Y Pwyllgor Iechyd, Lles a Llywodraeth Leol
The Health, Wellbeing and Local Government Committee

Dydd Iau, 11 Mawrth 2010
Thursday, 11 March 2010

Cynnwys
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Cofnodir y trafodion hyn yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir cyfieithiad Saesneg o gyfraniadau yn y Gymraeg.
These proceedings are reported in the language in which they were spoken in the committee. In addition, an English translation of Welsh speeches is included.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Lorraine Barrett	Llafur Labour
Peter Black	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Andrew R.T. Davies	Ceidwadwyr Cymreig Welsh Conservatives
Ann Jones	Llafur Labour
Helen Mary Jones	Plaid Cymru The Party of Wales
David Lloyd	Plaid Cymru The Party of Wales
Val Lloyd	Llafur Labour
Darren Millar	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)

Eraill yn bresennol
Others in attendance

Claire Bateman-Jones	Prif Nyrs Gwasanaethau Newyddenedigol ac aelod o'r Coleg Nyrsio Brenhinol Royal College of Nursing Member and Neonatal Sister
Pam Boyd	Cymdeithas y Nyrsys Newyddenedigol Neonatal Nurses Association
Dr Mark Drayton	Grŵp Arbenigol ar Wasanaethau Newyddenedigol Expert Group on Neonatal Services
Helen Kirrane	Rheolwr Ymgyrchoedd a Pholisi, Bliss Campaigns and Policy Manager, Bliss
Dr James Moorcraft	Grŵp Arbenigol ar Wasanaethau Newyddenedigol Expert Group on Neonatal Services
Lisa Turnbull	Cynghorydd Polisi, Y Coleg Nyrsio Brenhinol Policy Adviser, Royal College of Nursing

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

Marc Wyn Jones	Clerc Clerk
Sarita Marshall	Dirprwy Glerc Deputy Clerk

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

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

Darren Millar: Good morning, everyone. Welcome to today's meeting of the Health, Wellbeing and Local Government Committee. I welcome the witness and any members of the public in the gallery.

Facilities are provided for simultaneous translation and sound amplification on the headsets. If anyone has any problem using these, please tell the ushers and they will help. Committee members and members of the public may wish to note that the simultaneous translation feed is available on channel 1, while channel 0 provides the language being spoken. I would be grateful if Members, members of the public and witnesses could ensure that all mobile phones, BlackBerrys and pagers are switched off so that they do not interfere with the broadcasting and other equipment. If there is an emergency, the ushers will guide people to the nearest appropriate exit. Finally, I remind the witness that the microphone is operated remotely so you do not have to press any buttons.

We have received apologies from Irene James this morning. I am not aware of any other apologies or substitutions, so I will invite Members to make any declarations of interest under Standing Order No. 31.6. I see that there are none.

9.16 a.m.

Ymchwiliad i Ofal Newyddenedigol: Tystiolaeth gan Bliss
Committee Inquiry into Neonatal Care: Evidence from Bliss

Darren Millar: This item commences our committee inquiry into neonatal care. We will be taking evidence from Bliss. We have had a paper from Bliss, and I am delighted to welcome Helen Kirrane, the campaigns and policy manager, to our meeting today. We have circulated your paper, Helen, to committee members, so, if you are content, we will go straight into questions on that paper. Thank you for everything that you have provided so far.

You make reference in your paper to the all-Wales neonatal standards and the fact that they incorporate some of the national service framework standards and that these have been worked up and were published in October 2008. What progress has been made in terms of the implementation? I think that you referred in your paper to some concerns about delays in the implementation.

Ms Kirrane: There has not actually been any measurement of those standards, but, anecdotally, we hear from health professionals across Wales and we hear all the time from parents in Wales about the issues. So, it is clear that those standards are not yet being implemented. We know that they are contingent on other aspects of policy coming forward, such as the neonatal network and transport service.

Darren Millar: Why are these standards not being implemented? Is there any reason that you are aware of? Is it a money situation? Is it simply that people have not got their eye on the ball? What is stopping them being implemented?

Ms Kirrane: Certainly, there are obstacles in terms of investment. There has been underinvestment in services in Wales for a long time, and there has not been any investment yet to make these happen. The investment announced in December 2008 was specifically for the network and transport service, which is in the process of being set up but has not yet been put in place. So, parents and babies are not yet able to use that service.

So, certainly, funding is one issue. Another is that there is no process to monitor against the standards in place. There is no framework to make that happen. There is no system to report to, to see whether progress has been made, so it is up to individual clinicians to tell us, and that is how we have got our evidence so far.

Darren Millar: You made a statement about the underfunding of the service in Wales. With what have you compared the situation in Wales in order to make that statement?

Ms Kirrane: That is certainly the feeling that has come across very strongly from clinicians. We can compare the services available in Wales with those in other places in the United Kingdom, and they just do not meet the same standards. A 24-hour transport service, for example, has been in place for a number of years in Scotland. There is 24-hour transport of newborn babies across England. By looking at the different elements of the service, it is clear that, in many respects, services in Wales do not match up to those in other parts of the UK.

9.20 a.m.

Val Lloyd: I have a point of clarification about what you said at the beginning. Is any transport set up? Is it the 12-hour service that was promised, or is that not set up?

Ms Kirrane: That is in the process of being set up. They are currently working up the job descriptions and starting to advertise for those posts, so it is not yet being delivered.

Val Lloyd: Is it the same thing with the neonatal network?

Ms Kirrane: It is the same.

Val Lloyd: Thank you.

Peter Black: I apologise for being slightly late. How satisfied are you that changes have had a real impact on special care babies and their families, and what arrangements would you like to see in place to monitor this?

Ms Kirrane: We are not satisfied that any changes have yet been realised for special care babies and their families. We understand that there are mechanisms to monitor against the progress of other standards, such as the national service framework. That is something that could be looked at to monitor the all-Wales neonatal standards. We would certainly support something along those lines.

Darren Millar: We have covered some territory on funding, Ann.

Ann Jones: Thank you; again, I am sorry that I was late, Chair. There must have been traffic problems this morning.

The all-Wales neonatal standards acknowledge that neonatal units in Wales were grossly under-resourced and, therefore, inefficient. How confident are you that standards can be delivered within current levels of funding?

Ms Kirrane: We are not confident that they can be delivered. There needs to be significant funding in staffing.

Ann Jones: To what extent was the £10.4 million estimated by Health Commission Wales in 2005 a more realistic figure in realising the vision set out in the standard? Does it go far enough?

Ms Kirrane: Yes, I think that it is likely to be more realistic. However, that is five years out of date and it needs to be updated. The Welsh Assembly Government needs to look at services now to see what the current staffing levels are, what the current activity levels are, what the current issues are, and come up with up-to-date figures for that. Certainly, it is clear that the £2 million that was announced in December 2008 will only cover a very small element of the service, namely the setting up of a network and a 12-hour transport service. So, that does not cover staffing levels in the units, it does not cover the other 12 hours, during which babies and mothers will be being transferred during the night, and it does not cover the support and facilities that families need in order to be with their babies and to care for them.

Darren Millar: Are there increased pressures on services? Is the rising birth rate, for example, causing increased pressures?

Ms Kirrane: That is right. The 2005 estimation of around £10 million was at a time when there was a falling birth rate. There have since been significant increases in the birth rate for a number of years, so it is possible that that is an underestimation of current birth rates.

Helen Mary Jones: We are talking about staffing issues, following on a bit from what you have just said. In your evidence, you state that neonatal units in Wales are frequently closed to new admissions. You also describe the experiences of two mothers whose premature babies were transferred very long distances from home. To what extent are these actions putting special care babies at risk?

Ms Kirrane: There are risks associated with transferring babies. We accept that transfers are part of neonatal services if they are to make sure that the mother or baby receives the best level of care that they need. We understand that, if the baby needs intensive care, it needs to be transferred to a unit that can provide that care, but too often, there are unnecessary transfers caused by closer units that are appropriate to their care being closed due to understaffing.

Helen Mary Jones: You highlight in your written evidence that there is a shortage of trained neonatal nurses and doctors in Wales. How critical is that staff shortage and what steps do you feel need to be taken, both in the short term and the long term, to address these problems?

Ms Kirrane: In 2008 we did a survey of neonatal units in Wales, which found that 382 neonatal nurses were working across Wales. Using the staffing standard set out by the British Association of Perinatal Medicine, there needs to be 500 nurses. There is a shortfall of 120, according to those figures, across the 13 units in Wales, so it is a significant level of understaffing.

Helen Mary Jones: Did that piece of work tell you anything about the doctors?

Ms Kirrane: No, we did not ask questions about that, but we have heard from clinicians across Wales that there are particular issues with the implementation of the European working time directive, with changes to regulations around visas for medics from outside Europe, and obviously with the increasing pressure on staff due to increasing birth rates.

Helen Mary Jones: Bringing you back again to Health Commission Wales and the work that it did in 2005, it highlighted in its review that the medical and legal implications of delivering a service that does not meet the British Association of Perinatal Medicine standards on staffing levels in the units—so it highlighted the issue that you have just raised— would mean a drop of 25 per cent in capacity, if we were to try to implement those standards in full, which, of course, should be done. Would that fit with the way that you see it?

Ms Kirrane: I am sorry, I am not following you.

Helen Mary Jones: I am not making myself very clear. I think that it was saying that, if we were to drive the staffing levels up to the standards that the British Association of Perinatal Medicine thinks should be there, with the staff that were there in 2005—from what you are saying, it does not look as if it has moved on very much—that that would mean that we would actually have 25 per cent fewer beds. Does that ring true with you?

Ms Kirrane: I am sorry, I am still not really with you on that question.

Helen Mary Jones: If you do not have enough doctors and nurses to staff the beds that you have, there is one of two things that you can do: one is to increase the number of doctors and nurses; the other is to reduce the level of service, or the number of beds available. So, HCW was saying that, with that current level of staffing, to bring the service fully in line with the British association's standards without raising staffing levels might mean a drop of 25 per cent in the provision. Does that make more sense?

