Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

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

Dydd Iau, 18 Mawrth 2010
Thursday, 18 March 2010

Cynnwys
Contents

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

Dr Andrew Dawson	Cymrawd Coleg Brenhinol yr Obstetryddion a'r Gynaecolegwyr a Chadeirydd y Grŵp Cynghori Cenedlaethol ar Obstetreg a Gynaecoleg Fellow of the Royal College of Obstetricians and Gynaecologists and Chair of the National Specialist Advisory Group on Obstetrics and Gynaecology
Richard Lee	Cyfarwyddwr Rhanbarthol, y Canolbarth a'r Gorllewin, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru Regional Director, Central and West, Welsh Ambulance Services NHS Trust
Dr Jean Matthes	Cymdeithas Meddygaeth Amenedigol Prydain British Association of Perinatal Medicine
Carol Shillabeer	Cyfarwyddwr Nyrsio, Bwrdd Iechyd Lleol Addysgu Powys Nursing Director, Powys Teaching Local Health Board
Victoria Franklin	Bwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg Abertawe Bro Morgannwg University Health Board

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 9.16 a.m.
The meeting began at 9.16 a.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **Darren Millar:** Good morning. I welcome everybody to this morning's meeting of the Health, Wellbeing and Local Government Committee. I also welcome any members of the public who might be joining us in the public gallery. I remind everybody that headsets for simultaneous translation and sound amplification are available. If anybody has any problems with using these, the ushers will be able to provide assistance. Committee members and members of the public may wish to note that simultaneous translation is available on channel 1, while channel 0 is the language being spoken. I would be grateful if everybody could turn off their mobile phones, BlackBerrys and pagers so that they do not interfere with the broadcasting or other electronic equipment. If it is necessary to evacuate the room or the public gallery in the event of an emergency, everyone should follow the instructions of the ushers who will guide you to the nearest appropriate exit. Finally, I remind Members and witnesses that the microphones are operated remotely and that it should not be necessary to press any buttons.

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

9.17 a.m.

Ymchwiliad y Pwyllgor i Ofal Newyddenedigol: Tystiolaeth gan Fyrddau Iechyd
Committee Inquiry into Neonatal Care: Evidence from Health Boards

[3] **Darren Millar:** We will take evidence this morning from a number of organisations, starting with health boards. I am delighted to say that we are joined by Victoria Franklin, nursing director of Abertawe Bro Morgannwg University Health Board, and Carol Shillabeer, nursing director for the Powys Teaching Local Health Board. We have received papers which have been circulated to Members, which we are very grateful for. If you are content, we will go straight into questions. Thank you for joining us.

[4] We have already received evidence on the subject of the all-Wales neonatal standards and the fact that these do not appear to be met in Wales at the moment. How do you monitor clinical governance issues and why are these not being met? I do not know who wants to start.

[5] **Ms Shillabeer:** I am very happy to start. The way in which we will be and are monitoring the neonatal standards is through our safety and quality mechanisms within the health board. Being Powys, we receive all of our specialist neonatal services outside of the county of Powys, and therefore we have service specifications and contracts in place with other organisations, which are our strategic partners in delivering those services. Those services are reviewed against the service specification, contracts and the neonatal standards, and reported through to the quality and safety committee.

[6] In terms of progress, we are aware that good progress is being made against the neonatal standards, but there are still some areas where there is more work to do, particularly in relation to some of the units that provide services to the residents of Powys that are not consistently meeting the British Association of Perinatal Medicine nursing standards, and are working towards that.

9.20 a.m.

[7] The other issue is the implementation of the transportation scheme. I understand that there is considerable work in train, particularly in the Wales neonatal network, to implement that more fully.

[8] **Ms Franklin:** In terms of the Abertawe Bro Morgannwg University Health Board, we

have conducted quite a rigorous self-assessment against the standards, because that almost gives us a status in terms of where we are and where our gaps are. We have robust clinical governance arrangements, so we have a quality and safety committee as Powys does, and I am joint clinical governance lead with my medical director and the director of therapists and health scientists. The reports go through directly to the quality and safety committee.

[9] It is important to say that we are striving and have made significant progress against the standards within the health board. In terms of the workforce within our units, our staffing levels meet the BAPM standards and requirements. However, as we know, because it is a peak and trough service, we often have capacity and demand issues, but in terms of the workforce I am very pleased that we are able to state that we are meeting the BAPM standards in terms of our staffing levels within the neonatal unit. As a consequence, we have eradicated bank nurses within the units, and that ensures that we are delivering a more continuous and safer service.

