7% improvement. Can you explain the establishment figures against actual staff in post? As far as staff in post are concerned, in north Wales there has been a reduction in the last 12 months of 2.4%. Are you also aware that, although the north Wales board has adopted the standard national guidance as far as HR is concerned, all of its rotas include staff who are both suspended and on long-term sick? That is different from other health boards in Wales.

[27] **Lesley Griffiths:** Are you talking about nursing?

[28] **Aled Roberts:** Yes.

[29] **Lesley Griffiths:** I have asked for confirmation on your latter point. I think that it was raised in the Chamber—I do not know whether it was you who raised it. Following that, I have asked for confirmation or further information on that point. So, I will have to send a note to the Chair.

[30] **Christine Chapman:** Yes, if you could send that information to the committee as well.

[31] **Suzy Davies:** I have a few questions on the workforce plan, Minister. Obviously, we are very pleased to hear about the improvement with regard to nurses, but what do you expect to see in the workforce plan about preparing the pathway for consultancies? That is where some of our main concerns lie.

[32] **Lesley Griffiths:** Around neonatologists?

[33] **Suzy Davies:** Yes, but at consultancy level. There has been a problem with acute medicine in south Wales because there are not enough people on the pathway to become consultants. What do you expect to see in the workforce plan about this for neonatologists?

[34] **Lesley Griffiths:** The neonatal network is working closely with health boards and with the Wales Deanery.

[35] **Suzy Davies:** What do you mean by 'closely'? What sort of level of input is it giving?

[36] **Lesley Griffiths:** When I say 'closely', I mean that there is a focus. We have recruitment difficulties with regard to neonatologists—not just in Wales, but across the UK. I was talking to neonatologists a couple of weeks ago as part of my discussions with the network. Clearly, it is a very high-pressured, intense and stressful specialty. We know that we have recruitment difficulties and it is something that the deanery is aware of. It needs to consider not just neonatologists, but the nursing and the therapies workforce for the next five to 10 years when we are looking at neonatology. I think that the network also wants to establish nurse clinical rotation programmes, to support professional competency and development. You asked me how closely the deanery is working with the network; perhaps I will hand over to Chris on that point in a moment. I meet with the deanery twice a year and

officials meet with the deanery monthly. So, when I say ‘closely’, that is how closely I mean. I will pass over to Chris on the deanery.

[37] **Dr Jones:** The role of the deanery is often raised in meetings like this. The deanery is responsible for ensuring the quality of training for junior doctors as required by the General Medical Council. So, it has to advise what posts can enable that high-quality training to be provided. Sometimes, there may be too many posts in a smaller unit where the quality of the training is not good enough. It will advise about what it takes in terms of overall numbers of posts for Wales, to ensure that training is better. Part of that consideration is whether there are opportunities to develop careers in Wales. We have known in the past that, for paediatrics, which is the base specialty from which neonatologists are created, if you come to Wales for a junior post, there are very few opportunities to progress up the ladder, because there are many of those junior posts and not many posts at the level above. So, it also has to look at the Christmas tree of career progression.

[38] **Suzy Davies:** If you do not mind me saying so, it sounds more like a vicious circle. If you are not training or providing pathways for the top end of the consultancy route, we are not going to get people coming in at the bottom.

[39] **Dr Jones:** We have a clinical service and we have a responsibility to the population of Wales to provide paediatric and neonatal services. So, we have a requirement for consultants and we have to make sure that levels of training up until that point are attractive in Wales. The deanery just advises what kind of number of posts will be able to deliver that high-quality training and make Wales attractive. Then, it is up to the health boards, which work closely with the deanery, as the Minister said, to understand what that means for their populations.

9.30 a.m.

[40] **Suzy Davies:** This particularly affects north Wales at the moment.

[41] **Dr Jones:** It is an issue for all of Wales.

[42] **Suzy Davies:** Yes, but it is a particular issue in north Wales, is it not? Bearing in mind what you said, how do we even stand a chance of attracting more consultants into the north Wales area?

[43] **Dr Jones:** Again, it is an issue of reconfiguration. Services have to be attractive. They have to be state of the art, modern services that offer excellent training environments. Then, people will come to them.

[44] **Suzy Davies:** Do you think that that will go into the workforce plan?

[45] **Dr Jones:** Yes.

[46] **Suzy Davies:** Is that the sort of thing that you are expecting to see in there?

[47] **Dr Jones:** Yes.

[48] **Suzy Davies:** A genuine change of heart on how to get people to come to bits of Wales.

[49] **Lesley Griffiths:** Yes.

[50] **Suzy Davies:** It has been a bit of a long time coming, I have to say, Minister. Why

has that not happened before?

[51] **Dr Jones:** There has been workforce planning in Wales and the UK for many years. I do not think that suddenly anything dramatic has changed. There is always a need to consider the needs of the services. We need to understand in Wales what type of doctor we want and what type of services we want to support. We need to understand how to create the career paths that lead to that type of doctor. It goes back to undergraduate medical education as well, because we need to understand how we create doctors who are ready to work in the NHS, who are successful and who stay in Wales. I do not think that that is a new challenge. Obviously, the world moves on, as NHS services generally do, so this has to be refreshed continually.

[52] **Suzy Davies:** That was my point: it is not a new challenge. I want to know how this new workforce plan will make a difference, and when you expect it to be published.

[53] **Dr Jones:** I believe that the neonatal network is producing this plan more or less as we speak, and it will be published over the next few months. However, it presupposes excellent high-quality services with excellent clinical outcomes. That is our purpose.

[54] **Suzy Davies:** May I ask a brief question on the nurse acuity tool? That seems to have been something of a success story. How long do you think that it will take to introduce that throughout Wales?

[55] **Lesley Griffiths:** The acuity of the cot and baby is important. We have work in progress to ensure that all units fully implement it. The majority of units are now using the tool, and they record the data three times a day. However, before the roll out is complete, there is further development and quality assurance of information needed. Are you asking me when it will be fully rolled out?

[56] **Suzy Davies:** Yes; I would like a rough idea.

[57] **Lesley Griffiths:** I would say that it will be this summer.

[58] **Dr Payne:** There will be a report at the next neonatal network board meeting. That will allow the identification of any local difficulties with data quality, so that we can make sure that it is giving us information, as opposed to just numbers. So, that will be part of the iterative process of monitoring over this year.

[59] **Suzy Davies:** Lovely. So, by the time that we have the next update meeting, we will be able to see the results of that.

[60] **Dr Payne:** Yes.

[61] **Simon Thomas:** Byddaf yn dilyn rhai o gwestiynau Suzy ynglŷn â sut mae recriwtio a chadw staff ar bob lefel. Rydym yn ffocysu ar y gwasanaethau newyddenedigol. Weinidog, ydych chi'n hyderus bod gyda chi'r holl weithdrefnau yn eu lle erbyn hyn ar gyfer recriwtio yn y maes hwn? A ydych chi wedi eich plesio â'r hyn sydd wedi digwydd ers i ni gynnal ein hymchwiliad flwyddyn yn ôl?

Simon Thomas: I will follow up some of Suzy's questions about the recruitment and retention of staff at every level. We are focusing on neonatal services. Minister, are you confident that you have all the procedures in place by now for recruiting in this field? Are you pleased with what has happened since we had our inquiry a year ago?

[62] **Lesley Griffiths:** Obviously, staffing is something that we still need to work on. I

said before you came in, Simon, that certainly in nursing we have seen a fall in the shortfall by about 50%. You will be aware that we have just been talking about neonatologists, and there are concerns, particularly in north Wales. However, all organisations have reviewed their current arrangements for recruiting and retaining staff. We have to make sure that we have the optimal conditions to encourage people to come to work in Wales, and that is what Chris is referring to. We know that there is a shortage of neonatologists, not just in Wales, but right across the UK. We collect the data on recruitment centrally, to give us the detailed pictures. We know where posts are vacant and where they are hard to fill. Then that informs any decisions that we make around recruitment. We have to compete for these positions and it is an issue on which we need to do more work.

[63] **Simon Thomas:** When you collect the data and see where the bits are missing, do you proactively, at a national level, intercede with the local health boards, saying that you think that there is a problem and that they need to do something, or is it left to them?

[64] **Lesley Griffiths:** Obviously, it is up to the health boards to do it, but officials certainly have conversations with health boards. Those conversations are around the reconfiguration plans as well, which are helping health boards with their reconfiguration plans.

[65] **Simon Thomas:** As regards the Work for Wales plan, which I think was launched in September of last year, have you been able to assess whether that has had an impact on the profile of Wales as a place to work and on the type of NHS that we have in Wales?

[66] **Lesley Griffiths:** It does help. One thing that we have done in the campaign is to announce champions—I think that was in January. We have consultants and clinicians to front that. I have made sure that paediatricians and psychiatrists who work with children and young people are part of that. It is important that they go out and sell Wales in that specific capacity.

[67] **Simon Thomas:** We have talked a lot about Wales, but with regard to neonatal, one of the proposals is to take a service out of Wales and into the north-west of England. How would that impact on a campaign to recruit the best to Wales?

[68] **Lesley Griffiths:** As I said before you came in, it is difficult for me to comment on service reconfiguration.

[69] **Simon Thomas:** We are trying to build a picture of Wales as a place that has specialist places, as Chris Jones was just saying, where reconfiguration goes hand in hand with excellence, which will, in turn, strengthen our ability to recruit and attract. If you take neonatal out, there has to be a sense that you can build a career in Wales.

[70] **Lesley Griffiths:** It is important that any specialty is able to attract clinicians of the highest quality, but, to do so, the model has to be right for them to want to come here to have their careers here, to be able to be innovative and to have the best career that they think that they can have. The models have to be right in order for them to come here.