Ms Kirrane: I follow you now.

Helen Mary Jones: Does that ring true with you?

Ms Kirrane: Yes.

Helen Mary Jones: I know that it probably can only be an estimate. Would you say that that is still as likely to be true now as it was in 2005?

Ms Kirrane: I would say so, yes.

Helen Mary Jones: Thank you.

Andrew R.T. Davies: Obviously, you have identified a shortage in the number of nurses, and we have a number that would be desirable. We are about 120 nurses short. Are you confident that, if the will was there, the 120 could be made up? Val and I sit on the Petitions Committee and we have dealt with petitions on new visa controls, for example, which have created problems with recruiting staff in other sectors of the NHS. Given your understanding, is it just a lack of resource that is not allowing the nurses to be recruited? If the monetary resource was put in for training and for positions to be opened up, would there be an issue about filling the 120 vacancies that you have identified in your research?

Ms Kirrane: I do not think that those 120 posts could be filled overnight.

Andrew R.T. Davies: No, I appreciate that. There is a difference between having the will and putting the resource in. If the pool of talent is not there, you cannot fill the posts overnight or in a period of time, can you? The issue with junior doctors is that new visa controls have come in, so it is really hard to find the staff even if you put the money and the resource in.

Ms Kirrane: Yes.

Andrew R.T. Davies: So, what I am trying to get at is this: if there was the will to fill these posts, and the resource was there, could they be filled? Or is it the case that the talent is not there to fill these positions and even if you put the resource in and you gave the direction you would not be able to fill them anyway?

9.30 a.m.

Ms Kirrane: It is the latter. The workforce is not in place. There are challenges with developing that workforce, so there needs to be a long-term strategy to train more junior nurses, to recruit more nurses and to retain the nurses that work in neonatal care in Wales. So, it is a long-term aim.

Andrew R.T. Davies: Workforce modelling?

Ms Kirrane: Yes.

Andrew R.T. Davies: If that workforce modelling were in place, would it be possible to fill these vacancies?

Ms Kirrane: It is going to be a challenge to fill every post. We do not underestimate that challenge, but a plan needs to be in place to be able to make steps towards meeting it. However, there is no plan at the moment.

Peter Black: Following on from that, I note from the Royal College of Nursing's evidence that nurses have not been released from their NHS work to be trained in the specialism, which is one of the issues. Last month the Minister announced workforce planning targets for nurse recruitment, in which she has increased the number of recruitments of mental health nurses, but did not accept the case for the recruitment of any other nurses. Is that going to have an impact on the availability of nurses who might move into the specialism, and do those workforce planning targets need to be revisited?

Ms Kirrane: Yes, absolutely. The targets need to be across the board. We cannot just focus on one aspect of care. There needs to be workforce planning across all services, especially neonatal services because it is clear that there is a gross underresourcing of nursing staff.

David Lloyd: Following on from the last questions, I will not dwell in passing on my time as a callow youth when I was a paediatric senior house officer in a special care baby unit, as they were called then, in Bridgend. One of the issues is the European working time directive. Back in those times, I was contracted to work 84 hours a week and holiday cover put it up to 120 hours a week. The European working time directive obviously means that we are halving that.

Andrew R.T. Davies: Look how much better you are on it, Dai.

David Lloyd: Yes, but it also means that we must double the number of doctors, and we are nowhere near that. That is the issue as regards the European working time directive, before we mention anything about nursing numbers as well, which also follows the same sort of timescale.

You make a very valid point on services in north Wales and the absence of consultant neonatologists, but there are also other reasons for this inquiry, as you state in your paper, to pay particular attention to neonatal services in north Wales. Do you want to elaborate on those concerns?

Ms Kirrane: The point that I want to get across is that there are unique issues that the service in north Wales faces and there needs to be unique solutions. Additional support is needed, perhaps, to overcome some of the rurality and population issues. So, because the population is not as dense, there really needs to be that excellent transfer service to take babies and mothers to where they need to go to get the care that they need.

Darren Millar: You also mention in your paper a delay in the implementation of some issues that were agreed in relation to the location of the service in north Wales. Do you want to tell us a little bit more about that?

Ms Kirrane: I think that it is just creating further delays. We are keen that a solution is found and a decision is made as soon as possible because it is hindering the development of services. There needs to be a focus to make sure that that happens as soon as possible.

Darren Millar: Do you know what the delay has been in terms of the location of that primary neonatal unit?

Ms Kirrane: I am not quite sure about the reasons. I am sure that clinicians and service planners from north Wales would be able to give you a better picture, but I imagine that there are issues in relation to the maternity services and looking at whether the maternity services are up to standard in the north before decisions on how neonatal services will be configured can be agreed.

Val Lloyd: I will ask two or three questions together because they are all on the same issue. I would like to focus on the neonatal network and the transfer services. You told us earlier that they are not up and running yet. Do you have a date for when they will be operational? What are the challenges in the provision of these services? Why is it taking so long?

Ms Kirrane: I do not have a date for when they will be operational. I would like to ask the same questions myself. Bliss is a stakeholder on a group that has put together plans for that service, so I know that that group has been busy putting together job descriptions and trying to fill the posts that need to be recruited. I agree that it has been a very long time coming. The money was announced in late 2008. Here we are in March 2010 and that service is still not in place. There needs to be some urgency to get that service up and running.

Val Lloyd: I am sure that, if it was announced in 2008, it would have been for the operational year 2009-2010, so it is taking what seems to be a long time. I was trying to find out whether you know the reason for that.

Darren Millar: Helen Mary, do you want to come in on that issue?

Helen Mary Jones: This might not be a question for you, Helen, but you talk about the stakeholder group. Who is taking the lead on recruitment? Is it someone from one of the local health boards? If you do not know, do not worry because that is a question that we can ask the Minister.

Ms Kirrane: I am not 100 per cent sure about that.

Helen Mary Jones: So, you are on the stakeholder group but it is not clear whose job it is to deliver the plans that the stakeholder group is developing. Sorry, let me put that on the record as a comment rather than putting you in a difficult position by asking you to answer it.

Ms Kirrane: I am sure that that has been made clear. I am sure the other members of that group know. I am afraid that I do not know off the top of my head. I think that it is an issue for the different boards. There are some issues still being crunched out in relation to who is leading.

Helen Mary Jones: I would not be surprised if people do not know. There are many stakeholder groups where it is not exactly clear. It is one of the things that I would probably ban, Chair—partnerships and stakeholder groups—because no-one is responsible.

Andrew R.T. Davies: This is just for my own clarity because I think that it is critical to understand if there is a backstop to this. We are holding an extensive inquiry into wheelchair services and the stakeholder group has attended. One of the weaknesses in the uplift of wheelchair services, certainly in stage 1, was that no-one knew what the stakeholder group was doing. The Minister noted that and said that there was drift. Do you believe that there is drift in the stakeholder group? That is no criticism of the people who sit on the stakeholder group, but more of administration and the actual implementation of what the stakeholder group is trying to do. Obviously, if you have no backdate as to when these reforms and these improvements should have been made, it is very difficult for people to have confidence in the stakeholder group's direction of travel.

Ms Kirrane: I do not think that the delays have been caused by stakeholders that are on that group, but rather by Ministers in agreeing to decisions. A business plan was drawn up and was with the Minister for a long time before it was agreed. So, I do not think that the delays are the fault of the stakeholder group; the delays are in getting the proposals that it is coming up with approved.

Andrew R.T. Davies: So, would your understanding be that the fault lies with the executive, rather than the group?

Ms Kirrane: That is my understanding.

Val Lloyd: I will now concentrate on the transfer service. When it is set up, it is anticipated that it will be running from 9.00 a.m. to 9.00 p.m. Obviously, neonatal babies need to be transferred outside that time if their condition is deteriorating or if the birth happens outside those times. Would there still be ad hoc arrangements and are there any risks associated with that?

Ms Kirrane: Of course, babies are born in the middle of the night—there are as many born in the middle of the night as there are in the day. It is completely unpredictable and cannot be managed and planned for. Those sorts of ad hoc local arrangements will continue and it will require nurses and doctors who work on the units to be taken off the units to travel with the babies and mothers. That obviously causes the units to be underresourced and means that the babies on those units are not necessarily getting the level of care that they need.

9.40 a.m.

If more babies are transferred to that unit, it will obviously come under increased pressure. It may have to close to new admissions and babies that would be transferred to that unit will, therefore, need to be transferred to another unit. So, taking nurses and doctors off the units is not good enough and it does compromise the service.

Val Lloyd: There is not much point in me asking about increasing the service when we do not have the service at the moment and we do not seem to have a date for that, so I think that I will leave my questioning there, Chair.

Ms Kirrane: I would like to add a point there. We need to see the 12-hour service in place and working. However, there does need to be a long-term plan to set out how it is going to be rolled out to a 24-hour service. This links in with what I was saying before about workforce planning, because it is mainly a workforce issue as well as a resourcing issue. The staff are not necessarily there to provide a 24-hour service, so there need to be plans in place to figure out where those staff are going to come from, how they are going to be trained, and how that training is going to be funded. Also, if those staff are taken off the units to do training those posts need to be back-filled. Resources need to be available for other nurses to come in and provide the service when those nurses are doing their training.

Val Lloyd: So, it is quite a deep problem, then.

Darren Millar: Do you have a view on whether the NHS reorganisation has had an impact? Is that one of the reasons that there may have been a delay in terms of the implementation of some of these issues? There has been a lot of focus, of course, on trying to get the new administrative arrangements sorted with the new health boards. Is that one of the reasons why this perhaps has shifted to the backburner?

Ms Kirrane: I think that having clarity as to who is responsible for what will help, and, as soon as it can be made clear, in terms of Health Commission Wales, it will also help to know exactly what the arrangements are there. It goes back to the issue of under-resourcing. Until those services receive adequate funding and resources, they are not going to be able to start to improve them.