[10] **Darren Millar:** We will come on later to some of the staffing issues in particular.

[11] **Helen Mary Jones:** I am pleased to hear that you have been able to staff up to the standard, but we have heard other evidence that that is very difficult to achieve in terms of having the right qualified staff in the right place at the right time. Could you tell us a little bit about how you got there and how you have managed to achieve the standard? We have been hearing that it is very hard to do.

[12] **Ms Franklin:** A positive approach is that our head of nursing and midwifery is professionally and managerially accountable for neonatal nursing, midwifery and paediatrics. So, within the directorate of women and child health, our head of nursing manages all of that. That is one secret to how we have been able to move forward so positively, particularly with consistency of standards.

[13] Within the health board, we now also have a level 3 and a level 2 unit within the one health board. That also enables us to have more flexibility within the workforce.

[14] **Helen Mary Jones:** Thank you. That is helpful.

[15] **Darren Millar:** You say that you have seen improvements over the last couple of years. Is that in terms of your staffing? According to the figures that we have, there was a significant occupancy issue in 2008 for your high-dependency cots in particular, where occupancy was 125 per cent in terms of those cots. So, has the situation moved on significantly since then?

[16] **Ms Franklin:** We became the new health board on 1 October, by combining the former Swansea trust and Bro Morgannwg, but we had no problems in recruiting. In fact, our whole time equivalents match the standards because we have been able to be more flexible within the workforce. We only have two advanced neonatal nurse practitioners, and I would like more than two. So, there are some areas where we would like to enhance the service in that respect.

[17] **Darren Millar:** You say that you are meeting the staffing requirements for the cots that you have at the moment. Have the numbers of cots been reduced in the last two years, or has your staffing complement gone up?

[18] **Ms Franklin:** It has gone up.

[19] **Darren Millar:** The staffing complement has gone up. I just needed to get that on the record. Thank you for that.

[20] **Peter Black:** What is the relationship between the local health board and Health Commission Wales with regards to neonatal care?

[21] **Ms Shillabeer:** There is a neonatal network of which all of the health boards are members. From 1 April—so in the next week or so—the Health Commission Wales responsibilities transfer to the seven local health boards via the Welsh Health Specialist Services Committee. Every health board chief executive is a member of that committee, and their responsibility is planning and overseeing the implementation of services such as neonate specialist services for the population of Wales. So, there are some further changes that will strengthen the arrangements locally for specialist services, neonates being one of them.

[22] **Peter Black:** To what extent might the recent NHS reforms be responsible for the delay in implementing the all-Wales neonatal standards?

[23] **Ms Shillabeer:** From the Powys perspective, we have seen no detrimental service changes during the reforms. The development of the Welsh Health Specialist Services Committee will aid the speed with which the neonatal standards are being met, bearing in mind that this is a plan that stretches more than one or two years. My view is that WHSSC will help to move that on considerably.

[24] **Peter Black:** I want to ask ABMU about that, because you have had more upheaval than Powys, have you not?

[25] **Ms Franklin:** Yes, we have. [*Laughter.*] In a balanced way, that is where I see that the amalgamation of Bridgend, Neath Port Talbot and Swansea is a positive step forward for us, because we are able to have more flexibility in the service particularly because we have a level 2 unit in Bridgend and a level 3 unit in Swansea. We very much welcome the investment from the Assembly Government in terms of the dedicated transportation service and also the managed clinical network, because the arrangements are very much based on goodwill as opposed to needing more of a formal managed clinical network in that regard.

[26] **Peter Black:** Has the fact that you have had to reorganise the health board and concentrate on getting the structure right taken your eyes off the ball in terms of that?

[27] **Ms Franklin:** No, that is not my view.

[28] **Helen Mary Jones:** To what extent is the reduction in the number of intensive-care cots available in Wales as a whole impacting on mothers in labour and special care babies? We have heard evidence about there being more need to move people around and that being disruptive, and that sort of thing.

[29] **Ms Shillabeer:** I can recall from about a year and a half ago—when I was not in Powys, I should add—that there was a particular issue with a peak in demand where many of the units in Wales were full, and there had to be very close negotiation between all of the units to ensure that as many of mothers needing cots and services were able to be provided for within Wales. At that time, some did go outside of Wales, but I also understand through work that took place to review that situation that that was a fairly exceptional time back in May 2008.