[71] **Aled Roberts:** Os yw eich swyddogion yn derbyn esboniadau ynglŷn ag unrhyw broblemau ar lefel bwrdd iechyd lleol, pa esboniad y mae bwrdd iechyd Betsi Cadwaladr wedi ei roi ynglŷn â'r gostyngiad o 2.4% yn y staff sy'n cael eu cyflogi gan y bwrdd iechyd?

Aled Roberts: If your officials are given explanations about any problems at the local health board level, what explanation has Betsi Cadwaladr LHB given for the reduction of 2.4% in the number of staff employed by that health board?

[72] **Dr Payne:** We expect the LHBs to respond to the overall standards. If they are compliant with the standards, we do not have a problem. If they are not compliant with the standards, we ask them to have a plan. We do not necessarily go into the level of detail to which you are referring.

[73] **Aled Roberts:** However, you will know that this committee was very worried that Betsi Cadwaladr was the board that was least compliant with either the British Association of Perinatal Medicine standards or the Birthrate Plus standards. Every other board across Wales appears to have increased its workforce, apart from Betsi Cadwaladr. Given that we already had concerns, what explanation has been given by the board for the fact that, if anything, it has gone backwards?

[74] **Dr Payne:** Betsi Cadwaladr LHB is part of the overall Wales structure and we use the same principles across the board. We look to the board to comply with the standards as they are written, as opposed to any detail below that. The standards are what we are looking to. In terms of what the board's action plans were, as we have done with boards across Wales, we have conducted visits and had follow-up conversations. Every LHB has slightly different issues in terms of how they have to change to meet the standards. The conversations that we had related to improving throughput through the process, so that it was, effectively, getting babies out of the service so that they were not using cots at a higher level of acuity. The board gave us assurances that it was making clear progress on all aspects.

[75] **Aled Roberts:** But, it is not making progress, because the actual workforce is less than it was 12 months ago. You will be aware that, within the neonatal network's papers, concerns were expressed with regard to the rotas in Betsi Cadwaladr between level 2 and level 3—

[76] **Dr Payne:** That is medical staff, not nursing staff.

[77] **Aled Roberts:** I know, but there are also difficulties with regard to recruitment, particularly at Wrexham hospital, where, you know full well, they are currently one third under strength in the figures that we have from the neonatal network.

[78] **Lesley Griffiths:** I will go back to my answer to Simon, in that if you have not got the correct model, you will have difficulties recruiting.

[79] **Aled Roberts:** So, the only explanation that you have received is that the problem is the model.

[80] **Dr Payne:** No, we have had conversations about how to improve on the separate aspects. You are now bringing in three separate aspects to what is obviously a complex area of work. There are many components that go into the overall standards document. Each of those has a measure set against it. You have now brought in three separate things, and all of those will have had attention in any of the reviews that we have done.

[81] **Aled Roberts:** I have brought in three separate things, all of which are problems as far as performance at Betsi Cadwaladr health board is concerned.

[82] **Dr Payne:** The response to any area that is identified as being a shortfall on the standards is that we ask the LHBs to produce an action plan. So, where they have been identified as not making progress, we have asked them to escalate that to their boards.

[83] **Dr Jones:** We would agree with you that there are major concerns about the current service and the service arrangements in BCU health board. Whatever solution one chooses, it will be far-reaching. You are very well aware, as are we, that BCU has undertaken an awful

lot of work in the public domain about the future for neonatal services in north Wales. That is the work that it has had to do to deliver on the problems that you are outlining.

[84] **Aled Roberts:** The concern that some of us have is that Betsi Cadwaladr is in this position because of its failure, over many years, to undertake any recruitment and it is then using that as a reason to reconfigure.

[85] **Dr Jones:** The point that we are trying to make to you is that you cannot recruit into a service that is not an attractive environment to work in.

[86] **Aled Roberts:** They have not attempted to recruit.

[87] **Dr Jones:** I do not think that it is necessarily sensible to continually put adverts out, which come at a cost, when you know that you will not have any applicants.

[88] **Aled Roberts:** So, they have not recruited because—

[89] **Christine Chapman:** Aled, I have other Members who want to come in. I am sure that we will come back to some of these issues. We will have Rebecca and then Bethan.

[90] **Rebecca Evans:** To pick up on the theme of making Wales, and particularly north Wales, an attractive place to come to work, you mentioned that champions have been appointed as part of the Work for Wales campaign. What sort of thought have you given to appointing a specific neonatal champion? You mentioned that there are paediatricians doing that job, but would it be worth appointing someone specifically to promote neonatal medicine?

[91] **Lesley Griffiths:** Yes, it probably would, but I am asking very busy clinicians to give up time to support that. They have been very good, and it is certainly something that we could look to do. As I say, we have paediatricians and we only launched it in January. I do not expect them to do it for years, because it would too much to ask clinicians to do. We will have a change in our champions. They do not actually like the word ‘champions’, so we are trying to think of another one. Maybe ‘ambassadors’ would be a better word. We could certainly look at having a neonatologist to do that.

[92] **Bethan Jenkins:** I just want to follow on from what Simon said. I appreciate that you have launched the document to recruit more staff, but, for me, this was only done last year in 2012. You used the words ‘optimal conditions’ and ‘creating state-of-the-art facilities’, and Chris Jones said that it is not a new challenge. A lay person looking in here today could see that these are issues that you already knew about. Why did it take until 2012 for you to put these conditions in place? Are you saying to us now that the models are not ideal, that the facilities are not state-of-the-art and that we have not created the optimal conditions in Wales? If that is what you are saying, it is a very worrying situation for Wales, considering that health has been devolved for over 10 years. I want the public to understand where we are going now with reconfiguration in relation to these huge recruitment problems that we face in Wales.

9.45 a.m.

[93] **Lesley Griffiths:** That is not what I am saying at all. You talk about facilities, for instance, and one example is Singleton Hospital, where we have just announced £3.2 million for refurbishment. Refurbishment is always ongoing, and that was part of the refurbishment programme. We know that you can never put enough money into the health service. However, there was an issue at Singleton where they needed this refurbishment, and it is now near completion.

[94] There was a review back in 2009 of the neonatal service, and a lot of work has been done. The Wales neonatal network, for instance, is an excellent model. However, when I came into post in May 2011, I do not think that we were plugged in enough to the neonatal network. We were not getting as much data as we could have done. That has now been rectified, and we get much more robust data. Jenny referred to BadgerNet. The NHS never stands still; it is continually improving. We are saying that that is nothing new and we do not have the models, but it is obviously a matter of continual progress and making sure that we make Wales as attractive a place as possible for clinicians to come and that we get the models right. I am not saying that all the models are wrong or right, but there is work to be done.

[95] **Julie Morgan:** Good morning, Minister. I want to move on to cot capacity. We have had evidence that some cots are in the wrong places and that there is inappropriate use of the cots up to different levels. How are the recommendations in the neonatal capacity review getting on? What discussions have had you with the LHBs about cot capacity?

[96] **Lesley Griffiths:** As I mentioned before, every health board has a neonatal action plan. That is actively monitored by the neonatal network every six months. As I said, they are live documents. The network works very closely with health boards and the Welsh health specialised services committee to make sure that we improve the cot numbers in line with the capacity review. I know that WHSSC recently approved a business case to provide two additional high-dependency cots. The cots will improve the service by repatriating funds currently used to pay for cots outside the Wales network, which is important. Perhaps Heather wants to add to that.

[97] **Dr Payne:** No, I think that that is the main thing. In a service that is classed as emergency but which has relatively low volume compared with other services and enormous day-on-day variation, allowing for surge capacity is an important part. While working towards the actual standards of 70% and 80% occupancy, as the Minister said, it was constructive to look at the money that was being spent on cots outside the network—those that are going out to the south-west network or other networks—and say that if we are spending that money, let us spend it in Wales. That is another example of an improvement that the BadgerNet data and the neonatal network has allowed us to put in place by keeping closer track of exactly how babies are being cared for, where the resources are being used and where they are most needed. That is a very clear example of the substantial improvement.

[98] **Julie Morgan:** On this aim to move towards 70% occupancy for the level 3, do you know what stage you are at with that?

[99] **Dr Payne:** Again, that is a compliance component of the standards. We are not there yet.

[100] **Julie Morgan:** No; but you are on the way there.

[101] **Dr Payne:** Yes, there is steady improvement. We know that we are not complying with that at the moment, but that is the reason for looking at it.

[102] In terms of cot occupancy and usage, there are two ways to respond: you can either increase supply or reduce demand. We have worked on both those areas; the one I have just told you about. However, reducing demand is tremendously important, so that we make sure that babies who do not need that high level of acuity of service are moved down. As we mentioned in the briefing, a large aspect of the work has been in improving and reducing demand by moving babies down into lower acuity services and out into transitional services. This includes working with obstetricians to make sure that if there are elective caesarean sections, they are done nearer the 40-week limit, so that if you have a 25% caesarean rate and most of them are at the 37-week stage of pregnancy, then a greater proportion is going to need

special or intensive care than if you push that to 39 weeks. So, it is about a careful clinical balance, because, why would you do an elective caesarean at a certain point if people are worried about other risks? So, that requires close engagement with clinicians to get them to change their practice and make sure that, regarding weekends and bank holidays, people do not say, 'I will not be able to do it next week, so I'll do it this week instead'. So, it is about moving things forward on a professional basis that is clearly focused on clinical need and on the best outcomes for babies and their mothers.

[103] **Julie Morgan:** So, you are attacking it on all fronts.

[104] **Dr Payne:** That is right. If there was one big simple answer; we would know what that was, but we have a broad approach to trying to make sure that we make incremental improvement in each of the aspects identified as being important influences on this overall problem. However, reconfiguration is still the elephant in the room. If it is relatively small numbers, but high acuity—a very specialist service with a high day-to-day variation—then reconfiguration is the answer to that.