Lorraine Barrett: Fifteen months ago the all-Wales neonatal standards were published, which set out that care should be provided in a co-ordinated network, but the neonatal network is not yet up and running. Do you have some concerns about that delay? Do you envisage any knock-on effects for the delivery of other standards if that one is not set up?

Ms Kirrane: That is right. The standards document does say that it is for the network to be monitoring progress. Obviously, there is not a network so it cannot monitor it, but that goes back to what I was saying about there not being a process in place to monitor against those standards. As soon as the network is able to come into place, that will be really welcome and will help co-ordinate care throughout Wales. So, we would like to see it in place as soon as possible.

Lorraine Barrett: This is probably a question for the Minister or her officials, but, for the record, can you describe how a network works? Who heads up the network? I cannot quite picture this co-ordinated network. Someone has to be co-ordinating it.

Ms Kirrane: That is right. It will be recruiting for a network manager, who will be responsible for a wide range of issues, including what service can be delivered within the resources that are available, procuring those services, and making sure that they are working as they should be.

Lorraine Barrett: So, would the network provide us with an overall picture of the situation in Wales, then? With respect, I know that you are part of the stakeholder group, but a lot of the information that we are getting is, 'I am told this and I am told that', and, until the network is set up, there is no overarching view to give us that full picture of exactly what is going on and where the difficulties are concentrated.

Ms Kirrane: I think that the network will help with that, but I go back to what I said about processes being in place to monitor the standards and to audit the standards.

Ann Jones: We are talking about this network being across Wales, but I take it that that does not preclude it from looking across the border. So, where you have mums and babies living on the border, and there is a specialist baby unit across the border in England, would that work just as well? Surely it will have to look across the border, will it not?

Ms Kirrane: That is right. I think that where units are full—

Ann Jones: Well, not even where units are full. If someone is living on the border in Wales and there is a specialist baby unit in Shrewsbury that is nearer than the Welsh baby unit, if we want to call it that, which is 20 miles away, say, surely we have to look at cross-border provision. The border has to be porous, does it not?

Ms Kirrane: I agree. The experience of those families is really important. If it happens to be that an English unit is closer to home and can deliver the care that the baby needs, then that is probably a better outcome than transferring the family miles and hours across Wales.

Ann Jones: The issue that I am trying to tease out is whether the network realises that it will also have to operate across the border.

Ms Kirrane: I think that the network will continue to cover that. For example, there is no surgical provision for neonates in Wales, so there will continue to be transfers to Bristol and Liverpool for surgery.

Andrew R.T. Davies: Thank you very much for your evidence here today and also your paper. It is very informative and has given, certainly from my perspective, a great insight into not only the work that you are doing but the situation on the ground. One aspect of the paper touched on the support offered to parents, which was in some instances non-existent and in others inadequate. What would your viewpoint be on the level of support that needs to be provided to parents—especially parents who have one or two other children as well—in a family-friendly way so that the family can continue, as it were?

Ms Kirrane: That is really important to us. Obviously, having a baby admitted to neonatal care is an extremely traumatic experience for families. It is very worrying and very stressful. Families do need support. They need excellent communication from nurses and doctors about the care that their baby is receiving. They need to be really involved in the decision making and properly informed about the choices that they are making with regard to their baby's care, and that takes time for the nurses and doctors. They need to take the time to do that, and with the staffing issues that we have already heard about, that can be difficult at times.

Andrew R.T. Davies: No-one here would disagree with that viewpoint or the desire to implement that. Is this about basic communication, which is critical to parents' understanding of the situation they and their little one find themselves in? Is communication one of the services that is under particular pressure at the moment and, perhaps, in many instances, is not addressed at all? Is communication so poor that parents feel as if they are left out of the loop? Is that quite a common occurrence?

Ms Kirrane: I would not say that that is the most prominent issue. Generally, parents tell us that they are incredibly grateful for the care that their baby receives from the nurses and doctors in units in Wales. That is their No. 1 message: the care that their baby received was great. However, when it comes to how they were involved in the care, whether they were able to spend time caring for the baby, and whether the nurse was too busy to involve them in the care, we often hear from parents that they are not involved as much as they should be. Probably one of the top issues for families is the provision of accommodation in or near units.

9.50 a.m.

If the baby is in a unit far away from home, it is difficult to be there for the baby, to bond with it, and to get involved in caring for it. So, providing accommodation and other facilities and services for families in or near the units is really the key, including breastfeeding areas—and, on that point, support to breastfeed is needed. The experience of some families is that they are allowed to breastfeed but they are not supported or necessarily encouraged to express milk or to be involved in giving that milk to the baby.

Darren Millar: Can you tell us a little more about the accommodation that is provided? What accommodation is available for parents when their babies are in neonatal units in Wales, for example? We cannot deal with issues on the other side of the border, necessarily, but what sort of accommodation is provided in Wales to support parents?

Ms Kirrane: Our survey in 2008 found that most units that responded to that question had some accommodation, usually around one or two rooms. So, only one or two mums at a time could take advantage of that. We also asked whether there was enough accommodation for both parents, because it is really important for the dad to be with the baby, too, and we found that provision for both parents was a lot worse. It is really important for this accommodation to be provided. If parents are on the unit with their babies for longer, and are confident about providing that care, it can help with their earlier discharge from hospital. If parents are supported and know how to provide that care, there is really good evidence that the baby will go home a few days sooner, which is to everyone's benefit.

Darren Millar: On funding, I know that in Ysbyty Glan Clwyd, for example, the accommodation is supported by a charitable organisation, which has done very well in supporting the provision of some accommodation on the hospital site. Is that the usual arrangement in other hospitals as well?

Ms Kirrane: It is very ad hoc. Sometimes, a voluntary organisation provides the care, but I do not think that we can rely on the voluntary sector all the time. There needs to be provision, especially when it will help with babies' care.

Darren Millar: That is a very good point. Perhaps we need to take further evidence on the support provided through accommodation, the cost of that accommodation, and how it is paid for on a sustainable basis. Thank you for that.

I have one final question. Do you agree with the view that any changes to neonatal services should be done in the context of maternity and obstetric services, or do you think that these things are too important to be left until reviews have been undertaken in those services and so we need to get on with implementing what is already on the table?

Ms Kirrane: Neonatal services cannot be treated in isolation from maternity and paediatric services, but there are critical shortages and they need to be addressed straight away. If there is to be interim provision, that really needs to happen, even if some of the longer-term decisions are left until reconfiguration and until there have been reviews of maternity and paediatric services. We cannot delay in providing that vital resource to the units, even in the short term.

Darren Millar: Okay, thank you. That brings us to the end of our questions. Are there any closing remarks that you wanted to make, Helen?

Ms Kirrane: I really welcome this inquiry and the focus that it is placing on neonatal care in Wales. It is fantastic. If there is any further evidence that you want from us, or any further questions that you want to ask, please get in touch.

Darren Millar: Thank you very much for your evidence this morning, and thank you for the paper that you have provided. It has been extremely interesting to hear what you have had to say. You will be able to look at the transcript to make sure that it is accurate before the final version is published. If Members have no further questions, we will move on to item 3 on our agenda.

9.55 a.m.

Ymchwiliad i Ofal Newyddenedigol: tystiolaeth gan y Grŵp Arbenigol ar Wasanaethau Newyddenedigol
Committee Inquiry into Neonatal Care: Evidence from the Expert Group on Neonatal Services

Darren Millar: I am now delighted to welcome two members of the expert group on neonatal services to our evidence session, Dr James Moorcraft and Dr Mark Drayton. Welcome, gentlemen. Thank you for the paper, which has been circulated to Members. If you are content, we will go straight into some questions on that paper as part of our evidence session.

We have just heard from Bliss that the all-Wales neonatal standards and the children's national service framework have been developed with some quality benchmarks for the services here in Wales to try to meet. It appears that there is some delay in implementing those standards. What progress has been made towards them so far, and why is there a delay in putting them in place?

Dr Drayton: I share that frustration. The main problem with the implementation is that there is not really a mechanism yet for doing so on an all-Wales basis. The mechanism that we envisage implementing that is the formal development of a network. At the current time we have an informal network. We get together, we talk with each other, but we have no power and no executive authority, so things just drift, really.

Darren Millar: So, there is no formal network. What is this informal network that you refer to?

Dr Drayton: We meet together regularly, essentially as a sub-committee of the Welsh Paediatric Society. We have an input to the standards that you have all seen and that we subscribe to, but it is a talking shop. It does not in itself achieve change on the ground. Change on the ground requires resourcing, distributing the resources, monitoring the standards, and then action plans to deliver on the standards where we have some way to go. For most units, some of the standards are being delivered, I think, but a number are not.

Darren Millar: Ann Jones will just follow up on this.

Ann Jones: My question relates to the fact that it is 15 months since the standards were published for a network, and we accept your frustration with that. Then, you went on to talk about the informal network. If an informal network has been set up, why is it taking 15 months to bring the formal network into being? I heard what you said then, but surely if that informal network is there, it will be so much easier to put the formal network behind it. Why has it taken 15 months?

Dr Drayton: If we had had the formal network, we would have been able to move forward much more rapidly, but we are not empowered to do that. I understand that the advertisements for the posts that will lead the network, the clinical lead and the manager on the ground, will be recruited imminently, and that will be the first step towards making this thing work.

Ann Jones: Will it follow the form of the informal network that you have now? Surely we are not going to reinvent the wheel, are we?

Dr Drayton: No, it will have some authority. The informal network has no authority.

Darren Millar: Is it ministerial prerogative to establish this?

Dr Drayton: Yes.

Darren Millar: So, effectively, are you waiting for the Minister to say, 'Right, get on with it and establish it'?

Dr Drayton: Yes. My understanding is that there will be a letter on her desk this week or next from Health Commission Wales, if it is not there already.

Helen Mary Jones: I have a quick supplementary question on that. Does the responsibility for making these appointments rest with Health Commission Wales?