[30] The improvements within the standards, the information system and the transportation system will mean that we know at the touch of a button where the cots are and where we need to divert our transport to pick people up. So, that is more of a global rather than a rural perspective on that.

[31] **Ms Franklin:** We have developed some acuity tools within ABMU. For example, we look at the number of babies we have in the units and the number of staff, and we do that on a daily basis. It gives us almost an acuity model where we can see the peaks and troughs in the demand. We have determined that we have more peaks and capacity issues within our level 3 unit within Singleton Hospital, as opposed to Princess of Wales Hospital in Bridgend. We have occasions where it exceeds our funded cots and we have to transfer babies and mothers to other units. For example, in 2008—I would need to get some more up-to-date figures with for new health board—we were averaging about 10 transfers out per month and between one to six retrievals.

[32] **Darren Millar:** Andrew R.T. Davies, do you want to come in on this?

[33] **Andrew R.T. Davies:** I might have misheard. Did you say acuity tools?

[34] **Ms Franklin:** Yes. It is called an acuity model.

[35] **Andrew R.T. Davies:** As a simple layperson, what is that?

[36] **Ms Franklin:** It is a bit like a capacity model where, at a glance, we can see what our peaks and demands are on a daily basis. It enables our head of nursing to match the workforce and to almost have escalation protocols as well. So, we can see when we are getting up to our peak capacity. It is a management tool, really.

[37] **Andrew R.T. Davies:** Have you developed those tools for your board?

[38] **Ms Franklin:** Yes.

9.30 a.m.

[39] **Andrew R.T. Davies:** Are you piloting those tools as part of a wider aspiration for the health service in Wales or is it something that you have specifically taken on to try to make better use of the capacity that you said that you have got?

[40] **Ms Franklin:** Over the last 12 months, we have done a considerable amount of work on safe staffing levels, which equates to the neonatal units. So, we have implemented that, but we wanted to specifically develop a model for our neonatal unit so that we could have a greater understanding of managing the capacity and demand.

[41] We are quite excited about this because when we look at that information on a daily basis, we can apply it now to all of our other areas across the health board. I have not brought information with me today, but I could forward that to the committee.

[42] **Darren Millar:** That would be helpful. Lorraine, do you want to come in here?

[43] **Lorraine Barrett:** Yes. I am interested in that because previously this committee has done workforce planning inquiries and matching up what you need and who you have got seemed to be a big problem right across the NHS. Are you able to take the opportunity at some point to share that good practice? Do you meet with your counterparts in the other health boards and share that good practice?

[44] **Ms Franklin:** Yes, and I understand our head of nursing and midwifery has shared that with our Minister. We need to share best practice, do we not?

[45] **Darren Millar:** Can I ask you to clarify something? Did you say that you are currently sending around 10 patients out of your area on a monthly basis?

[46] **Ms Franklin:** That was according to my 2008 data.

[47] **Darren Millar:** We received evidence last week from some of the consultants that are working in some of the neonatal wards, which made it clear that that is a weekly occurrence—they are having to phone around, taking many hours sometimes, in order to find an appropriate cot and a bed for people who are going to go into labour. That seems at odds with your evidence.

[48] **Helen Mary Jones:** They are different health boards.

[49] **Darren Millar:** I appreciate that, but you are not just here in respect of your own health board, but to give us a Wales-wide perspective. I appreciate that the situation might be as it is in your particular health board, but what is the picture elsewhere across Wales? That is what we are trying to establish here and we know that there are problems in other parts of Wales.

[50] **Ms Franklin:** Obviously, I am here representing the ABMU health board today, but from my other director of nursing colleagues, I understand that there are capacity issues and that not all units have been able to meet the British Association of Perinatal Medicine standards on staffing. Of course, the absolutely fundamental issue here is that we give a high quality, safe service to our mothers and babies. There are capacity issues, no doubt about that, across Wales.

[51] **Darren Millar:** Okay, thank you. Helen Mary, you are next.

[52] **Helen Mary Jones:** In the written evidence that you have given us, you describe the distances that some women and families have to travel—and that is particularly pertinent perhaps to Powys—to access neonatal care. Many of them are accessing services in England which, of course, is fine, but could you tell us a bit about the challenges that having to provide services across such distances presents in terms of safe maternity and neonatal services?