[105] **Christine Chapman:** I am conscious of time, because there are some very important issues that we need to look at, so I remind Members and witnesses to be as concise as possible. Aled, you wanted to come in on this point.

[106] **Aled Roberts:** From your evidence, it is difficult to identify where those additional two cots have been provided. You were saying that you want to repatriate services to Wales—

[107] **Dr Payne:** It is south central.

[108] **Aled Roberts:** So, in south central, we are bringing services back from England, and in north Wales the proposals are to send them out.

[109] **Dr Payne:** Again, this is a particular response to a particular situation. The reason that it has been possible to do it for the south central is because that is where there has been a considerable level of pressure on cots. We have the information from the south, from the peninsula network.

[110] **Aled Roberts:** On the cot capacity review, do you have any concerns that all the projection figures are based on south Wales? The reason given for that in our note is that a complete north Wales data set is not available for 2011 from the Wales neonatal network, which includes capacity in England. What analysis has been done, given that you do not have the data set for north Wales, whatsoever? Births are increasing in north Wales and reducing in south Wales, therefore the neonatal network itself—on page 20—is questioning the projections. So, we are reconfiguring on the basis of 'perhaps'. This might be because there are significant volumes of critical care activity for north Wales residents being delivered in England.

[111] **Dr Payne:** You are talking about the 2011 figures. It is because north Wales did not manage to get its figures into the BadgerNet IT system, which was targeted as a shortfall. We spoke to them about that and they have submitted figures for 2012. So, while they do not exist for 2011, there are more up-to-date figures that have started to be reported upon. That just shows that the process has actually made sure that there are improvements. Of course, you have to start reporting data before you can start getting information out of it. We now have data from north Wales, and we will be able to start answering those questions. However, there is a time lag, I am afraid.

[112] **Aled Roberts:** Is that data available to us?

[113] **Dr Payne:** The neonatal network has reported it. It still needs some data quality assessment, as far as I understand.

[114] **Christine Chapman:** When will the analysis of the latest figures be done?

[115] **Dr Payne:** That will be with the neonatal network. We will be asking it to do that.

[116] **Christine Chapman:** Can you remind us when that will be available? You did mention it earlier.

[117] **Dr Payne:** Do you mean on that precise set of data?

[118] **Christine Chapman:** Yes.

[119] **Dr Payne:** I know that some were reported at the last neonatal network meeting on 7 February, but we have not actually received a written version of that yet.

[120] **Christine Chapman:** Do you have any idea of when you might expect that?

[121] **Dr Payne:** I think that it will be available. I do not think that it will give all of the answers that you are hoping to obtain from it because, again, the first tranche of data reporting is never likely to be as valuable as when it has been reported, analysed, interrogated and—

[122] **Lesley Griffiths:** I can certainly ask the network whether it can let Members have that when it is available.

[123] **Christine Chapman:** I was just about to say that we would need to make sure that it is accurate, as such.

[124] **Lesley Griffiths:** Yes. We can ask the network to let you have that data.

[125] **Christine Chapman:** That would be useful. Thank you. I now move on to Rebecca.

[126] **Rebecca Evans:** We have looked at workforce capacity and recruitment. I would like to move on to training. In 2012, the committee heard evidence that neonatal nurse practitioners had to complete their advanced theoretical preparation in Southampton and then come back for supervised practice in the units in Wales because the whole course was not available here. You told us, Minister, that this situation was being examined. Perhaps you could give us an update on the progress that has been made.

[127] **Lesley Griffiths:** Heather has an update on that.

[128] **Dr Payne:** The situation with neonatal nurse practitioner training is very much dependent on having somewhere for them to go after they have been trained. Once you have trained someone, you need to put them in a post in order for them to continue to develop the skills. The chief nursing officer has certainly had conversations with a number of education providers in Wales. It is perfectly possible for courses to be run because, as you say, colleagues are currently going to Southampton for that training. It could be done in Wales, but the rate determining step is having jobs for them at the end of it. Again, that is massively influenced by the reconfiguration. Advanced neonatal nurse practitioners can actually take the role of junior doctors on some rotas, but you must have the rotas set up in a way where there will be realistic employment for the nurses once trained.

[129] **Rebecca Evans:** Is there not a shortfall in these posts currently? Presumably, they

should be able to slot very easily into post.

[130] **Dr Payne:** Not in the advanced posts.

[131] **Christine Chapman:** Aled has a quick question.

[132] **Aled Roberts:** Is there not a requirement, after they have qualified, that they have to be placed for six months in a level 3 unit? On that basis, if the reconfiguration proposals proceed in north Wales they would then have to be in England for six months, being paid for by Betsi Cadwaladr University Local Health Board.

[133] **Dr Payne:** Again, we would be looking to the stated standards. The logistics of how those are achieved in any particular area would vary according to the model that was in place at the time.

[134] **Aled Roberts:** Has any modelling been done on the basis of the proposals that are being put forward?

[135] **Dr Payne:** The modelling is all done on the basis of reconfiguration planning.

[136] **Christine Chapman:** Lynne has a question.

[137] **Lynne Neagle:** One of the things that the committee was concerned about when we had our review was that there appeared to be a lot of variability among health boards in how they were actually reporting on compliance with the standards; for example, Aneurin Bevan Local Health Board was reporting quarterly at board level, whereas Hywel Dda Local Health Board did not really seem to have any kind of set mechanisms for reporting. So, I wonder what progress has been made in ensuring a more uniform approach to reporting against the standards.

10.00 a.m.

[138] **Lesley Griffiths:** There is a much more uniform approach now. All health boards are fully reporting to the neonatal network. Going back to what Jenny said, the BadgerNet information system is now used to capture the data on compliance. So, it absolutely has improved the quality and there is much more uniformity.

[139] **Lynne Neagle:** We got the impression that one of the things driving improvement in Aneurin Bevan was the fact that the report was at board level. So, as well as reporting to the neonatal network, are they all reporting to their own boards on their compliance with the standards?

[140] **Lesley Griffiths:** Yes.

[141] **Lynne Neagle:** Right.

[142] **Bethan Jenkins:** Yn dilyn o'r hyn a ddywedasoch yn gynharach am Abertawe, a allwch roi syniad inni o'r amser ar gyfer cwblhau hynny? Hefyd, pa ystyriaeth ydych yn ei rhoi i'r ad-drefnu arfaethedig yng nghyd-destun hyn, a'r adolygiad o gapasiti? Rwy'n darllen bod y newidiadau wedi eu seilio ar yr hyn sy'n bodoli ar hyn o bryd, nid ar yr hyn a fydd yn bodoli gyda'r ad-drefnu

Bethan Jenkins: Following what you said earlier about Swansea, can you give us an idea of the timeline for completing that? Also, what consideration are you giving to the proposed reconfiguration in that context, and the review of capacity? I have read that the changes have been based on what exists at present, not on what will exist with the reconfiguration in the field of health. If I am

ym maes iechyd. Os wyf yn anghywir, plîs, cywirwch fi.	wrong, please correct me on that.

[143] **Lesley Griffiths:** It was nothing to do with reconfiguration. This refurbishment work had to be done, and it was needed because of professional advice given by infection control colleagues, for instance. There was a review of the quality standards of the physical estate, if you like. So, this work had to go ahead. It had nothing to do with the reconfiguration; this work had to go ahead and it will be completed by the end of this month.

[144] **Bethan Jenkins:** Okay. May I just make another point following on from that? It is stated in your evidence, and in the evidence that we have had from WHSSC, in the capacity review of 2013, that it was underutilised in Bridgend, and that that is why it was transferred. I just want to understand why it was underutilised in Bridgend for it to be moved. Is it because the staff speciality was in Swansea? Is that why the move happened?

[145] **Dr Payne:** They had intensive care beds there that they were not using. The hierarchy of intensity in the level of care is inversely proportional to how frequently you are going to need it. Most babies, if they need neonatal care, need special care, which is the lowest level. Fewer than that need high dependency care, and the least number of them need intensive care. At this place, they had intensive care cots that they just were not using. So, basically, they were overstaffed. The tendency then is to put high dependency or special care babies into an intensive care cot, and that is a very expensive way of going about it, and it is inefficient. Again, the general principle of centralising a high-intensity but low-volume service just means that you have that greater flexibility. So, that was the reason: the service looked at itself and said, 'How can we be as efficient and effective as possible? How can we give the greatest benefit to the most sick and premature babies?' Having seven or eight cots here and two over there is not as useful as having those two over here and just supporting the lower intensity services in the peripheries, but centralising the very intensive services. So, that was the reason for that.

[146] **Bethan Jenkins:** I have a final question. In the capacity review, it says that discussions on a south Wales plan provided by fewer sites are ongoing. Does this include this particular service in Swansea? Would that be part of the plan that is being looked at at the moment?

[147] **Lesley Griffiths:** If you are you talking about the south Wales reconfiguration plan, I would assume so.

[148] **Suzy Davies:** I want to come back to the refurbishment and the purpose of it. You are probably aware that, this week, the community health council in our area has agreed to proposals that the critical care given at Singleton at the moment be moved to Morriston in due course, which will actually leave the special care baby unit with fewer cots, because, as Bethan said, some of them will be going to Bridgend. If you are putting this level of money in, was it aimed at providing the relevant level of hygiene for the critical care cots, or was there an issue with the special care cots?

[149] **Lesley Griffiths:** Are you talking about the £3.24 million?

[150] **Suzy Davies:** Yes.

[151] **Lesley Griffiths:** I cannot really add any more to my answer to Bethan. The reason it was done was that we had advice that this refurbishment needed to go ahead, because we had advice from professionals that this refurbishment was needed. The critical incident reporting showed us that this refurbishment needed to go ahead. It was nothing to do with reconfiguration.