Dr Drayton: Yes, with the Assembly Government.

Helen Mary Jones: Via Health Commission Wales.

Dr Drayton: I think so, yes.

David Lloyd: Just to flesh out this business about the all-Wales neonatal standards and the children's NSF, documents and strategies exist at a certain level, and we can have the debate about what is happening or not, but at the clinical coalface things are happening and developing, and you are aware of those standards.

10.00 a.m.

So, would you say that changes are happening and that improvements are being made? What sort of impact are those changes having on special care babies and their families? How would you like to see the situation monitored so that any changes that are happening are quantified as being down to the new standards?

Dr Drayton: I think that there are a lot of positive changes. Clearly, we keep up with medical developments and we adapt our processes, and our survival rates steadily improve. We have evidence of that. At the same time, some things change in directions that we would not like them to go. We have major issues in terms of manpower. Previously, those have been in nursing manpower, primarily, but in the last 18 months to 2 years medical manpower has become a very severe limiting factor. James may well wish to talk about the impact that that has had on his own hospital, the Royal Glamorgan, and the negative impact that that has had on our ability to deliver services.

Dr Moorcraft: Yes, I would like the chance to illustrate the difficulties that we have been under. The Royal Glamorgan Hospital was an intensive care provider and the original review decided that there would be three centres in south Wales. So, there was always a plan for the Royal Glamorgan to downgrade to level 2. However, this was never a planned and co-ordinated change, because the difficulties with medical staffing overtook the planning process, if you like. So, we were left with no option but to reduce the level of service at Royal Glamorgan because we were unable to fill essential medical staffing rotas, as a result of the national shortage.

This difficulty meant that we had no reprovision of cots and capacity anywhere in the south Wales set-up for those babies. The intention, obviously, had been for a co-ordinated and phased changeover, but we were unable to achieve this. This has left us with a very serious problem at the Royal Glamorgan Hospital. Historically, the hospital provided the intensive care service not only for the local population—Taff Ely and Rhondda—but also was a net importer of high-risk obstetric cases and neonatal work from the other south Wales units that lacked capacity. So, there was never enough capacity in the system.

The moment that the Royal Glamorgan Hospital was unable to continue to provide this service, there was always likely to be a very serious effect on the whole of the service across south Wales. This is what we have seen following this occurrence.

Darren Millar: You referred to level 2. We are not clinicians, obviously, so we are not sure what levels 1, 2, 3 or 4 might be. Can you just explain what the difference is between the level that you were previously at and the level 2 service that is available now?

Dr Moorcraft: I beg your pardon. It might be better to describe it in terms of an intensive care unit, a high dependency care unit and, if you like, a local neonatal unit. The Royal Glamorgan used to provide intensive care neonatal services, which supports high risk obstetric work. The moment that we were unable to provide that because of the lack of doctors we had to go to the high dependency level of service instead. The standards for staffing a high dependency service are lower, in terms of medical staffing.

Darren Millar: So, were you forced into that because of staffing? Was it not something that you planned to jump the gun on before the reconfiguration of the services elsewhere in south Wales?

Dr Moorcraft: That is correct.

Darren Millar: Okay. We will move on to the staffing in more detail.

Peter Black: Obviously, you have just illustrated one instance of where staff shortages have forced the service to change. How critical are those staff shortages across Wales? What steps should be taken in both the short term and long term to address the problem?

Dr Drayton: The staff problems, as I mentioned a moment ago, are both medical and nursing. If we go back to the standards that we have had in Wales since 2008 based on the BAPN standards, no unit in Wales meets those standards in terms of nursing provision in relationship to the cots that are on the ground. That has enormous impacts on how well we are able to develop and deliver our services. I know that you asked the previous person sitting in this chair about communication with families and parents, and we all value that very highly, but, clearly, when your nurse staffing is perhaps 50 or 30 per cent below the standards, the priorities are to deal with the medical problems that are in front of you. Inevitably, from time to time, communication is not as good as you would like. So, those are some of the issues on the nursing side.

There are very complex issues on the medical side, because there are very many things that have changed in the last two to three years, particularly surrounding modernising medical careers, training for junior doctors, and Home Office and immigration rules that have led to our previous source of junior doctors and trainees pretty well drying up. That is one reason, for instance, why in Cardiff we currently have four of our critical care cots closed. Just down the road from the Royal Glamorgan Hospital, where James is struggling with the same problem and has had to downgrade his unit from level 3 to level 2, we are providing the level 3 services but we have had to close four of the 14 critical care cots, exacerbating the mismatch between capacity and demand.

This is leading, of course, to excessive inappropriate transfers of mothers and babies around Wales. We try to avoid sending mothers and babies out of Wales, as far as possible, but we do not achieve that all the time; mothers are going to Bristol, Birmingham and London because we can no longer deal with them here.

Ann Jones: I want to pick up on the cross-border issue. If you have a family on the border close to a special baby unit in England, are you telling me that you will try to locate that family in a Welsh unit? Or will you always take the nearest appropriate unit?

Dr Drayton: Yes, absolutely. It applies, I suppose, to a relatively small proportion of the total population.

Ann Jones: I do not know; the border is quite long, is it not?

Dr Drayton: It is quite long, but a lot of it has quite low population density, fortunately.

Ann Jones: Yes, that is true.

Dr Drayton: No, I take the point entirely. We are pragmatic and, of course, that works in both directions. We receive significant numbers of babies from England, and that is our duty as well, particularly from the Gloucester and Cheltenham area.

Peter Black: This may be a slightly unfair question, but to what extent are staff shortages putting special care babies at risk?

Dr Drayton: It is difficult to measure that risk, but anybody with common sense can understand that, if you cannot put the doctors and nurses on the ground in the number that is needed, you are going to stretch the resource and there will be risk. It is partly about managing that risk down to levels that we do not feel are acceptable, but that we can live with for a while. We have had to close, temporarily, those four cots, despite the impact that that is having on the public and on our mothers and babies.

Dr Moorcraft: I think that it is a fair question and an important one. I feel that the levels of risk are unacceptable as a result of the medical staff shortage. The downgrading that I alluded to earlier has not removed the risk, because there is nowhere for these babies to be transferred to and there is no transport mechanism to move them, so they have been left at times at the Royal Glamorgan Hospital. I know that we are not unique in this, but I can share with you my professional experience. The babies have been left with an inappropriate level of medical staffing, because there is nowhere to transfer them out to.

David Lloyd: Just on that point, obviously you have both outlined different solutions, if you like, and I can see where you are both coming from as regards medical and nursing staff shortages. In the Royal Glamorgan, we seem to have gone from an intensive care unit to a high dependency unit, whereas in the Heath we have stuck with an intensive care unit and closed beds. I can see from both points of view how that has come about.

10.10 a.m.

I think that it is a bit of a blow, really, for the Royal Glamorgan to lose its paediatric intensive care status, particularly when, say, ambulance staff would naturally still think it is an intensive care unit for paediatrics. What discussions were held and how have you come to two different conclusions, as it were? Ideally, I think that we need paediatric intensive care units in as many places as possible, rather than to just arbitrarily downgrade. I come from Swansea, where we have a particular sensitivity about intensive care beds, or rather the lack of them, which is one of the reasons why paediatric neurosurgery ended up in Cardiff.

Dr Drayton: I think that there are two separate issues there. One relates to the centralisation or concentration of critical care services on a relatively small number of units. I think that that is absolutely essential in order to make best use of what is a very limited resource, and I think that we are all realists and realise that the economic climate is not going to give us all the money and all the resource we want. Even if we had all the resource we want, we may not be able to find the staff on the ground to recruit.

The only way to use that resource effectively is to apply a degree of concentration of the services, to have good transport services to allow those babies to get to those centres, to have the capacity in those centres to deliver the care, and then, equally, to focus very strongly on getting babies back to their local units to recover when the critical episode has passed.

You put your finger quite rightly on the problem in that there is not at this moment in time any overarching mechanism that manages that process. These things are happening to us, and we both, from different perspectives, feel frustrated that we have no control over those processes and that there has been no planning in the processes. They have happened to us and we just have to react to manage the clinical risk as best we can. What we need is a planning process, and we see the development of a formal network as being key to that.

Developing that on its own is not going to suddenly make the world wonderful and deliver all the solutions because there is, underlying all of this, a big resource issue. May I just draw your attention to the Health Commission Wales report on the review into neonatal services commissioned right at the beginning of this decade and which ran for about two years from 2001 to 2003, I believe? The paper then sat on desks for a long time and I think that it was eventually finalised in 2005 but never published. That review at that time, relating back to the study in 2001-03, identified revenue under-resourcing of approaching £10 million. I think that the reason it was never published and never went anywhere was fear in relation to the size of that number.

What has happened since is that the birth rate in Wales has increased. Up until that point in time it had been decreasing for a few years. It has been increasing by more than 3 per cent a year since 2002, which is a total increase, since that report, of about 20 per cent, and there has been no significant input of extra resource. There are little bits of dribble here and there, and always a little dribble in response to acute pressures, but no overall planning goes on.

Helen Mary Jones: I just want to ask a very simple factual question. Dr Drayton, the four cots that have closed are four out of how many?

Dr Drayton: They are four out of 14 critical care cots. We have other low-dependency cots as well.

Helen Mary Jones: That is quite a high percentage.

Dr Drayton: It is quite a high percentage.

Helen Mary Jones: It is a third of them, more or less.

Dr Drayton: Of those, two are normally high-dependency cots and two are normally intensive care. It makes a big difference.

Peter Black: That Health Commission Wales review identified that one of the consequences of understaffing would be a 25 per cent drop in capacity in terms of neonatal units. Has that actually happened? We have heard already what is happening in the Royal Glamorgan. Has it happened across Wales?