[53] **Ms Shillabeer:** Yes. Some considerable work has been undertaken over the last five years or so in Powys on maternity services. The maternity services now provided in Powys are a midwifery-led model with very close links to the district general hospitals for more of the shared care and the obstetric-led services. Our midwives in Powys, therefore, have to have very highly developed risk assessment skills when they first see women and have to try to determine with a fair degree of accuracy what the plan of care is going to be towards the delivery stage.

[54] That plan is reviewed as the pregnancy develops and at any time, the midwife will make a referral to the obstetrician in the district general hospital. Where women are deemed as being at high risk, they are likely to need obstetric care and/or neonatal care and they will be cared for and the care will be led from the district general hospital.

[55] So, our aim is that our pregnant women, who are likely to need some neonatal support, already develop that relationship with their paediatric unit from the off as much as possible. It is not always possible. However, we have contingency plans in place. For example, if a woman is delivering in Powys and something is felt not to be right and that more specialist care is required, a contingency plan is put in place. I am very pleased to say that our risk assessment processes have meant that that contingency plan has not yet been activated. Therefore, our women are generally in the right place.

[56] Clearly, if they are having a delivery in a level 2 unit, but the baby requires level 3 services, there will be a need for that baby to be transferred. The feedback that I have received

is that parents are very understanding of that and want the specialist services available for their baby and are willing to travel, although the service is some considerable distance in Powys from the parents' home.

[57] The midwifery service in Powys continues to support the mum in particular and the family. There are also a number of support networks available. Furthermore, we have a community children's nursing service that then takes up that care with the family about 28 days after the baby is born. So, there are some real challenges, but I think that there is an acknowledgement that there is a need to travel to access that specialist service and we mitigate that need wherever possible.

[58] **Helen Mary Jones:** My next question is perhaps particularly relevant to you, Carol. You mentioned earlier that once we have the proper neonatal network in place, it will be possible to monitor quite easily what transfers are happening within Wales from different health board areas.

[59] **Ms Shillabeer:** Yes.

[60] **Helen Mary Jones:** What mechanisms are in place now or what mechanisms will be in place to monitor the transfers from health boards in Wales—that is particularly relevant to you—to the secondary setting specialist units in England? Is there any monitoring of how much that costs? Obviously, that is a net cost to the NHS in Wales, although, of course, there may be a question of a net gain when babies from England come to Wales. Are those cross-border mechanisms monitored?

[61] **Ms Shillabeer:** There are a couple of answers to those questions. The first is that England already operates an arrangement between neonatal units, so they know where the capacity is. So, if one of our mothers is at Shrewsbury, Shrewsbury provides a level 2 service, although it does have some expertise in level 3, but it is not a designated level 3 service. If a baby requires a level 3 service, they will know where those cots are and the transportation will be arranged. That is fairly secure.

[62] On transportation in Wales, if a woman is having her baby in Nevill Hall, but requires a level 3 service, the neonatal standards and the BadgerNet will mean that the clinicians in Nevill Hall will know where the nearest level 3 unit is. It may be at the Royal Gwent Hospital, but if it is full, it may be at Cardiff or Swansea. So, that improvement will be significant.

[63] I think that I might have answered your questions, but you had a few more.

[64] **Helen Mary Jones:** No. Could I just ask—

[65] **Ms Shillabeer:** About the costings—I remember now. I do not have the information with me, but I am very happy to provide it. We have the costs that we pay for services in England. We have a contract in place and have had for some time. When I looked at some of the activity numbers going through over the last few years, there have been peaks and troughs again. This is a service that operates in that way. However, generally, we have a fairly stable contract in place. I am not aware of the volume of English mothers, if you like, coming into Wales.

[66] **Helen Mary Jones:** Would that information be in another trust?

[67] **Ms Shillabeer:** Yes.

[68] **Helen Mary Jones:** If Shrewsbury is your usual level 2 unit, where would families

from Powys and presumably all the way down the border be likely to go if they needed a level 3 service?

[69] **Ms Shillabeer:** They are likely to go to Worcester.

[70] **Darren Millar:** They obviously have a system in England that is similar to the one that we are hoping to introduce in Wales in terms of being able to identify where the nearest appropriate cot is. How long has that been in place in England?