[152] **Suzy Davies:** I am trying to get to the specifics of why the refurbishment was needed. Was the demand coming from the critical care end, or was it something that affected the special care end of delivery as well?

[153] **Dr Payne:** You cannot separate those aspects. It is a neonatal unit.

[154] **Suzy Davies:** Was it about the physical condition of the unit?

[155] **Dr Payne:** The cots were too close together, physically.

[156] **Suzy Davies:** That is helpful. That is what I was trying to get at.

[157] **Dr Payne:** You get a much higher rate of cross-infection if there is physical overcrowding in the unit, and if there are not enough hand-washing facilities, or places for the day-to-day storage of equipment. It is critical for the quality and safety of care for newborns, who are unbelievably susceptible to cross-infection.

[158] **Suzy Davies:** I accept that, but if the critical care beds end up going, you will have loads of space in Singleton, will you not?

[159] **Dr Payne:** That is a different argument.

[160] **Aled Roberts:** When our report was published in September 2012, you accepted recommendation 8, which was to review the effectiveness of the Wales Deanery as far as forward planning was concerned. In your response in Plenary, you indicated that you would be meeting with Professor Derek Gallen to discuss the work of the deanery. Where are we regarding its profiling of medium to long term needs at the moment?

[161] **Lesley Griffiths:** Discussions are ongoing in relation to this. Again, the deanery would say that a lot of its discussions around rotas would rely on reconfiguration. There are concerns about paediatrics, which are well-documented. It has its paper, 'Facing the Future', and within that the Royal College of Paediatrics and Child Health sets out training requirements. That is very much the driving force behind the deanery's discussions at the present time. However, they are ongoing.

[162] **Aled Roberts:** If reconfiguration proposals are accepted—and I accept that that is an 'if'—there is reference in the network's evidence to us today that it remains unclear how Betsi Cadwaladr health board intends to model or re-model its neonatal services once Arrowe Park commissioning is implemented, if it is implemented. It is difficult to understand why the reconfiguration proposals do not outline what the level 1 and level 2 provision rotas, et cetera, will look like, given that the reconfiguration proposals still allow for level 1 and level 2 provision across the three sites in north Wales. There is a difficulty as far as we are concerned: given the failure to act over many years on medical and nursing rotas, one would have hoped that its reconfiguration proposals would give reassurance regarding the work that it has in place to properly staff those units if reconfiguration goes ahead. It would appear from the network's evidence that that is not the case.

[163] **Lesley Griffiths:** I really do not think that I can comment, because of my position; sorry.

[164] **Aled Roberts:** Can we move on to the transport arrangements? In your evidence, in recommendation 12, you accepted in principle the need for an all-Wales 24-hour service. We suggested that you should undertake a cost analysis of implementing that. What progress has been made on that recommendation?

[165] **Lesley Griffiths:** The 12-hour service is working very well. I know that a scoping exercise is looking at the options around whether we should move up to a 24-hour transport service, and again, the neonatal network is considering those options. I am expecting recommendations later this year on that issue.

[166] **Aled Roberts:** Does the cost of that then fall on the Welsh Ambulance Services NHS Trust? I am just concerned that, if the reconfiguration proposals proceed in north Wales, the ambulance trust for Cheshire and Merseyside will be responsible for transport of level 3 in north Wales, and I understand that the Betsi Cadwaladr health board will have to enter into contractual arrangements with the English ambulance service. I am a bit concerned that we are looking at cost analysis for an all-Wales service, when north Wales will have to pay separately for service provision from England.

[167] **Lesley Griffiths:** We fund the service at present. That would be part of reconfiguration plans.

[168] **Aled Roberts:** So, you would provide additional resource to Betsi Cadwaladr for the cost of the service from England.

[169] **Lesley Griffiths:** That would have to be looked at within the reconfiguration plans.

[170] **Christine Chapman:** Minister, turning to another issue, one of the recommendations of our report was that the Welsh Government should ensure that local health boards, in collaboration with the all-Wales neonatal network, produce a programme by December on how parent and community services will be expanded and improved. You accepted this recommendation in principle, so what progress has been made in identifying parent and community services for expansion and improvement?

[171] **Lesley Griffiths:** I will ask Heather to answer that question.

[172] **Dr Payne:** That is an active work stream of the neonatal network. There are parent group representatives on the neonatal network, and it is engaged in a number of pieces of work. From listening to what it has to say and using its messages on modifications to services, we rate it as being extremely important. However, the thing that most mothers, fathers and families want for their babies is the best chance of long-term survival without any long-term problems, and that comes back to the issue of service quality.

[173] **Christine Chapman:** When will the programme be published?

[174] **Dr Payne:** The group is reporting at each meeting of the neonatal network. We can provide an update on that.

[175] **Christine Chapman:** So, it is basically a living document, and we could see what updates are being made to it.

[176] **Dr Payne:** It is an ongoing process, and we can provide you with an update on where it is at the moment.

[177] **Lynne Neagle:** I have written to you, Minister, about the case of a baby who died, whose parents I have been dealing with. The baby was readmitted to hospital after leaving special care, and because of the policy of not readmitting to special care, which I understand, the baby was put on a paediatric ward and got an infection. As part of the community services that you have put in place for neonates, are you looking at how we can minimise the likelihood of that happening to any babies in the future?

[178] **Dr Payne:** A number of babies, having been graduates of neonatal units because they are premature and have less well-developed immune systems, are more susceptible to infection. To avoid cross-infection, it is clinical policy not to readmit them to special care. They would be cared for in the same way according to clinical need. If they required paediatric intensive care, they could be admitted to that.

[179] It is very difficult to speak about individual cases, because circumstances such as these are unbelievably tragic and are a great problem for everyone involved. However, the answer is not to readmit babies such as this to special care units, because that would not be better all round.

[180] **Lynne Neagle:** I completely understand that, as do the parents of the baby. What people are looking for is that the very specific needs of neonates are taken into account when they are admitted to a paediatric ward; they are that much more susceptible even than the sick children who are there.

[181] **Dr Payne:** Absolutely, and I guarantee that every individual child, whatever their situation, will be looked at in terms of clinical need. That is separate from the provision of neonatal services, but I have confidence that that does happen.

[182] **Christine Chapman:** I am now going to close this part of the meeting. I thank the Minister and her officials for coming here today. It has been a very useful session. I am sure that there will be further updates and discussions, but I thank you for attending, Minister. We will send you a transcript of the meeting so that you can check it for factual accuracy.

[183] **Lesley Griffiths:** We will send you the information that you requested, Chair.

[184] **Christine Chapman:** The committee will now take a short break, and we will come back at 10.30 a.m..

Gohiriwyd y cyfarfod rhwng 10.15 a.m. a 10.30 a.m.
The meeting adjourned between 10.15 a.m. and 10.30 a.m.

Ymchwiliad i Ofal Newyddenedigol
Inquiry into Neonatal Care

[185] **Christine Chapman:** For the second part of the meeting and our update on neonatal care, I welcome our witnesses, Dr Mark Drayton, consultant neonatologist and clinical lead from the Wales neonatal network, and Daniel Phillips, executive director of planning, the Welsh Health Specialised Services Committee. I welcome you both this morning. Thank you for sending us a paper in advance. Members will have read the paper, so, if you are happy, we will go straight into questions.

[186] I want to start by asking you what changes have been made to the local health boards' action plans to ensure that they are robust and fit for purpose.

[187] **Dr Drayton:** We have been working very closely with the health boards over the last six to 12 months, and we have visited every single health board either by video conference or directly within the last three weeks since we issued the most recent capacity review—the 2013 capacity review. Our role is to provide them with professional advice and support in terms of developing plans to strengthen their services, and I am happy that that advice is being heard and received. In relation to the updated advice that comes out of the 2013 review, health boards have only received that relatively recently, in February, and have not as yet, in

every aspect, been able to give us detailed responses in terms of their action plans, but they now understand the advice and the reasons for it, and, by and large, accept it.

[188] **Christine Chapman:** The performances of local health boards are different. Are you visiting some more than others because of their performance?

[189] **Dr Drayton:** I would not want to give you a ranking. The fair way of putting it is that the issues for each health community and each health board are different. We are not dealing with all the same issues in all the health boards. There are some issues that cross all health boards, such as nurse staffing, for instance, and medical staffing issues, but, even in that regard, the individual local issues are also different, depending on the configuration of the services and the particular problems and challenges that are being experienced locally. We deal very even-handedly with all our health boards and all our communities, but focus on their particular issues.

[190] **Mr Phillips:** Over the year, Chair, it distributes, but, obviously, at certain times of the year, some health boards want more support from the network than others—when they have pressing issues, or, in particular, when they are developing their configuration plans.

[191] **Christine Chapman:** What I am getting at is the fact that performances are different—and, understandably, there are different issues, but, obviously, some need to do things quicker than others. You talked, Dr Drayton, about being even-handed, but, in terms of getting things moving, do you need to speak to some more than others?

[192] **Dr Drayton:** I think it is inevitable that sometimes we need to go back again, is it not? If, the first time around, they are not able to give us all the answers that we need, we need to revisit the issues. It will be no surprise to your committee that there are particular issues in north Wales surrounding the services there. They have been modelled in a very different way from those in the rest of Wales, and, indeed, from those in the rest of the UK, in recent years and we have been working with them to try to address those issues. On capacity, the most recent review demonstrates that many of the pressures are in the south-central region and we have been working closely with Cwm Taf and Cardiff and the Vale LHBs to try to come up with plans that can help us to move those capacity pressures forward because, clearly, they constitute a serious risk to the delivery of the service.

[193] **Christine Chapman:** I know that Members will want to come in on the specifics and details, and I will bring in Rebecca first of all.