Dr Drayton: I think that it has happened in many units. It is somewhat difficult to identify what happens on the ground. These things occur by drift and it is quite difficult sometimes to define in a unit, 'Do you have a high-dependency bed? How many high-dependency beds do you have?' because how many you have depends on how many nurses you have at that moment in time. The pressure on budgets is forcing units all round the place to put nursing posts and sometimes medical posts on hold, but primarily nursing posts are frozen, sometimes in the short term, and sometimes the short term becomes the long term. So, it is very difficult to get to the nub of what there is on the ground. One person's high-dependency cot may be different to someone else's high-dependency cot; the staffing levels may be different. It is undefined.

Dr Moorcraft: One of the core functions of the new network will be to designate not only which unit is working at which level, but also which cot is allocated which status, and that will allow the correct resource allocation for staffing so that we know exactly where we are. At the moment, we have this uncertainty about exactly who is calling which cot which, and many units, because of the lack of staff, have had to be flexible about how they use the cots because there is no transport system to move the patients. So, that will be one of the essential functions of the new network.

Peter Black: Dr Drayton, you mentioned how one high-dependency unit might have different staffing levels as compared with another unit. Does that mean that there is not a set standard, or is that standard not being met because of the various pressures?

Dr Drayton: There is a set standard and I am sure you will have seen it in the standards document. The standards in that document are an accurate reflection of the UK-wide standards. No-one in Wales, to the best of my knowledge, meets those standards. We are a considerable way away from those standards. If we were to say, 'Tomorrow we will meet the standards', there would be a massive reduction in capacity and we would not be able to cope with that. England would not be able to take the slack, it would be hopeless for families and parents, and that would not improve the matter. So, we manage below the standards.

Andrew R.T. Davies: I just want to go back a step, Dr Drayton, to your point about nursing positions being frozen. We pick up now and again that that is the situation. Is that a general position across Wales or would you say that there are certain areas where that freeze is greater? With the financial pressures that the NHS faces and with the choices that people have to make, freezing a position is one way of saving quite a considerable sum of money but, obviously, it is to the detriment of the overall delivery of the service. So, when you say that posts are frozen, is that isolated in certain hotspots or is it a general pattern across Wales?

Dr Drayton: I am not sure that I can answer the question accurately because, clearly, I work in one place. I talk to my colleagues all across Wales and I hear that this is happening. I know what is happening in my own hospital, and I hear that it is happening in other hospitals. We have almost 10 nursing posts not filled at this precise moment this week in Cardiff. That is largely due to the freezing of some nursing posts and failure to backfill nursing posts when we have nurses off on courses and so on. So, I know what is happening in Cardiff, but I also hear that it is happening elsewhere.

Andrew R.T. Davies: On the point about the failure to backfill or to fill posts generally, have you felt that pressure increasing recently, or is it not dissimilar to the position in February and March of previous years?

Dr Drayton: My impression is that the financial pressures are growing.

Andrew R.T. Davies: So, the situation is getting exacerbated.

Dr Drayton: Yes.

Ann Jones: You have just been talking about capacity, and experts have recommended that neonatal units should aim to work at 70 per cent occupancy. Is there sufficient capacity for that in Wales?

Dr Moorcraft: No, there is not, and there is good data from the units, which I understand is being summarised for you by one of our other colleagues, Dr Jean Matthes, on behalf of the British Association of Perinatal Medicine. There is good evidence to show that many of the units have been working at 130 per cent or 140 per cent occupancy, as determined by the number of nurses you have available that day and the level of intensity of the patients in your unit that day.

10.20 a.m.

Clearly, this is absolutely unacceptable. It puts undue pressure on the staff, who then feel unable to perform their duties in a family-friendly way. As we have already touched upon, the staff are simply addressing the immediate clinical needs of the patients.

Ann Jones: Do you agree, then, that an overall increase in cots is needed in Wales? If you do, do you have any views on where they should be located and what level of intensity they should provide?

Dr Drayton: There is clearly a need for more critical care capacity. From my perspective, the biggest problem relates to the high-dependency capacity because we have babies who are receiving high-dependency care who back up, if you like, into our intensive care capacity. One of the reasons why we have difficulty in accepting babies with surgical conditions from hospitals like James's or from west Wales is not necessarily that we are using all our intensive care beds with intensive care patients, but we have high-dependency care babies that we cannot move anywhere else. So, clearly there needs to be an investment in that critical care capacity for south Wales in the three designated units. I can speak with much less authority for north Wales, as I am much less familiar with how things work there, but I think that the problems are similar.

Again, picking up on what Dr Lloyd said earlier, although we need to concentrate the critical care capacity in those three units to make the best use of limited resources, there equally needs to be investment in the local hospitals, because the three big hospitals will only function properly if we can get the babies back once they no longer need that critical care element and get their recovery care delivered locally. That is a problem at the moment. So, every component of the network needs to work together, everybody needs to understand and accept what their duties are within that network, and they need to be resourced so that they can actually do that.

Ann Jones: Could we find out what the position is for north Wales as well? With all due respect, Dr Drayton has just said that he cannot speak with any authority on north Wales, but as a north Wales Member, like yourself, Chair, we would like to know what the position is there.

Darren Millar: Yes. We can request a paper on neonatal services in north Wales. That would be helpful.

Helen Mary Jones: I want to come back to the transport service, which you have already mentioned. Our understanding is that there is a 12-hour transport service planned but that that is not operating yet. Can you tell us, if you feel that it is appropriate, what your perception is of the reason for the delay? I suspect that it may come back to the network. In Scotland and England, of course, the service is a 24-hour service. I understand that there is research that demonstrates that babies born at night are potentially at a higher risk of mortality. So, do you have concerns that the current plan for the service is only for 12 hours and that we are not delivering that? Can you put a bit of flesh on the bones for us?

Dr Drayton: I think that those are all valid points. On a point of accuracy, not all of England has a 24-hour service, but England and Scotland, to the best of my knowledge, have transport services that operate for at least part of the day. I do not think that there is anywhere like Wales, which does not have a service at all. I am well aware that a number of services in England that are not 24-hour services are currently working towards making those services available 24 hours.

Am I worried? Yes. The neonatal standards that we referred to earlier state that a 24-hour transport service should be provided but, clearly, running a 24-hour service requires more resource than has been made available to us. On the positive side, I expect it to be possible to manage 85 per cent or so of transports within the hours that are available. In other words, you get the most benefit per pound spent in those hours. There will still be demands out of hours for babies who need urgent transfer and who cannot wait the few hours until the transport service is available. There will be some babies in that category and for the time being we will have to fall back on what happens now.

It is not that there is nothing happening now. We try to find out what staff we can pull together. If it means taking staff who are delivering incubator-side care to provide that transport, that is a problem and sometimes we do not have sufficient people to do it; we are working at too high an acuity to deliver that. However, we do try, and we are successful, although I do not know what percentage of the time. We are also dependent on the Welsh Ambulance Services NHS Trust to support us and that can be a problem. So, it is not that there would not be anything out of hours; it is just that there would not be a guaranteed service. We need to get the service up and running for 12 hours and then we need to be resourced to move forward.

Helen Mary Jones: Could you tell us a little more about what happens now when the baby is born and the level of care that it needs is not available? I am trying to get a feeling for what happens.

Dr Drayton: There are two perspectives. There will be James's perspective from the last 12 months as a level 2 unit—in other words a unit trying to transfer babies out—and there will be my perspective as a level 3 unit receiver. I can tell you what I do and I am sure James will then tell you what he does.

When I am on service, quite a large proportion of my service week is taken up with managing the capacity. That takes my time away from doing what I ought to be doing, which is providing hands-on care for the babies and dealing with the communication issues that we referred to earlier. Almost invariably, I have either no critical care capacity whatsoever or one cot and one, two, three or four mothers on my antenatal ward or delivery suite, all of whom have high-risk pregnancies and who may need to deliver their babies in the next 24 hours. Then I receive a telephone call from one of my colleagues somewhere in south Wales or England requesting that I take another baby. So, all the time I am doing this balancing act and considering how far I can push my team, the risks that I am running, looking at the babies that I have in and whether there is anything that we can do. We end up doing some really convoluted things sometimes, such as multi-way transfers. If I can get a certain baby back to a certain place then we can do a three-way transfer. Then we end up wanting a three-way ambulance transfer to take the baby from us to a certain place, pick a baby up from there and move it elsewhere, and then get the critical care baby back in.

Helen Mary Jones: It is giving me a headache just hearing about it.

Dr Drayton: It is a nightmare and I must say that I and most of my colleagues feel that that is the most stressful part of our job. It is more stressful than dealing with really sick babies whose lives are at risk. It is more stressful to try to manage that capacity. James will tell you what it is like for him.

Dr Moorcraft: Yes. From our perspective we have hours of wasted time. When there is the risk of a very premature baby's birth and we have enough warning that this is likely to happen, the midwifery staff and the obstetrics staff are the first teams to be hit because they will have negotiated with us. We will have informed them that we should not keep this woman in the hospital any longer because we do not have the staff to cope. Then, usually several hours are spent by us in trying to locate a cot for this baby and by the obstetricians in trying to locate space on a labour ward that also has the necessary midwifery support. Sometimes that involves moving out of Wales. Quite often we can be on the phone for four or five hours trying every hospital in the south-west of England, and all along the M4 corridor. Very recently, we were trying to get into a hospital in London and we got as far as Wexham Park Hospital in Slough who told us, 'Do not bother phoning the network. We have just tried and they have no capacity today.'

Then you have no choice. Quite often the mother's condition has altered, the pregnancy and the labour have progressed, and it is then unsafe to move the mother. So, we then have no choice but to manage the baby in our understaffed unit; it is a very risky situation. This occurs regularly, I am afraid to say.

10.30 a.m.

Dr Drayton: It also occurs in Cardiff. We end up having to transfer out mothers who may live just outside the Heath hospital in Gabalfa or Birchgrove or wherever. We try, insofar as we can, not to transfer out babies who have surgical conditions. We try to accept them in, because there is nowhere else in Wales that those babies with surgical conditions can go and we know that if we say 'no', Bristol is very often full and so they may then have to go to Birmingham or London, and so may have to travel very long distances. So, we bend over backwards, but, of course, the other side of that is we do not do well by our local population. So, the population of Cardiff gets transferred and that has a knock-on effect on our obstetric and midwifery colleagues. You are well aware that the midwifery service is under considerable pressure due to staffing issues, but, of course, if you have to transfer a mother out in early pre-term labour you are on the road for two or three hours. It needs a midwife and it takes another midwife away from the service. So, the problem is just compounded.