[71] **Ms Shillabeer:** I am not sure, but I know that when I was involved in neonatal services back in 2008, it had already been established there because we were having conversations with the south of England in relation to their capacity issues.

9.40 a.m.

[72] **Darren Millar:** It would be interesting to try to establish whether Wales was invited to participate in that in terms of helping us find a way forward. Thank you for that.

[73] **Val Lloyd:** Good morning. I have some questions about support for parents, which you touched upon, Carol, in your evidence. What parent facilities, particularly accommodation facilities, are available to the families of special care babies when they are in your area?

[74] **Ms Shillabeer:** I understand that all of the hospitals have accommodation. This is something that the services have been focusing on because often the accommodation is limited. As neonatal services have grown over the years, there has been a need to increase neonatal parental accommodation. Many of the units that we procure our services from have highlighted that they wish to expand their parental accommodation. Some units use their accommodation as part of pre-discharge arrangements, giving parents the confidence to look after their newborn before they go home. I believe that is very good practice, because taking a newborn neonatal baby home is often fairly daunting after you have had the high-tech intensive-care and special care of the hospital. So, the benefits to parents of accommodation cannot be underestimated, and it is an area that I am told people are aware of but are seeking to improve all the time. So, that is the answer on accommodation.

[75] **Ms Franklin:** In terms of ABMU, we have accommodation but we recognise that we need to further improve that accommodation, particularly for families that live further away. Our director of planning has been working with the directorate to look at the facilities, and we recognise that we need some further improvements in that field.

[76] We also do not have a transitional care model or unit. A number of our mothers and babies will be looked after on the postnatal ward. We know that for the mothers and the babies, before they go home, that bonding and support is important. I firmly believe that we need a transitional care unit.

[77] **Val Lloyd:** I have a couple of supplementary questions on what you have said. Are the improvements that you are talking about quality issues or simply numerical?

[78] **Ms Franklin:** Both.

[79] **Val Lloyd:** It is a combination of both.

[80] **Ms Franklin:** We need some extra rooms in Singleton Hospital in particular, but we were also looking at almost a parent hotel-type facility because they need some respite as well. So, we are working through that.

[81] **Val Lloyd:** Do you have any links to the voluntary service? Do they help you at all? We did hear some evidence that there is a strong relationship between the statutory health sector and the voluntary sector in relation to provision for families.

[82] **Ms Shillabeer:** In Powys, the Stillbirth and Neonatal Death Society is a voluntary sector organisation that supports families who have been facing some very difficult times and bereavement. That service is valued right through the maternity pathway—so, whether something has happened early in pregnancy or towards the end. Again, speaking from the rural perspective, because we do not provide neonatal services in-county, we need to be very mindful of the need to ensure that mothers and families in Powys can access support networks. We know that they access Bliss, but there is no local group within Powys. It is part of our governance mechanisms to ensure that parents have the support that they need, so there is certainly room for improvement there in that rural setting.

[83] **Val Lloyd:** Did you want to add anything?

[84] **Ms Franklin:** Likewise, I am aware of the involvement with Bliss. We also have some considerable involvement from former parents. We had a significant contribution to update and improve our accommodation within the Princess of Wales Hospital, so that was very positive. I am not aware of all of the specifics around the voluntary sector engagement there.

[85] **Val Lloyd:** Thank you very much. Staying with the same subject, the British Association of Perinatal Medicine told us that a systematic review of facilities for parents of babies receiving neonatal care in Wales is much needed. Would you agree with that?

[86] **Ms Franklin:** Yes.

[87] **Ms Shillabeer:** Yes.

[88] **Val Lloyd:** It does not need qualification. [*Laughter.*]

[89] **Darren Millar:** No, I think that it is very clear.

[90] **Andrew R.T. Davies:** I have a point of clarification for you, Victoria. Val, in her supplementary question, asked whether you want to increase the number or the quality of the accommodation that you are looking to provide. You identified that there is a need to do something on this. Is there a timeframe for that improvement? How would you describe the current accommodation? Would you be satisfied to use it over a period of time, or is it lamentably poor and needs dramatic action quickly?

[91] **Ms Franklin:** We are striving for a world-class service and the best possible accommodation for our parents. I would describe our accommodation as satisfactory at the moment, but it needs further cosmetic improvement. We need more space. So, the environment of care needs to be updated and made more comfortable so that it is not so, sort of, national health service.