[194] **Rebecca Evans:** In your evidence, you state that, in order to monitor the implementation of the all-Wales neonatal standard, LHBs assess themselves against a number of indicators, which are then presented on a six-monthly basis to the neonatal network. Is it appropriate that the LHBs assess themselves or would some kind of independent view be of benefit?

[195] **Dr Drayton:** That is a good question. There is no doubt that some health boards are harder on themselves than others in those self-assessments. However, we do not just take the traffic-light returns that come in to us at face value—we always consider them and discuss them with the health boards to understand why they think that they are not compliant, if they are not compliant, and therefore understand what their plans are to become compliant. In many instances, it is more important to understand and work with the health boards so that they get plans in order to get themselves where they need to be within a reasonable timescale. Clearly, some aspects of the compliance will take longer to achieve than others.

[196] **Rebecca Evans:** Do you think that six-monthly reporting is about right or could some health boards benefit from more regular reporting?

[197] **Dr Drayton:** When we started this process two and half to three years ago, it was on a quarterly basis, but it became apparent that that was not giving health boards sufficient opportunity to take action between the visits and that it was a little bit bureaucratic and pointless. So, I think that half-yearly is about right, because that allows us to continue to track the progress and ensure that some of the issues do not slip below the horizon again.

[198] **Simon Thomas:** I want to follow up on a specific example, which is the Hywel Dda Local Health Board because, when we conducted our original inquiry, Hywel Dda said that it never recognised the need to produce an annual report, for example, on the quality of care as described. However, it responded to the inquiry by saying that it would change its practice. In our previous evidence-taking session with the Minster, she confirmed that Hywel Dda now produces that. However, reflecting on the earlier point, Hywel Dda came quite late to that kind of reporting, so are you confident that everyone is reporting to the same standard and analysing themselves in the same way? In particular, are there processes in place to ensure that a health board like Hywel Dda, which has only just started to do this in that fuller way, is picking up the speed with the very best practice in this?

[199] **Dr Drayton:** We were in Carmarthen just a couple of days ago, talking to the Hywel Dda team and it was a very positive meeting. It clearly has come a long way and I would like to think that we have played our role in helping it to make that progress. It is very keen to develop its services, particularly at high-dependency level—that middle-type level of neonatal care—and we have been encouraging it to do that, because we think that, through doing that, it will be able to provide more babies with care closer to home. We have been equally clear with it that it is important for it to develop robust medical staffing plans, because medical staffing plans are challenges for every single health board in Wales at the present time. Hywel Dda has particular issues, in that babies are being delivered in consultant units on three separate sites. That presents unique challenges for the provision of neonatal services relating to the geography. We have a good understanding with it on where it is in terms of developing those plans. I do not think that those plans are yet perfect, but it knows where it needs to get to.

[200] **Simon Thomas:** Is there clarity there regarding the use of paediatricians, for example, and neonatologists because there was some confusion in the past, was there not?

[201] **Dr Drayton:** Yes. The services provided within Hywel Dda will be provided by general paediatricians. That limits the scope of the services that can be provided. That is nothing new; that has always been the case. Intensive care of the sickest infants in Hywel Dda LHB area is provided in Swansea, and in Cardiff for those babies who require specialist surgical care. What we are very interested in is making sure that only the babies that need to go to Swansea or to Cardiff go there and that they get back as quickly as possible. That is what we are trying to help Hywel Dda develop in terms of its forward planning.

[202] **Simon Thomas:** Just to be clear, in taking that forward, there is clarity and understanding between yourselves and Hywel Dda about what the definitions are, who does what, the use of paediatricians and so forth. If there has been confusion in the past, there is no confusion now about that.

[203] **Dr Drayton:** No. I am confident that there is no confusion about that. That is not to say that there are not still challenges that relate to recruitment, staffing issues and the geography.

[204] **Suzy Davies:** You have been rather diplomatic in your answers to those questions. On those occasions when you are disappointed with the stage that the various health boards have reached, particularly with their action plans, what level of influence do you have to

make sure that they come up to standard? What happens then if they do not?

[205] **Dr Drayton:** That is a very difficult question, but I think—

[206] **Suzy Davies:** How much can you tell them to do stuff, as opposed to supporting and advising them?

[207] **Dr Drayton:** Our role is very clear. We do not have executive authority; that always resides with the chief executives of the health boards. Our role is to provide advice and to provide it as clearly as possible. We are now able to collect quite a decent data set, which helps to support the evidence base for some of our advice. If we are not comfortable, then we have to go back and say that we are not comfortable, and sometimes there is a little bit of negotiation. However, ultimately, the decisions have to be those of the health boards. The other thing that we bring to the party as a network is the fact that the services are organised in a network fashion. In other words, no single health board works in an isolated capsule. It is about patients flowing up to the neonatal intensive care units and then back down again to the locality services. So, it is also about supporting and encouraging the health boards to work together to develop their local plans.

[208] **Mr Phillips:** I reiterate Mark's point. We are very clear about the role and function of the network, which is to provide advice. I can assure you that Mark gives clear advice. Also, if you look at last year's review of capacity, there was clear direction and I think you will see good progress against it. Yes, there is a lot more to do, but I think that you should be encouraged that, through Mark and colleagues, we give clear advice and progress is being made against that advice. However, it is advice. The accountability lies with the health boards.

[209] **Suzy Davies:** So, if you hit a particularly recalcitrant chief executive, you do not go to the Minister and say, 'I've got a problem with this chief executive', do you?

[210] **Dr Drayton:** We discuss where we are at with the Minister's officials at intervals.

[211] **Mr Phillips:** I have not come across that yet.

[212] **Dr Drayton:** I do not think that we have hit a recalcitrant chief executive.

[213] **Suzy Davies:** That is good to know. Thank you.

[214] **Aled Roberts:** In your evidence, you say that local health boards have been making good progress on their reconfiguration plans. However, you say that there is little evidence on the ground that they are developing robust medical workforce plans to meet British Association of Perinatal Medicine standards. I assume, on the basis of your answer, that you have had discussions with chief executives to say that there is little evidence. What has been their response?

[215] **Dr Drayton:** Since we wrote that, we have had this recent series of meetings with every health board. With most of those health boards, the meetings have included executive members of the board and there has been more progress. In relation to south Wales and the south Wales planning process, those plans are not yet clear and are not yet finalised. That is an ongoing process, so there can be no manpower plans to support them. In relation to north Wales, the planning process so far has tended to focus on the very small number of the sickest babies, as you are aware.

10.45 a.m.

[216] We have been talking to the health board about focusing on the 90% or so of babies that will not transfer to Arrowe Park Hospital under its current plans. It is taking that advice on board in considering how it configures its internal services, particularly in trying to centralise care for the sicker infants on one of the sites in order to keep more of those babies in Wales. That will provide the concentration of expertise and the sickest babies in one place. It is taking that advice on board, and its manpower plans need to be based on that. So, that is still work in progress.

[217] **Aled Roberts:** It is rather surprising, given that its reconfiguration proposals are for the whole of neonatal services, that it has not developed plans that deal with the 90% of babies who are not level 3.

[218] **Dr Drayton:** There is a little bit of a two-stage process, and we have been highlighting that with the board. I think that it fully understands those issues. Again, we had a video-conference with them, last week or the week before, and we went through those issues in some detail. So, I would prefer to see it done in a more comprehensive way, in a single stage, but it is clear that it has addressed one bit of it, and that it is now working on the detail of the model for the remaining part.

[219] **Simon Thomas:** As you are probably aware, one of the references to the Hywel Dda plans by the community health council to the Government was on the basis of poor workforce planning, and that there was no clarity, not just about neonatal care, but generally. You have decisions in relation to Hywel Dda and north Wales now being taken by Ministers in some way, shape or form, and workforce planning is a key element within that. So, just looking at the neonatal issues—I accept that you are not the executive decision makers, but you are making recommendations—do you feel or recommend that for Ministers to take a coherent decision there should be more information on the points that you have just discussed with Aled Roberts around this workforce-planning element in north Wales and Hywel Dda?

[220] **Dr Drayton:** The point that you are making is very reasonable. We all know that one of the main reasons for all the reconfiguration discussions in every community in Wales is medical manpower and the unsustainability of the current way of delivering services. So, it is important that new proposals for new configurations clearly demonstrate whether they address those manpower issues, or to what extent they do so. I think that there is a need for greater clarity on that.

[221] **Simon Thomas:** Part of the clinical driver for reconfiguration, clearly in Hywel Dda in relation to level 3, is manpower or staffing. However, you take a step back from that, and it is not clear yet where the improvement would come in the staffing, if we went down the road of reconfiguration. That is what I am trying to get at. That is the missing link, in terms of what we can see publicly, is it not?

[222] **Dr Drayton:** There is some truth in what you say. I am clear that the proposals that Hywel Dda has put on the table will strengthen its clinical delivery of service by bringing together high-dependency care so that a greater percentage of high-dependency care can be delivered within the health board area. That will allow the nursing and medical expertise to be built up. I do not think that it has any chance of building it up in two, or even three, sites—

[223] **Simon Thomas:** I am not talking about site-specific arguments.

[224] **Dr Drayton:** Absolutely, but there is a wider issue, which is definitely not just a neonatal issue, about the sustainability of staffing models in terms of continuing to staff three sites. There is an opportunity for greater clarity there.

[225] **Suzy Davies:** I have a specific question on the workforce plan, which is supposed to

take you to the next five to 10 years. In earlier evidence, the Minister said that it is likely to be ready in the next few months. Is that being a little over confident?

[226] **Dr Drayton:** For the south Wales component, we need to see what the preferred reconfiguration option is. As far as I am aware, there is currently no preferred option. Until you have that option, you cannot have a manpower plan that runs alongside that option. So, that is a significant issue.