Andrew R.T. Davies: I just wanted to clarify something. You said that the situation you outlined for us happened regularly on your unit, in terms of managing the birth on your unit and then looking after the little one. As the Chair indicated earlier, none of us have your familiarity with the work. So, how often is 'regular'? How often do you have to face that situation on your unit and manage it? Is it once a week, twice a week, once a month or twice a month?

Dr Moorcraft: Several times every week. We keep records of the levels of intensity of the care of the babies on the neonatal unit. They are collected constantly according to British Association of Perinatal Medicine standards. So we have all these data available. They are fed into the Welsh neonatal committee and I think that they are going to be presented to you at a different time. The result is that at any one time we almost always have intensive care babies on our unit that should not be there.

Darren Millar: Is that several times a week in your hospital alone?

Dr Moorcraft: Yes. Records were kept during the month of March 2009 and fed in from all Welsh units to the Welsh neonatal committee and the figures suggest, once you multiply up from one month's worth of experience from the units, that there would be over 500 displaced women or babies that were not accepted by a unit when there was a request for help.

Andrew R.T. Davies: Did I hear you say that those figures are coming to us?

Darren Millar: Yes, they are.

Val Lloyd: Having heard that large number my question is more pertinent. I understand fully the absolute need for the clinical input that you would be giving, but does the process of ringing round need some-one of your standing? You must set the parameters; I am not suggesting anything else. Really, you have to set the parameters, as you have the clinical knowledge, but if this is happening with this frequency should there not be some-one akin to a bed manager? That is a very crude term that I am using, but I am sure that you get the import of what I am saying: it is very precious time that is being used up several times a week. Should it perhaps, under your guidance, be transferred to some-one more appropriate?

Dr Drayton: We do try to do that. However, if you are looking for a bed, the clinician contact has the best chance of success. Once you have found a place you need clinician-to-clinician contact to transfer the clinical details with safety, but the reality is that if you try to do this through secretarial support, through ward clerk administrative type support, those staff tend to get the brush-off rather more easily. That is just life. With us getting on the phone at the clinical level, we are good at applying pressure.

Val Lloyd: I am just trying to look at ways of ameliorating the workload, really, so that you can concentrate on your prime function, which is caring for those in your care. If you had some-one, he or she would build up an area of expertise. I am sure that that person would never surpass your expertise in terms of contact, but he or she would build up a knowledge of people that would assist in the process.

Darren Millar: We have a couple more questions to go and time is against us, so I ask Members and witnesses to be brief in their questions and answers.

David Lloyd: Thank you, Chair. I will be focused. The all-Wales neonatal standards state that any changes to neonatal services in Wales need to be considered within the context of maternity and obstetric services. You have largely covered that. I take it that you would agree with that point. Moving on, in terms of integrated services, Newborn Hearing Screening Wales states that as many babies as possible should be screened before leaving hospital. To what extent is that service provided to special care babies, in your experience?

Dr Drayton: I can be extremely positive on that one. It is nice to be positive about something in an area that has so many problems. A very high percentage of all babies are receiving that screening. All babies on the neonatal unit get that screening. Again, I think that you are going to get the absolute figures provided through BAPM’s written evidence, but it is a very effective service and it is working very well on the ground.

Darren Millar: That is very good to hear. I think that you have already referred to the fact that you cannot really answer for the north Wales service, so we will try to get some information on that subject.

Dr Drayton: I can say that it is some way behind us in organisational terms. There is a desperate need for additional neonatal input in north Wales and, in particular, for dedicated neonatal consultant staff to provide that focus and develop those services. I know that my north Wales colleagues would agree with me on those issues, but I will have to leave the detail.

Darren Millar: I have just one final question. Has the new structure of the NHS in Wales had any impact at all on the delivery of neonatal services so far, positive or negative?

Dr Drayton: I think that it just produces organisational memory loss and delay and we sometimes seem to be starting the cycle yet again with a new set of managers.

Darren Millar: Do you think that is perhaps one of the reasons that there has been the delay in the implementation of the all-Wales neonatal standards, because the focus has been—

Dr Drayton: It may be a factor. I doubt that it is the only factor and possibly it is not even the major factor, but it may be a factor.

Dr Moorcraft: I think that this reorganisation has had the potential to place the new health board management structures in a difficult situation. There are, to my mind, some competing priorities that they have to tackle, and the network issues of the day may not be the same as the local health board priorities, certainly not early on in the merged organisation. So, I think that there is the potential for some tension there.

Darren Millar: Thank you for your evidence. That brings us to the end of this particular item. I thank Dr Moorcraft and Dr Drayton for their evidence today. We have really appreciated your insight into neonatal care and the services that people are getting in Wales. You will be sent a copy of the transcript of today’s meeting so that you can correct any inaccuracies. Thank you very much for your oral and written evidence.

10.39 a.m.

Ymchwiliad i Ofal Newyddenedigol: Tystiolaeth gan Sefydliadau Nyrsio
Committee Inquiry into Neonatal Care: Evidence from Nursing Institutions

Darren Millar: We are delighted to take evidence now from some of the nursing organisations and institutions. I am delighted to welcome Pam Boyd of the Neonatal Nurses Association, Lisa Turnbull, a regular visitor to our committee, and policy adviser to the Royal College of Nursing, and Claire Bateman-Jones, a member of the Royal College of Nursing and a neonatal sister. Welcome to our meeting.

10.40 a.m.

You have very kindly circulated some evidence papers, which all Members have had the opportunity to take a look at. So, with your permission, we will go straight into questions.

The all-Wales neonatal standards were published in 2008. We have heard from previous witnesses that there have been some problems with the delivery of those standards here in Wales. To what extent does the development of the all-Wales neonatal standards address the problems that were identified in previous reports, and why do you think that there has been a delay in implementation? I do not know who wants to a take a lead on that.

Ms Turnbull: I will start. Part of the issue is that the local health boards are struggling with day-to-day operational issues and have a focus on the short-term financial pressures, so their focus is on trying to make short-term financial savings. To ensure a sustainable workforce, you need to make investment in education and workforce planning to ensure that you have the right number of staff, and that is not happening at the moment. No-one is taking responsibility for that kind of long-term approach. The most fundamental issue, however, is the shortage of neonatal nurses in Wales.

Ms Boyd: I would reinforce that it is a national shortage of neonatal nurses, and, as an association, we are trying to promote people to come into the service. You may get people coming in, but they are not staying, and we need to look at why that is. Is it education? Is it that it is just not what they wanted and they did not realise what it implied? For the long term, we should be trying to encourage people into nursing and making more of a career pathway.

Darren Millar: We will look at the staffing in a little more detail in a moment.

Andrew R.T. Davies: The changes that were introduced in 2008 obviously had some impact, but do you believe that they had a significant impact? How do we monitor the changes to see whether they were effected? Is there a need to have some form of regular monitoring so that we can see which way we are going with what has been proposed?

Ms Turnbull: Absolutely. That is the key, and we are calling for regular monitoring against the standard on an annual basis, for example, so that we can see progress. Perhaps that is one of the responsibilities that could be entrusted to the network.

When preparing for this session, I consulted with members across Wales, and I very much regret to say that the picture that they painted was one of part-time and full-time nurses working very long hours, maternity leave regularly not being backfilled, incredibly limited access to education—and no access at all, in some places—and even of non-specialist nurses being rotated onto the wards in some cases, to try to maintain minimum numbers. So, the picture that was presented to us was one of a service under pressure rather than a service with high staff morale and one in which great progress had already been made.

Andrew R.T. Davies: Pam just touched on trying to keep people within the service, and Lisa just gave us a snapshot of a survey that she undertook before this evidence-gathering session. So, everything is there for you, or the administrators, to understand. Is it the case that people are turning their backs on the opportunity to become specialist nurses because of a lack of investment and a lack of career modelling? Even if you had the will, it will take a lot of engagement to encourage people to go back into the profession.

Ms Boyd: Sometimes, the girls who come straight into neonatal nursing after qualifying may not have an understanding of what neonatal care is. As you progress through neonatal care, it becomes a very stressful environment. It is very rewarding but also very stressful, especially in intensive care, if you work in a regional unit. We need to support nurses with the right educational tools. With the national shortage of staff, staff may be put in a position of looking after babies whom they are not geared up to look after, and then they think that they cannot do it and they may leave.

It is very hit and miss. Some units are brilliant at providing education, there is funding there, and they have are proactive. Others may not have that resource. So, where you work and how your career progresses can be very hit and miss. Then you will get people who leave that area to go elsewhere where there are better opportunities.

I think that the way forward is to invest in the education of staff and to value the long-term and experienced staff. Speaking from personal experience, I know that, in the next 10 years, a lot of staff at the top level, who provide the neonatal intensive care, plan to retire. Who will come in behind us? Will they stay? When I came into nursing, we were all in it for the long haul, but people do not think like that anymore.

Andrew R.T. Davies: Those examples of good progress in units, are you talking in a UK context or a Wales context? I am just bearing in mind what Lisa said earlier. She gave us a snapshot and, sadly, there was not—

Ms Boyd: I am speaking on behalf of the Neonatal Nurses Association, which covers the UK. In pockets, some are very good. In some places, you fight tooth and nail to get on a course, to get a study day, to attend a one-day conference, or to get funding or time, but other units are more proactive. There, they will say, 'Yes, go on this course', or 'We will get you on a module and, when you have done module 1, we will get you doing module 2, and then on a degree pathway'. So, it is hit and miss, depending on the management and the funding.