[92] **Andrew R.T. Davies:** Is there a timeframe for the improvements that the board has identified, or is it something that is aspirational at the moment rather than something that is definitely going to happen?

[93] **Ms Franklin:** I cannot confirm the timeframe, but it is certainly not aspirational. It is something that we are looking at very seriously. Now that we have done a very detailed self-assessment against the standards, it is one area that has been highlighted as something we need to improve. We need to firm up now the timescale for that and, of course, the capital funding and the support for it. That is currently with our director of planning, but I can get

some firmer timescales back to the committee if you wish.

[94] **Darren Millar:** Yes, that would be helpful.

[95] **Helen Mary Jones:** I have a specific question about support. Ms Franklin, you mentioned the bonding between mothers and babies. It has been put to us in other evidence that it is quite difficult for nurses to provide the support for mothers to breastfeed or to express milk. You mentioned, Carol, the connection with the community midwives and continuing support. To what extent in your two health board areas are the nurses and midwives able to support mothers of vulnerable babies? It is not always going to work and it is not always going to be appropriate, but to what extent are they able to do that? Do they have the time?

[96] **Ms Shillabeer:** I can pick up both points in relation to the point at which babies and mothers return to Powys. There is a significant emphasis on breastfeeding and the baby friendly accreditation process is under way. Within neonatal units, I can speak only about my experience of visiting the neonatal unit in the Royal Gwent Hospital, where there is a breastfeeding room. Quite clearly, the environment for either expressing or breastfeeding needs to encourage that process—so, there needs to be a dedicated breastfeeding room. The senior nurse of that unit felt that even more improvements can be made in line with the parental accommodation to breastfeeding. So, more can be done.

[97] For care back at home, that support is available. Many areas have breastfeeding leads or breastfeeding co-ordinators to support that. We have quite a lot of support from the National Childbirth Trust in relation to breastfeeding support. There is a buddy system where someone who has been through breastfeeding before can support parents.

[98] **Ms Franklin:** In Bridgend and Neath Port Talbot, we have achieved the full baby friendly accreditation. We have a breastfeeding co-ordinator and work quite significantly towards encouraging our nurses to facilitate and support that. Currently, in Swansea we have achieved levels 1 and 2 and we are working towards further levels. So, there is quite an emphasis on encouraging and facilitating breastfeeding. We also have a training and education nurse across the sites, who is a lead band 7 and who has implemented a dedicated clinical skills training day that is also mandatory, to focus on and encourage the priority of breastfeeding and the baby friendly accreditation.

9.50 a.m.

[99] **Darren Millar:** For the record, before we move on to the staff training issues, you have both indicated, particularly you, Victoria, that the investment into the accommodation is coming from the NHS. In some parts of Wales, it literally is charitable organisations that are providing that accommodation. Is it fair to say that the involvement of the NHS in the provision of accommodation across Wales is inconsistent? Is that a fair point to make?

[100] **Ms Franklin:** It is difficult for me to speak for other health boards across Wales, as I am not privy to all of the specific details around that.

[101] **Darren Millar:** I know that, for example, in Ysbyty Glan Clwyd in north Wales, it is a charitable organisation that provides the accommodation. Clearly, in your part of Wales, it is the NHS that provides the accommodation.

[102] **Ms Franklin:** It is a bit of both, because the work that we did in the Princess of Wales Hospital was done through funding that we had from parents.

[103] **Darren Millar:** So, is it an inconsistent picture?

[104] **Ms Franklin:** It is.

[105] **Darren Millar:** Okay, thank you for that.

[106] **Lorraine Barrett:** We have heard evidence about problems with staff training, and that staff have to fund their study and use their annual leave for study days. What is your experience of that?

[107] **Ms Shillabeer:** I will pick this up from a Powys maternity service provision perspective to say that in terms of neonatal resuscitation and skills around the newborn all of our midwives are fully trained and have the training time to do that. However, we do not provide the neonatal specialist services so we do not procure that training. It is fair to say, from previous experience, that the training for the neonatal staff, in line with the recruitment of neonatal staff, has required further development. Specialist courses for advanced neonatal nurse practitioners have not always been available in Wales and some people have had to travel for them. You would probably find mixed provision if you were to look across Wales in relation to funding and access, but I do not have the evidence to support that, while you probably do.