[227] Some of the issues around getting a sustainable workforce will take a long time to be put in place. We are well aware that advanced neonatal nurse practitioners are an extremely valuable staffing resource. In Cardiff, we make heavy use of ANNPs; we currently have the greatest concentration of them in Wales and we strongly value them. However, to develop ANNPs in greater numbers throughout the rest of Wales will take a long time; it takes a year to train and then another six months before they can start working on rotas. Then, if we want to graduate them to working on the tier 2 rotas, that probably takes another five years after that. So, that is a very long-term plan. It is one thing to develop a plan and another to actually have a realistic implementation plan.

[228] **Suzy Davies:** The publication of a plan is perhaps not as imminent as we might like to believe.

[229] **Dr Drayton:** There needs to be complete clarity on what the reconfiguration is, before we can have a manpower plan that makes sense.

[230] **Suzy Davies:** I understand. Thank you for your answer.

[231] **Bethan Jenkins:** Fe ddarllenais yr adroddiad ar gapasiti ar gyfer y llynedd ac yr oedd yn gynhwysfawr iawn. A allech chi esbonio pa ddiwygiadau penodol sydd wedi eu gwneud i safonau newyddenedigol Cymru gyfan a phryd y bydd disgwyl i fyrddau iechyd eu cyrraedd?

Bethan Jenkins: I read last year's capacity report and it was very comprehensive. Could you explain what specific revisions have been made to the all-Wales neonatal standards and when health boards will be expected to meet them?

[232] **Dr Drayton:** The new standards have been finalised and agreed by the national specialist advisory group. We are in the process of discussing how they can be formally launched, so that they become the new standards for Wales. We expect to launch them within a few weeks and we will then expect health boards to take them on board and look at what differences they make to their compliance.

[233] The new standards bring on board the most recent professional advice from the BAPM and Bliss, the parent support organisation, in terms of facilities for parents, and they strengthen the previous standards, particularly in relation to therapists and professions allied to medicine. They add a bit more detail in terms of medical and nursing manpower. They do not actually up the standards, but they produce more detail. So, we will launch those hopefully within a few weeks; we are just discussing what the appropriate mechanism would be to do that. We will then ask health boards to self-assess against them in the same way that they have been doing against the previous standards. It is only fair to say that the new standards will reveal some more reds and ambers initially; that is inevitable. However, it is a way of trying to take the service forward and keep it up-to-date with the standards that are being used nationally within the rest of the UK.

[234] **Bethan Jenkins:** Diolch am yr ateb. Roeddwn yn mynd i ofyn sut y byddech yn monitro hynny, ond yn ôl yr hyn yr wyf yn ei

Bethan Jenkins: Thank you for that answer. I was going to ask how you will monitor that, but as far as I understand, you want to use the

ddeall, rydych am ddefnyddio'r un broses. Pa rôl a fydd gennych ar ôl hynny i fonitro safonau? Hefyd, i ddilyn yr hyn y mae nifer o bobl wedi ei ofyn y bore yma, rydych yn dweud bod y rhwydwaith penodol hwn yn cydweithredu'n agos gyda byrddau iechyd, sut y mae hynny'n mynd i ddigwydd yn y dyfodol, wrth feddwl bod rhai ardaloedd wedi penderfynu ar ad-drefnu a bod rhai heb benderfynu? Sut fydd y safonau ar yr un lefel, pan rydych yn ymwybodol am yr hyn y mae rhai byrddau iechyd yn ei wneud, ond nid eraill? Sut fydd y rheini yn modelu eu gwasanaethau yng nghyd-destun y safonau newydd?

same process. What role will you play after that in monitoring standards? Also, following on from what many have asked this morning, you say that this specific network collaborates closely with health boards, how will that happen in future, bearing in mind that some areas have decided on reconfiguration and others have not? How will standards be on the same level, when you know what some health boards are doing, but not others? How will they model their services in the context of the new standards?

[235] **Dr Drayton:** How the standards are applied within different health boards and units depends on what level of services is being provided and there are different standards for different levels of unit. So, clearly, not all units or health boards will assess themselves in the same way. Some parts of the standards will not be relevant. I am not sure how well that answers your question or whether I have entirely understood it, but the responsibility for delivering against the standards will remain with the individual health boards.

[236] **Mr Phillips:** Most of the standards are about provision. There are some standards that are about commissioning, which will apply equally to all seven. The standards are about the levels of care and the facilities that you need for a level of provision that we can easily assess, and that each health board can assess. I think that our assumption for Betsi, for example, is that we would expect to be looking at how the standards in Arrowe Park Hospital—if that if the final decision—meet those standards, because the same standards apply for the Welsh population.

[237] **Bethan Jenkins:** I am trying to understand: despite the fact that the plans have not come out for my area, say, would you expect that the reconfiguration would meet those standards regardless of what happens? Therefore, would you not necessarily need to know what those plans are? I am just confused. How can you plan for all of Wales? For example, the new unit in Swansea has been created, but the reconfiguration plan could mean that that would be better somewhere else. How do we know that we are going to get an all-Wales view or standard?

[238] **Mr Phillips:** If a service is saying that it is providing neonatal intensive care, there is a set of standards relating to what it needs—whether it is for medical staffing, nursing, environment or the support of parents. So, whether that is in Singleton, Morriston or somewhere else, that is what we would assess, half year on half year. What we want are clear plans and to know where we are. As you say, we will use the same sort of tool as we have now and the same sort of self-audit. I think that what we will see next time is a final set with an assessment against the current standards and the first assessment against the new standards at the same time, so that we can see the transition. So, we will have a fixed point to go forward on the new standards.

[239] **Aled Roberts:** Do your new standards also lead to a common basis as far as reporting is concerned? Is there a timeline? Part of the reason why we conducted a further inquiry was that there were standards in place going back to 2006 and 2008. Many health boards had made no attempt whatsoever to achieve the standards—up until our inquiry, we had one health board that had made no progress towards achieving the standards in the four or five years that they were in place. Is there a timeline within which you would expect compliance

with any new standards?

[240] **Dr Drayton:** We thought about that as we drafted the new standards. Unlike in the 2008 standards, where there were timelines that were not frequently achieved, we decided that we would not include a timeline. The philosophy that we developed and agreed with Welsh Government officials was that the standards should be the standards—in other words, it is not a standard for tomorrow—it is a standard for today. What is important is the pathway or action plan to bring a board into compliance. If you set standards and then say that this is for 2013 and that is for 2015, the inclination is not to start doing anything until 2013 or 2015. If you have developed national standards—and these are based on the UK-wide BAPM standards that were published in 2010—they should be the standards for today. We accept that not all health boards can get there today, but we want to work with them and discuss their timelines for compliance.

[241] **Aled Roberts:** Have you agreed a common basis for reporting? This morning, the Minister said that she would have to check a claim that has been made in north Wales, for example, that nursing staff who were suspended or on long-term sick leave are still included on rotas. Even though we have common human resources guidance across Wales, there are different interpretations of what is reported in respect of those standards.

11.00 a.m.

[242] **Dr Drayton:** Yes. We make quite detailed reporting arrangements for nurse staffing. You will see that those are reported in the 2013 capacity review. We look not only at nurses on establishment, but we also ask questions about the nurses on the ground and how many of those nurses on the ground are doing hands-on care, as opposed to managing shifts and so on. I do not have the information that you may have about nurses who are suspended, or whatever. I really do not have that information. I do take at face value that if the reports state that the nurses are on the ground providing hands-on care, that is what is happening. To the best of my knowledge, those are the statistics that we collect.

[243] **Aled Roberts:** There is no definition in the standards as to what actually represents nurses on the ground.

[244] **Dr Drayton:** The standards are drafted in rather more general terms, both nationally and as we have translated them into the Wales standards.

[245] **Mr Phillips:** Just for clarity, the acuity tool that we are looking to roll out does actually measure the number of staff on shift during every shift. That is one of the reasons why we are looking to use that as well as the generalised establishment figures. That tells you what percentage of shifts will be compliant with the standards, which I think—

[246] **Aled Roberts:** The claim in north Wales is that people are on a shift even though they are not actually working.

[247] **Mr Phillips:** That will be a measure of how many people are there.

[248] **Christine Chapman:** Do you have any further questions, Aled?

[249] **Aled Roberts:** Yes, on the workforce, because we are moving on to that anyway. Obviously, the figures with regard to the total nurse establishment are quite positive, but there is a difference in definition between establishments and staff in post. In your discussions with Betsi Cadwaladr health board in particular, has any explanation been given regarding the reduction of 2.4% in staff in post in Betsi Cadwaladr given that, at the time of our earlier inquiry across the piece in Wales, we heard a lot of evidence with regard to staff being under

a great deal of pressure? Obviously, there must be some concern that there has been a further reduction in staff in post.

[250] **Dr Drayton:** It is my understanding, from the health board, that that was a short-term issue. We take our staffing returns at a point in time. We have to say, ‘Report to us on this day’, because otherwise people can report all sorts of different things; so, we say, ‘That is how it was on that day’. We will then come back in another six months’ time and take another look. So, it is snapshot based. Inevitably, with snapshot-based assessments, there are issues regarding sickness, for instance, or the recruitment cycle. Sometimes, we may catch health boards when they are in the process of recruiting. All health boards recruit on a cyclical basis to manage turnover. So, it is our understanding that they have improved the establishment and they are moving in the right direction. Although it is not reflected in the figures on the ground in that return, their expectation is that, next time around, it will be.

[251] **Aled Roberts:** Are these the figures for July 2011?

[252] **Dr Drayton:** They were revised in November, I think. We went out a second time on the nurse staffing. The medical staffing was looked at in July, and we did collect nursing figures in July, but because of the issues in relation to the work that we had been doing with the health boards—quite a number of health boards were still in the recruitment process in July and August—we decided that it would be reasonable to go back and ask them again in the autumn, and that is what we did.