Ms Bateman-Jones: You do not get time off for study days, so it is usually all done in your own time. If you are working full-time, you do not have the time to take off for study days as well. There is no career progression in neonatal nursing any more. You come in but no-one is moving on, and that is the problem that band 5s have. There will not be a band 6 job for two to three years at a minimum, and so they think that, if they go somewhere else, they might get a band 6 job. So, there is no career progression.

Ms Turnbull: I would just stress that there is certainly evidence of people who would like to move into neonatal nursing and would like to become more specialised in neonatal nursing. Otherwise, we would not receive so many reports of members using their own funding or their own annual leave to do this. So, there is clearly a willingness out there to enter this specialisation.

Secondly, on a positive note, I want to commend the work at Bangor University, which has produced an excellent education unit. However, sometimes the funding of these education units is quite precarious, because they are dependent on the service releasing people to come to their unit to train. So, there is some positive activity out there in Wales. It is just a question of how we support that and recognise it.

Lorraine Barrett: Andrew has picked up on some of the questions I was going to ask. Pam, you just said something about 'the girls' who come straight in. What is the proportion of men and women? I have this picture in my head that it is women in the majority who go into neonatal nursing, but what is the situation with male nurses?

Ms Boyd: I do not have that figure to hand but, anecdotally speaking, in the 28 years in which I have worked in this specialism, I have known only three male nurses on a neonatal unit in my area.

Ms Bateman-Jones: About two years ago, I think that there were five in the whole of Wales, and three of those are now gone. They came in but have now moved to other countries.

Lorraine Barrett: There is no reason why we should not have more male neonatal nurses. You have all talked about the staff shortage, and we just started talking about the difficulty of retention. How critical would you say staff shortages are at the moment? I refer you to the Bliss report, which we covered earlier with Helen, which said that there were 382 neonatal nurses in spring 2008, but the need has been estimated to be 500. We are two years on now, so do you have an update on that figure of 382?

Ms Turnbull: I believe that that figure is still accurate.

Lorraine Barrett: Is it still about the same? Has there been no real change in the two years?

Ms Turnbull: It is an ongoing issue to try to get workforce information.

Darren Millar: You say that that figure is still accurate, but the birth rate is continuing to increase, is it not? We know from the evidence that we have just heard from the two doctors that there has also been a reduction in the number of cots because of staffing pressures. So, if 500 nurses were required in 2008, and if we have maintained the same number of cots, there would be at least 500, possibly more. If we reduced the number of cots, that may have balanced out because of the reduced need to support those cots, would it not?

Ms Turnbull: I believe that the figures are broadly accurate, but I think that you would have to do two things. We would be happy to work with Bliss, as we did before, to come up with the figure that is needed.

10.50 a.m.

On the figure that is there, it is actually quite difficult, as this committee is aware from other inquiries, to get accurate information from local health boards on how many posts they have but have not filled or how many posts they have frozen. Sometimes it is quite difficult to piece that information together to get a national figure—more difficult than it should be. So, that piece of work would have to be undertaken by the Welsh Assembly Government. We would be more than happy to work with Bliss to look at this again, but I believe that that figure of 500 is still broadly accurate.

Peter Black: I understand what you are saying in terms of attracting nurses into neonatal nursing and the training, the day release and all that sort of thing. There is an issue here about workforce planning as well, in terms of training and recruiting nurses, that will hopefully lead to that increase. The Minister published figures last month on future workforce planning for nurse recruitment and training, in which she increased the number for mental health nurses but not any other nursing specialities. Is that going to have an impact, and what is the general result of the publication of those figures?

Ms Turnbull: I think that the main issue here is with the post-registration education in neonatal nursing. Claire may want to say a bit about this afterwards, but the one point that I would make is this: whose responsibility is it to do this long-term planning? I think that, wrongly, there is a perception among those at the local health board level that their problem is today and that it is an operational issue and not just a question of resourcing. It is often a question of concept, that they do not feel that they have the responsibility to do this long-term planning. If you look, for example, at Scotland, the Scottish Government has provided not just money to commission places for training, but also money to backfill places to ensure that nurses can be released to go on those courses. So, it has taken that extra responsibility to do that. One issue at the moment is that the Welsh Assembly Government can commission as many places as it likes, but if LHBs refuse to release nurses, that has no impact on the service. I do not know if you want to say something about pre-registration or post-registration, Claire.

Ms Bateman-Jones: When I did my post-registration neonatal training, you went off and did your two courses. You were supernumerary, so you got to experience all the different types of neonatal care. The way that they are doing it now is that nurses are not being released; they are being released one day a week to do college work but they are still part of the normal nursing team for the rest of the week. So, they are not supernumerary; they are not, therefore, getting the experience of transfers, because they still have to look after their own patients as well as doing their college work.

Lorraine Barrett: Sticking with staff shortages, we heard from the two doctors earlier about the impact on them of juggling where babies go when others are coming in, so they are trying to create some capacity. Can you give us any practical examples of the day-to-day pressures because of the shortages?

Ms Boyd: Not from the association but from my own unit, as a ward sister. We have an informal network, if you like, where we ring Cardiff and Swansea and ask, 'Are you open? What is your cot status?', so that we know roughly who has beds and where. We liaise with midwifery; we know what is coming up on our antenatal wards. As your unit fills you are looking at other units. Then, as Dr Drayton said, you look at a complex swap—'If you take this one back, we will take that one from there'. That is common. You are juggling babies—'I will move this one up to Abergavenny, then I can take that one to the Heath, and if we have that one back from the Heath, which is technically ours, but it is Caerphilly'—and so on. You are juggling, and I would say that we do it regularly. It is not a daily occurrence but it is happening regularly.

Ms Bateman-Jones: The problem with having to move babies is that you are taking nursing staff away. If you have a three-way swap, that is three nurses out of the clinical area.

Lorraine Barrett: We have talked about the 24-hour transport that is not in place yet. What personnel would be involved? Would there be dedicated personnel with the transport? I cannot quite picture what the difference would be.

Ms Bateman-Jones: At the moment what would happen is that, if you had, say, a ventilated baby, a registrar would have to go along with a senior nurse who would be able to look after that baby. If it was a transfer—say we were taking a baby back to its local hospital—a junior nurse might go with a slightly junior doctor. Sometimes it can just be a nurse.

Lorraine Barrett: So, would it always be the staff from the unit who would go with the baby?

Ms Bateman-Jones: Yes, or you compromise—'If I bring your baby, will you bring ours back?'

Darren Millar: So, in many ways, if there was some investment in staffing levels within those hospitals and more cots, fewer babies would be transferred, there would be less resource on the road and, probably, better use of resources within the units. Is that what you are saying to us?

Ms Turnbull: Yes. Correct me if I am wrong, but I understand that 70 per cent occupancy is the level that is intended, in terms of best practice. Quite clearly, that is massively exceeded at the moment, because people are constantly in the position, as you were saying, of having to say 'We have said that we have closed but something else is coming in, so are we really closed?' There is pressure on them not to close. Then you have long, complicated transfers over quite long distances—someone was talking to me about Gloucester the other day—and that can really put an extra strain on the system.

Ms Boyd: Anecdotally, if you have x number of staff that you plan for each shift and you have an unexpected transfer, you may think, 'I can send her, but I will have to get somebody in'. If you have not got what we call bank nurses or someone who is willing to come in on their day off, you could be looking, if your hospital agrees, at using agency nurses, at a huge cost to the organisation. You are paying for an agency nurse to come in to take the place of your experienced nurse whom you have sent on the road. So, you have other implications as well as the staffing that you are taking away, if you are allowed agency staff, and depending on what agency you use, what the cost is and what type of nurse you want.

Ms Turnbull: I will just add that one of the pressures at the moment is that, because people are trying to make financial savings, the use of agency nursing is being drastically curtailed. Clearly, we have sympathy with that, because it is not, in the long term, an ideal strategy. Nonetheless, it is, in the short term, causing tremendous pressure, because no other alternative being put in place to ensure that you have the right staffing level for a safe level of care.

Val Lloyd: I wonder about feasibility. When we get the 12-hour transfer scheme, rather than having to take personnel off the wards, will we have suitably trained personnel with the ambulance? In that way you would not be depleting your staff all the time. I would imagine that, when you get that dedicated transfer system, you are going to have the facilities for the type of children and babies that you transfer.

Lorraine Barrett: That is what I was trying to get at when I asked about transport. Would that make a difference to unit staff having to go with the baby? I had in my mind maybe a dedicated on-call service.

Ms Bateman-Jones: It would make a difference as long as you could then backfill the nurses who were going to be in the transport team.

Val Lloyd: No, you would recruit those separately.

Ms Bateman-Jones: However, they would come from us.

Val Lloyd: We are broaching the idea, rather than the practicalities.

Darren Millar: If these were additional posts, dedicated to the transport service, would that be of benefit?

Ms Boyd: Yes. Then you would have your team and you would ring up and say, 'I need to take this baby from x unit to y unit', without losing medical or nursing staff from your unit. To set up the transport team, you are going to need very experienced staff to do all transfers, and they are going to come from your unit. You then need to train up your staff to take the posts of the girls or boys who have been taken from your unit. You are talking in the long term about training, because there are no experienced staff to be cherry-picked.

Lorraine Barrett: We started to talk about the 70 per cent occupancy and I think that we have covered that. I do not think there is any more that can be added, Chair, with regard to action that is needed to tackle the shortage of qualified neonatal nurses in the short term and long term. You said earlier, Pam, that you were looking at why they do not stay in the service. Is there anything that you would like to add to that on what could be done, maybe, to improve retention and recruitment?

Ms Boyd: I think that having taster sessions on neonatal services pre-registration would help. I do not know if it is the same in other units, but we have a lot of child branch staff coming in, whereas I came in from adult and midwifery nursing. Maybe we need to tell universities that there are other careers in neonatal, other than people coming from child branch, which should be supported through education, post-registration courses, such as the modules, and career progression, whether they are advanced neonatal nurse practitioners or things like the R23, which is an enhanced practitioner course.