[108] **Lorraine Barrett:** Would you be able to provide that? What we are trying to get at is how many there are. You said there is mixed provision. Is it across Powys that there is mixed provision?

[109] **Ms Shillabeer:** No, not in Powys.

[110] **Lorraine Barrett:** Sorry, are all midwives able to access training?

[111] **Ms Shillabeer:** All midwives are able to access training and they do access it. Training in neonatal resuscitation is mandatory. Each midwife has to go through that. They all do that and we are fully compliant with that; we are very pleased. People do not have to pay for that themselves, and they do not have to do that on their days off. That is fully provided. That is crucial for us to be able to provide a safe maternity service in Powys, so we are pleased with that. I am not in a position to give any evidence on the other health boards' provision of training, but I am aware that there have been some challenges and developments over the last few years.

[112] **Ms Franklin:** In ABMU, I can confirm that we have a staff training plan in place for our newborn life support programme and we are 100 per cent compliant with that. However, the staff have to be in the unit for six months before they go through that programme. We have a post-registration education plan in place, and having that dedicated in-house training helps so that we can work through that mandatory compliance. It is also linked to the knowledge and skills framework and that is also in the job descriptions.

[113] We also have a neonatal research nurse, which is crucial for us. As we are now Abertawe Bro Morgannwg University Health Board, evidence-based practice and research are critical. The dedicated education nurse who delivers the clinical skills training has also been key for us. So, we have made progress in our health board in terms of our training and education plan.

[114] That is obviously a challenge in areas where the staffing levels are not perhaps as they should be. We find right across the board that it is a little bit of a vicious circle if you have low staffing levels because then you will have high sickness levels and low morale. It is then difficult to release staff for mandatory training. So, by bringing it in-house and having it at the grass roots, it is easier to release staff to attend that training.

[115] **Lorraine Barrett:** It seems that you have some really sensible procedures in place, so that is positive.

[116] **Ms Franklin:** I am very pleased with what we have put in place. It is very simple, really.

[117] **Lorraine Barrett:** Can you say anything about the role of maternity care assistants in developing the neonatal nursing workforce?

[118] **Ms Shillabeer:** I am aware that a programme has been developed to prepare staff to become maternity care assistants that covers a broad spectrum of skills and knowledge. We are currently implementing that programme. It was developed on an all-Wales basis and all of the heads of midwifery and other senior nurses have been involved in its development. It is a significant move forward for support staff and starts to outline a career path for people who have yet to enter a registered profession, either midwifery or nursing, but is another step on the ladder.

[119] It also provides increasing support to parents at a very local level. We will be evaluating how parents receive that type of support and, obviously, we may modify our programmes as a result. Part of the challenge will be to ensure that maternity care assistants, particularly in a rural setting, can work not just in the prenatal and postnatal period but also into young childhood and possibly up to the age of five. We are currently exploring that and we feel that that may be a real way forward in a rural setting where geography is a particular challenge for us.

[120] So, that is the progress that we are making. We are very pleased with the programme and hope that our future registered professionals will have another route to come through.

[121] **Ms Franklin:** In ABMU, we were part of the pilot scheme in the development of the programme for the MCAs and equally, as in Powys, we are supportive of the role. As non-registrants, there are issues around appropriate supervision and delegation of duties, but it is a positive way forward in terms of enabling the midwifery staffing workforce to be more flexible. We need to move towards a more flexible workforce, particularly now, as our midwives are developing and undertaking more the role and responsibility of examining the newborn, for example. My point earlier was that the advanced neonatal nurse practitioners particularly play a critical role.

[122] **Darren Millar:** I ask witnesses and Members to be very brief in their questions and responses, because we are up against the clock. We have gone slightly over the allotted time, but it is important that we take all of the evidence on these particular issues.

[123] **Ann Jones:** Turning to the dedicated neonatal transport service, my question is perhaps more directed at Carol. You have raised concerns in your evidence that cross-border service provision has not been factored into the development of the 12-hour neonatal transport service. Would you like to expand a little on that?

[124] **Ms Shillabeer:** I am saying that there are very different natural flows of our parents, so if you lived, for example, in Radnorshire, your natural flow would be through to England, whereas if you lived in the north of Powys in Montgomeryshire, the natural flow would be two ways: to the east, to Shrewsbury and the flow to the west would be slightly more complex. You may have your baby in Bronglais, but, if neonatal care is required, that is where the transport system will come in, and that has not been factored in, I understand. It is not intended to be a criticism that it has not been factored in, it is just a flag to say there are different flows here that we need to be cognisant of.