[253] **Aled Roberts:** Are those figures available?

[254] **Dr Drayton:** Those are the figures.

[255] **Simon Thomas:** Are they the autumn figures or a synthesis of the two?

[256] **Dr Drayton:** The figures that you have are the autumn figures. We will be going out again in the course of this year. I do not think that we have decided precisely when, but we clearly need to go out again.

[257] **Aled Roberts:** Would it be possible to receive the July figures, if the claim is that it is a short-term recruitment issue?

[258] **Dr Drayton:** Yes.

[259] **Christine Chapman:** July 2012.

[260] **Dr Drayton:** July 2012.

[261] **Aled Roberts:** July 2011—

[262] **Christine Chapman:** 2011; sorry.

[263] **Aled Roberts:** July 2011 and 2012.

[264] **Christine Chapman:** Okay. I now call on Jenny.

[265] **Jenny Rathbone:** This is a very complex area. It is a bit like a series of spinning plates and keeping them all going at once. For example, in south Wales, you have managed to not have an unexpected rise in special care baby unit use because you have people on postnatal wards who are better able to keep those babies there. On the other hand, in your analysis of why there has been a rise in the number of very early births—23 weeks’ gestation

and above—you mention that obstetric practice in relation to pregnancies may be moving towards earlier delivery to reduce the risk of foetal loss, and I just wondered, given the small numbers, whether you might have one rogue practitioner who was overly enthusiastic about intervening, and what impact that could have on your spinning plates.

[266] **Dr Drayton:** There is clearly variability between clinicians in all specialities. Some of those are evidence based, and some are opinion based. It is very difficult for me, or indeed for anyone, to get anything that is statistically meaningful about that. That part of the analysis was speculative, because we identified that the birth rate appears not to be still rising in south Wales, but we are getting more babies into the neonatal unit, and they are very pre-term babies, so we had to ask the questions about why that was so. We came up with some potential answers. I do not think that we have all the answers. It would be very tricky to tease out all the answers. One of the issues, for instance, is that Aneurin Bevan health board has a particularly high incidence of very pre-term births per thousand live births. It is looking at that closely currently. We talked to it about that yesterday, and it is involving its public health medicine people to look at that and see whether there are any factors there that they can understand. However, we do not understand that at the moment.

[267] **Christine Chapman:** Could it be the effect of poverty and social deprivation, for example?

[268] **Dr Drayton:** That is undoubtedly one component. The issues that determine the incidence of pre-term delivery are very complex. Certainly, socioeconomic deprivation is known to be associated; twinning, as you will know from reading my report, is a strong determinant, and that is one that we can look at more easily in numeric terms; obstetric practice, certainly, is a factor; the maternal age at conception is a factor; and there are others. I am probably not expert enough to set those out.

[269] **Jenny Rathbone:** It is good that your report reflects some of these issues around people having fertility treatment, having more multiple births, et cetera. The one solid problem that remains is the medical rotas, which you obviously highlight: Prince Charles Hospital in Merthyr does not have separated rotas, so it is trying to do paediatrics as well as neonatal care, and you highlight the fact that it is the level 2 doctors who are the front-line doctors making those decisions. I wondered if you could tell us a little more about how you are advising on resolving this problem.

[270] **Dr Drayton:** Across Wales as a whole, everywhere, tier 2 is a real problem. As you rightly say, these are the doctors who, in a former existence, were called registrars, who are the front-line, competent, on-site practitioners, and you will have seen from the report that we did from returns that there is a high level of non-compliance of establishment with the professional recommendations, which are reflected in the standards. Even on that sub-optimal establishment, recruitment is very poor. The snapshot that we took in July showed that 18% under-recruited. That is not going to improve, unfortunately, whatever we do, because we know that there are factors beyond our control that have reduced the pool of doctors, and will reduce the pool of doctors from which, in future, we can pull those types of people. Really, that is why solutions are likely to be deliverable only in relation to reconfiguring services, and that is one of the major drivers throughout Wales.

[271] My personal opinion is that reconfiguring services on their own will still not be the full solution in terms of producing a robust manpower plan, and that, in addition to that, we will need to look at increasing the use of resident consultant sessions beyond the normal daytime hours when consultants are in hospital. Already that is happening to a limited extent. I foresee the need to extend that. Of course, in the longer term, there will be the development of advanced neonatal nurse practitioners to take on some of the roles of tier 2 staff, but that is a long-term project; it is not a project that is going to deliver solutions for us immediately, I

am afraid.

[272] **Julie Morgan:** You say in your paper that there is a rise in the number of children born pre-term and needing a lot of care. What do you say about the overall birth rate?

[273] **Dr Drayton:** It is a bit different in north Wales and south Wales. In south Wales, as you will know, for nearly 10 years now, the birth rate has been rising by approximately 2% per year—it is just under 2%. For the last two to three years, that no longer appears to be the case; in south Wales, it appears to have flattened out and, indeed, it has fallen slightly.

[274] **Julie Morgan:** That is south Wales; how wide is that?

[275] **Dr Drayton:** That is everywhere except Betsi Cadwaladr health board area for the purposes of this analysis.

[276] **Julie Morgan:** I just wondered whether you had any separate information about Cardiff, for example.

[277] **Dr Drayton:** We do have separate information for Cardiff; I can give it to you later, I think.

[278] **Julie Morgan:** If you would, that would be good because we have had evidence that the birth rate in Cardiff was continuing to rise.

[279] **Dr Drayton:** Yes, I have that information, but I do not have it in my head.

[280] **Julie Morgan:** That is fine.

[281] **Lynne Neagle:** The capacity review said that four additional intensive care cots and three additional high-dependency cots are needed in south Wales immediately. What are you doing to ensure that that is addressed, and in what timescale?

[282] **Dr Drayton:** In my view, that is one of the most important problems facing us at the current time, and until we can get that right within the service, the service will continue to be problematic and mothers will still be sent to England for non-medical reasons—reasons that I would regard as not best practice—and babies will be cared for in England. On the way that we are addressing that, a decision was made recently to commission two new high-dependency cots in the Cwm Taf area—we have been discussing that with them in the last two or three weeks—and nursing staff appointments to support those new high-dependency cots will be made jointly between Cwm Taf and Cardiff and Vale. That will have the additional value of starting the rotation of staff that we have been trying to get going for some time; that will kick-start that and start bringing those two health boards into a closer working relationship.

[283] Implementing those high-dependency cots will allow us to get high-dependency babies who are currently occupying intensive care capacity out of Cardiff, to a place where they can be safely cared for—not necessarily the closest place to the parents' homes, unfortunately, but, pragmatically, there is a limitation on the space currently available in Cardiff to deliver that care. So, it will allow us to free up some intensive care capacity in Cardiff, to start addressing the shortfall.

[284] On the broader issues in south Wales, we have been discussing the need for more high-dependency care to be sited in Swansea. Clearly, with the new refurbishment of the unit, physical space will not be a major impediment there. I think that we still do not have a full understanding as to how the funding streams will work. Mr Phillips may wish to come in in a

moment and fill you in on that.

[285] We have also been in discussion with Hywel Dda board about increasing the amount of work it is doing at high-dependency level. I think that there is a limit to how much that will increase, but I think that there is something that can happen there. Also, I think that we understand that it may need to keep an extra high-dependency bed—it may not be able to occupy its beds up to 70% capacity, just because of the relatively small size of the unit. We are sympathetic to that and understand it, and we have an understanding with the board.

[286] That still leaves a shortfall of intensive care in the south-central region, and I think that that is a particularly challenging issue to address, because of the very constricted nature of the neonatal unit in Cardiff. Cardiff and Vale is working on plans to relocate the unit to larger premises. Its current plans are not particularly short-term, unfortunately, because they require a chain of moves elsewhere in the hospital to achieve that. So, the challenge remains.

11.15 a.m.

[287] We have been exploring with the other health boards either side of Cardiff whether they can take on some of that intensive care capacity in a more planned form than currently happens. It currently happens as an emergency any time of the day or night. That is something that we need to avoid. It is clear that Swansea would be in a position to take on some of that extra intensive care in the relatively near future. Newport could take on some of that care, but probably not for a couple of years because it is still working in a very constricted real estate.

[288] I am not clear how the revenue consequences of that with work. Mr Phillips may be able to help us with that.

[289] **Mr Phillips:** There are probably three stages to this. There has been a redesignation of cots between Swansea, Princess of Wales and Nevill Hall hospitals, which has helped to utilise the cots there and, therefore, been a big help. We have made an agreement with Cwm Taf health board to increase the number of cots that it runs permanently rather than on an ad hoc basis, which is a step forward. You will be probably be aware that Cardiff, as part of its plans for making improvements to the neonatal unit, has created additional capacity. It has not opened those beds yet because it wanted to be sure that it dealt with the cross-infection issues before it came up with a plan to recruit and to open those cots. However, we hope that Cardiff will make a decision on that shortly, because we hope that the issues around the control of infection will be clarified.

[290] As Mark said, we have had constructive discussions with a number of units about the capacity that they have. We have also had discussions where there has been a recognition that, as the network has matured, babies are flowing between units in slightly different ways. To help balance the risks, we must ensure that the funding follows that, and that if units take some of the sickest babies, they get the funding from the relevant health board. We must make the system a little simpler and make sure that the money follows. We have had constructive dialogue about that, and everybody agrees in principle, so we will be taking that forward shortly.

[291] So, there has been good progress on a number of levels in the last 12 months. There has been a particular shift in Cwm Taf. We are hopeful of progress in Cardiff and Vale shortly, and we can then ensure that the money follows. For example, if one of the units is able to staff more intensive care and that is needed, they will be remunerated for that.