11.00 a.m.

Ms Bateman-Jones: We predominantly recruit from child branch. The students that come on to our unit are child-branch students, and I do not know how we would get adult-branch students. We do have midwives, but if more midwives could come to see what we do, that would be very beneficial.

Ms Turnbull: I think that the one thing I would urge the committee to consider is who has responsibility for doing the long-term planning to ensure access to education. Whether that is the local health board or the Welsh Assembly Government in a sense does not matter. The issue at the moment is that someone has to take that responsibility, and that does mean a protected budget, even if it was small or notional. At the moment, we have the situation where local health boards simply cut CPD. We know that there are local health boards out there where they have just said, 'Right, that is it; even in the middle of courses, people are not going to be released', and that is causing tremendous problems. I can understand that they are doing it because of financial pressures, but it is not really a sensible way forward in terms of planning for the future. So, perhaps that is something the network should explicitly have responsibility for.

Ms Bateman-Jones: From a personal point of view, I have had three study days cancelled in the last year because there were no nurses to backfill. These courses were in-house training, but they still had to be cancelled.

Darren Millar: It is important that we get that on the record. Thank you for that.

Peter Black: We have heard today about issues related to the recruitment, retention, training and personal development of nurses, and we have heard about funding pressures and related issues. The all-Wales neonatal standards have a commitment to deliver one-to-one nursing care to babies in intensive care. In terms of what is preventing that from happening, is it down to funding, is it down to those staffing issues, or is it a mixture of both? If it is the latter, what is the balance between the two?

Ms Bateman-Jones: My unit should be run with 14 nurses, but we are lucky if we get 11.

Peter Black: Is that down to recruitment issues or funding?

Ms Bateman-Jones: There are 10 places at the moment—10 nursing posts not being filled.

Peter Black: Are they funded posts?

Ms Bateman-Jones: Yes.

Peter Black: So, are there recruitment issues preventing this from happening?

Ms Turnbull: It is a case of both, because it is down to education as well. Clearly, you cannot recruit to a post unless you have established that pool of people who will want to apply. So, it is both sides of the coin.

Ms Boyd: You need to have the correct skill mix. It takes a while to bring someone up to the level at which they can work in intensive care. So, you are not talking about coming in and, in a couple of weeks, you are there. It is a progression, and you need to back that up with the correct courses in order to establish a competent workforce.

Peter Black: If we got all these workforce planning issues right, would we then meet that standard or would we still have funding issues that prevent us?

Ms Turnbull: If you have the workforce, of course, then you can talk about increasing provision. There is no point at the moment in saying, 'Let us put some more cots in', because you would not be able to staff them appropriately. So, really, the first thing that we need to do is to increase the workforce pool because we cannot talk about expanding our provision properly until we have those people.

Peter Black: That is very helpful. Thank you.

Darren Millar: Are you saying that for these 118 posts for which you have identified a shortfall—or you did in 2008—even if there were money to pay for 118 posts, we do not have the nurses in Wales to be able to staff up to those levels?

Ms Turnbull: I am saying that you need to put a plan in place that provides the pool of people at the same time as making those posts. I would not want to lose the focus on creating posts because you do need to create posts. Claire has given the example in her area of the 10 posts that are not being filled. The danger of not focusing on that is that the LHB then says, 'Well, we cannot fill them and perhaps those 10 posts should just disappear off the books.' So, I am reluctant to say, 'Take your attention away from the creation of posts'. Nonetheless, I think that it is a valid point that you will need to, over the next five or 10 years, put resources into backfilling posts to allow people to train and to train up the next generation.

Ms Bateman-Jones: It is not just about having a post, but what type of post it is. It is okay to say that we will have 180 band 5 nurses, but we also need career progression and the skill mix, and there is no point having 180 nurses if there is nowhere for them to go because they are just going to leave again.

Andrew R.T. Davies: I want to clarify one point before I ask the questions that I was going to ask. A previous witness said that the 10 posts were vacant because of a recruitment freeze. Is that correct?

Ms Bateman-Jones: Yes.

Andrew R.T. Davies: So, it is not a case of the money not being in place to allocate to those 10 posts, but a case of the local health board freezing the posts and not recruiting. Obviously, the two are slightly different. Thank you for that clarification. It is an important difference.

Regarding the managed clinical networks, which have been considered in order to improve services, in the evidence we have received, especially from you, Pam, the indication was that they could play an important role in developing better communication and a better service full stop. Obviously, there has been some delay in Wales with implementing these networks. How important are the networks in terms of driving up the service and to have the impact that your evidence suggests?

Ms Boyd: I am the only Welsh person on the committee of the neonatal nurses. Most of the people there already work in a managed clinical network and, from listening to them, it is clear that they all know each other and that the flow between them is very good. Although we do it informally here by ringing units, especially along the M4 corridor, if you have a managed clinical network and, for example, a baby in my unit in need of surgical treatment needs to go to another unit, you have that flow. So, you should not have the delays and you would be able to liaise very quickly across boundaries. In the networks that I have heard about from colleagues in England, you do not have the same barriers that you need to overcome. I think that it would just improve the flow. You would improve your cot occupancy because you would be able to free up cots and get babies back from your regional unit, who are blocking your beds; you could get that back to a level 2. You might have a high-dependency baby that is blocking a bed that could go back, but because of transport or nursing or just the way the service is sometimes—

Andrew R.T. Davies: So, the delay is quite substantial in allowing that progress to be made?

Ms Boyd: Yes, and that can cause blocked cots, and that then has an impact on what you accept for ITU or for other areas. So, speaking from the association's point of view, I think that a network would help things flow and you perhaps would not have regional differences in certain areas, because you would be one network and you could get over those differences. I am not quite sure how, because it probably is going to be a long-term move forward, but, from listening to my colleagues in England, they seem to have got over this and have a good working relationship. From the east midlands into Yorkshire, for example, they know what the cross-network cot occupancies.

Andrew R.T. Davies: We have heard in previous evidence about the difficulties of communication and, in particular, the disparity between north and south again, which seems to be a major theme in most inquiries we hold in this committee.

We have had the announcement about moving to 12-hour specialised transport, but how important is it to get to 24-hour specialised transport? I am probably asking you to state the obvious. The quickest way to achieve that would be to understand who should pay for 24-hour transport, because if you have a person or body who makes the decision as to where the funding has to go in order to create the capacity, then you are moving the wheels a lot quicker, are you not?

Ms Boyd: As a nurse who works in a clinical unit, 24-hour transport would be the ideal. I do not know if you agree, Claire.

Ms Bateman-Jones: Ideally, you want to move babies during the day when it is safer and when you have more staff, but there are occasions when you do need to transfer in the middle of the night. So, 24-hour transport would be very beneficial.

Andrew R.T. Davies: Where would you see the money coming from or who should have responsibility for that 24-hour transport?

Ms Boyd: Personally, I do not really know. I know that I speak for the association, but I work as a clinical nurse. I do not work in an area where we discuss moneys, unfortunately, so it is a bit out of my realm.

Andrew R.T. Davies: If you do not ask the question, you do not get the answers.

Ann Jones: We heard from Bliss that while parents of children in special care baby units say that the clinical care is fantastic, they are often left without any support, or with inadequate support, in terms of the other issues related to having a baby in a special care unit. What steps do you think should be taken to ensure that services are provided in a family-centred way?

11.10 a.m.

Ms Bateman-Jones: In my unit, we organise coffee mornings and activities for the parents, but the nurses do that on top of their normal role. We have nurse counsellors as well who help the parents, but it is about trying to get engaged and work together rather than the nurses doing it as well as their clinical role.

Ann Jones: What about support for mums who are trying to breastfeed when the baby is off the tube feed or something like that?

Ms Bateman-Jones: Again, the nurse at the bedside would do that, on top of everything else.

Ann Jones: If you are working at, as we have heard, 140 per cent capacity in some units, then I can understand that issue.

The all-Wales neonatal standards state that any changes to neonatal services in Wales need to be considered within the context of maternity and obstetric services. Do you agree with that? Is that the way forward?

Ms Boyd: My personal view is 'yes'. I come from a midwifery background and liaise very closely with midwifery as a neonatal nurse. You cannot have one without the other, but that is my personal view.

Ms Turnbull: The members that I have spoken to have stressed the need to improve communication with maternity services. That has been something that I have heard pretty consistently.

Helen Mary Jones: This is quite a specific question. To what extent is the newborn hearing screening service provided to babies being looked after in special care?

Ms Bateman-Jones: I work nights and it happens during the days when I am not there, so I am not 100 per cent sure about that.

Ms Boyd: In my unit, we have a regular service and it seems to work very well. Babies are screened on the unit. If for any reason they cannot be screened on the unit, they are picked up as outpatients once they go home. If any problems are picked up on screening, then they are referred to the audiology centre in our hospital. So, speaking for our unit, we seem to have a very good service.

Darren Millar: That is very good news. It seems to chime with what we heard from an earlier witness.

I have one final question. You mentioned the variability between England and Wales or the UK and Wales, Pam, earlier in your evidence. Are there any specific concerns about neonatal services in north Wales? We have heard the situation is different within Wales as well.

Ms Boyd: I am not familiar with north Wales. I know that there are specific issues because of the geography of the north, but I do not have an opinion on that.

Ms Turnbull: I believe that we are still waiting for a decision on how the services are going to be structured in north Wales. That was the latest information that I had and, certainly, at that time members were anxious for that decision to be made. I would just draw people’s attention to the excellent work that is being done at the University of Bangor. I do not want to present too negative a picture, and I think that it is important to recognise that that centre of education is excellent.

Darren Millar: On that positive note, that brings this evidence session to an end. I thank you all for the evidence that you have provided, both written and oral. You will be sent a copy of the transcript so that you can correct any inaccuracies.

That brings our meeting to a close. I ask Members to stay so that I can give them some information.

"Daeth y cyfarfod i ben am 11.13 a.m.
The meeting ended at 11.13 a.m. "