[292] **Lynne Neagle:** In terms of the four intensive care cots and the three additional high-dependency cots, what has been already delivered are two high-dependency cots, which leaves a shortfall of one high-dependency cot and four intensive care cots. Will any intensive

care cots be made available by the redesignation that you referred to?

[293] I recognise that it is a very complex area and that you have various irons in the fire, but some indication of timescale would be helpful, given that the recommendation said that this should be immediate. It sounds as though there are many uncertainties in the system with these other four intensive cots and one high-dependency cot.

[294] **Mr Phillips:** Those are relatively recent recommendations, although they are urgent. It is important to remember that if you look at last year's recommendations, we have made good progress to date. There have been some really good meetings. I cannot give a timescale to the committee today, but I can assure you that people are working on this and are looking at the options and have laid out four steps. We will have timescales in a short while, but I cannot commit here today.

[295] **Christine Chapman:** It is just a comment, but there seems to be a bit of uncertainty; these are recommendations, but some health boards are not adhering to this while others are. Is that not a confusing message? It seems to me that not everybody is absolutely clear about what they should be aiming for, or when they should be aiming for it? Do you think there should be more clarity in the system for local health boards?

[296] **Dr Drayton:** The way in which we have worded the recommendations is fairly clear. Some of the recommendations require a total health community response because some individual health boards cannot deliver on their own. That is very much the role partly of the network and partly of WHSCC, under whose auspices we sit, namely to help the health boards come together to come up with a solution that sorts things out for the whole of the community. We have just had a question about the whole of south Wales. A problem in south central, or a problem in Cardiff, does not stay in Cardiff because Cardiff gets clogged up and then that problem is radiated because we end up with poor mothers living just outside the Heath hospital in Cardiff ending up going to Swansea, Taunton or Gloucester for delivery. That is what we are trying to avoid. The problem exports itself so that it becomes a total community problem.

[297] **Christine Chapman:** A few Members want to come in with questions. I am conscious of time because we need to finish by 11.30 a.m. Mr Phillips, did you want to say something before I bring Lynne back in?

[298] **Mr Phillips:** My response would be that it is a complicated problem and I cannot deny that the capacity review is a complicated document. The target audience was probably not you, but it has led to some pretty clear conversations with each of the health boards since it has been published, and I think what you will see from each of the health boards is much more tangible plans, having had that discussion. That is how the process works; we produce that and we then go around the health boards and talk to them, and we then get much more concrete plans around the recommendations and what they are going to do. I hope, therefore, that there will be a clearer plan shortly on how each health board is going forward against those recommendations, but I accept your point that, from where you are, it would look complex.

[299] **Lynne Neagle:** Do you feel that you have complete buy-in now from all the health boards in the south Wales area to tackle this? We have seen in the past people working in individual silos. Do you need anything further from Government to ensure that they come together to deliver on this?

[300] **Mr Phillips:** I think it is very clear that this is a ministerial priority. There is a lot of chief executive sign-up to this. They gave evidence to you before, and we are feeling the effect of that, as are the people we work with, and the maturity of the system and the way

people engage has improved. It is still difficult, but—

[301] **Dr Drayton:** From our most recent round of visits, every health board has accepted the evidence that we have presented to them from the BadgerNet data and other data sources. They understand it and understand the principles of what needs to be done. There are still some residual issues about making it happen and those are the issues that Daniel has just referred to. In terms of making it happen, I do not think that we are yet at the final step.

[302] **Aled Roberts:** I would like to move on to uncertainty and confusion in north Wales. Am I right that the 2013 capacity review will be based on 2011 data? Civil servants indicated to us that the 2012 BadgerNet data had not yet been fully analysed.

[303] **Dr Drayton:** That is not quite accurate. The capacity review that you have all received for the whole of Wales, including north Wales, is based on 2012 data. It is based on the first three-quarters of 2012, and the reasons for that are date-related or two-fold. One is that we wanted to give all the health boards time to tidy up their data before we started analysing them. We did not want to analyse on 1 January data that had been entered on 31 December. Also, some of the analysis related to the child health system and data does not get on to the child health system for up to two months after the end of the year. So, it is for the first three-quarters of 2012, and, where appropriate, we have extrapolated that to projected full-year figures.

[304] **Aled Roberts:** The data for north Wales do not include activity based in England.

[305] **Dr Drayton:** They do not include activity based in England, because we do not currently have access to those data. We are discussing with the Cheshire and Merseyside neonatal network whether we can get access to those data. Of course, one of the difficulties about data is that they belong to the health board or primary care trust that provides them.

[306] **Aled Roberts:** Given that the special care baby units in the north—in Glan Clwyd and in Wrexham—have not been open for significant periods due to staffing difficulties, have you undertaken any analysis of whether there has been increased activity in England over the last two years? Does your cot capacity review take into account not only the increased birth rate in north Wales, but the proposals as far as maternity services are concerned? By that I mean the proposals that Flintshire be repatriated to Wrexham and that north Powys, because of changes from Shrewsbury to Telford, will also be repatriated to Wrexham. So, there is going to be increased activity in Wrexham. Also, I do not understand from the paper why the activity levels on BadgerNet in north Wales, as far as intensive care and high dependency are concerned, are very low for the size of population. Betsi Cadwaladr LHB is basing its whole reconfiguration proposals on that low level of activity.

[307] **Dr Drayton:** The answer to the question about the activity that may be delivered for Welsh residents in England is the same one: I do not have access to those data at the present time. I would like access to those data, because, as you are right to say, it will help us to fill in a corner of the data that is missing. The data are the data for north Wales. It is the activity that has been delivered. I know that about 9% to 10% of Betsi Cadwaladr LHB residents deliver in England and so any neonatal activity in relation to that will clearly be provided in England. Most of that will be in the Countess of Chester Hospital, but not all.

[308] **Aled Roberts:** Its forward plans for neonatal services, even though its maternity services are transferring back, do not take account of that neonatal activity.

[309] **Dr Drayton:** I am sure that it makes its plans on the basis of the information that it has. In terms of the recommendations that I can give them, they have to be based on information that I can get access to. I have some of their own data, but I do not have access to

all those English data. I know that about between 9 and 10% of Betsi Cadwaladr LHB residents deliver in England. I can get that from the child health system. However, I cannot get the neonatal activity that occurs in the Countess of Chester, in Arrowe Park, in Crewe and in Liverpool. That is not currently available to me.

[310] **Aled Roberts:** Has it given you any explanation as to why the activity levels are, in your opinion, very low for high dependency and for intensive care?

[311] **Dr Drayton:** It has not. However, it has said that it is going back to look at its own data to make sure, for a start, that the data going onto BadgerNet are good. We have had some quality control audits, but it realised that it needed to go back and make sure that the data that have been collected are robust for planning purposes. I hope that it will help us to get access to those data about care going on in England, because it is something that we need to triangulate where we are going.

[312] **Aled Roberts:** The community health council has taken a decision on what appears to be a very incomplete picture.

[313] **Dr Drayton:** We have said what data we have and we have been explicit about what data we do not have. I suppose we only know what we know.

[314] **Christine Chapman:** That is quite clear. I am conscious of time. Simon wants to come in very quickly, and we have one question from Julie.

[315] **Julie Morgan:** Mine has been answered.

[316] **Simon Thomas:** I have two very quick questions. First, when we talk about south Wales, we are talking about Hywel Dda LHB as well in that area, are we not? I just want to be clear.

[317] **Dr Drayton:** Yes. Although the south Wales plan does not include Hywel Dda.

[318] **Simon Thomas:** But when you were talking about intensive care and high dependency, we are talking about Hywel Dda as well.

[319] **Dr Drayton:** Yes.

[320] **Simon Thomas:** Its reconfiguration proposals have a rather vague reference to intensive care in Glangwili and a level 3 unit being established there.

11.30 a.m.

[321] **Dr Drayton:** No, I do not think that that is its proposal at all. They cannot sustain ongoing intensive care in Hywel Dda. It has not done that historically, and given the size of the service, that could not happen. All units, though, have a responsibility for stabilising babies who are born there and who are unexpectedly sick, and that is integral to every neonatal unit at whatever level: they must have an ability to do good high-quality resuscitation and stabilisation until the baby can be retrieved to a suitable place for ongoing intensive care.

[322] **Simon Thomas:** I asked that because I wanted to be clear that you were not expecting a contribution from Hywel Dda, even in its reconfiguration proposals, towards the additional intensive care that is needed in south Wales.

[323] **Dr Drayton:** Not at all. That will be provided.

[324] **Simon Thomas:** That would be in Morriston or Singleton hospitals.

[325] **Dr Drayton:** That would be primarily provided in Swansea, on whichever site.

[326] **Simon Thomas:** There will be some knock-on effects then on the rest of south Wales, but that is another matter.

[327] **Dr Drayton:** Yes, but that is what is occurring at present, so that would be no change. Some of it will occur in Cardiff as Swansea is full on occasions, but most particularly for the specialised services that are available in Cardiff.

[328] **Simon Thomas:** Okay. Thank you. I just wanted to understand that.

[329] **Christine Chapman:** We have come to the end of this session. I thank Dr Drayton and Mr Daniel Phillips for attending. It has been a useful session. We will send you a transcript of the meeting for you to check for factual accuracy. Thank you very much for attending.

11.31 a.m.

Cynnig o dan Reol Sefydlog Rhif 17.42 i Benderfynu Gwahardd y Cyhoedd o’r Cyfarfod
Motion under Standing Order No. 17.42 to Resolve to Exclude the Public from the Meeting

[330] **Christine Chapman:** I move that

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order No. 17.42(vi).

[331] I see that the committee is in agreement.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 11.32 a.m.
The public part of the meeting ended at 11.32 a.m.