[125] We are not aware that there are any transportation issues in relation to our parents who receive their services in England and then need to move on. There is transportation; it is not the same, I understand, as what we are developing, but there is a transportation scheme in England.

[126] **Ann Jones:** How likely is it that local health boards in Wales—and I know that you cannot speak for the other five—will fund a 24-hour transport service? So, are you likely to fund a 24-hour transport service?

10.00 a.m.

[127] **Ms Franklin:** Part of the role of our level 3 unit in Swansea is to provide a 24-hour emergency retrieval service for the region. We are currently providing this on an ad hoc basis, frankly, and it is dependent on the availability of medical nursing staff, particularly from existing resources. At present this is a goodwill arrangement. So, we do not currently have an appropriately staffed and equipped transport system, which is why we would welcome this. This is an issue for us, but we would only be able to appropriately fund 12 hours as opposed to 24 hours. So, it is a big issue for us and we welcome the development of this transport system and also the managed clinical network.

[128] **Andrew R.T. Davies:** Very briefly, I seek a point of clarification from you, Victoria, on training. You said that the health board is meeting its obligations on training because you have a training plan in place. However, is the board ensuring protected time for training for individual staff members? The evidence that we had last week was quite conclusive in that time was not protected and staff could not access it.

[129] **Ms Franklin:** Abertawe Bro Morgannwg University Health Board is giving that time. We have had to change the approach in how we deliver training and we also have some dedicated resource to enable our education nurse-lead to have a very hands-on approach to enable staff to be released.

[130] **Andrew R.T. Davies:** We have representatives from two health boards here, so that must leave five health boards that are not doing it.

[131] **Ann Jones:** Sorry, Andrew, but before you go on, given that we only have representatives of two health boards here, can we write to the other five health boards and ask them to provide some information on how they provide training and whether staff have study days? I accept that you are saying that, but I think that the picture could be pretty different in other boards.

[132] **Darren Millar:** The clerk and I have been discussing that while the evidence is coming in and we will follow that up.

[133] **Andrew R.T. Davies:** I will now go on to my next question. The British Association of Perinatal Medicine is giving evidence later. It is making us aware that the reconfiguration of in-patient paediatric units, namely a reduction in the number of units, could have an impact on the services and, in particular, on midwifery services. Do you believe that to be the case?

[134] **Ms Shillabeer:** I recognise that there are considerable pressures on maintaining as many paediatric units as we have in Wales. It is not only a Welsh issue; it is also the case across the border. We have to meet the European working time regulations and we have to ensure that our doctors can see enough children to maintain their skills. I think that there is potentially an issue here, particularly for a rural setting, where you may have to travel further if the number of paediatric units is reduced. However, there is a need to balance that with

accessing safe services and services that are relevant to the patients' needs. I think that it is a particularly challenging area that we will need to take forward.

[135] **Andrew R.T. Davies:** Could you give one or two specific examples of the type of impact that we might see?

[136] **Ms Shillabeer:** Yes. For example, on the cross-border issue again—and this is the same issue in Wales—we may have a district general hospital just across the border in England with a very small paediatric unit that is struggling to meet the European working time directive. There has also been a significant difficulty in recruiting paediatric doctors because there have been some changes in the Home Office regulations and the number of paediatric doctors trained decreased a few years ago; that is now having an effect on us. If that paediatric unit were to close, because it was not able to maintain those safe staffing levels, and if it were to merge with another to make a new unit, our children would need to travel further. The challenge for us would be to ensure that only those children who require that service travel that far, that we have assessment services much closer to home and that we use Telehealth, Telecare and all of those technical communication tools.

[137] **Andrew R.T. Davies:** That leads on, obviously, to communication and the importance of communication. Given the state of communication, as you understand it, between community midwives and the neonatal units as currently constructed, is it up to the ability that you might require if we were to lose capacity at the neonatal units, especially in an area like yours, which is so rural and when communication becomes even more pronounced?

[138] **Ms Shillabeer:** Yes. The issue with paediatric units is the same as for neonatal units. Communication needs to be enhanced. At the moment, often the units are at quite a distance for people in Powys. I am very accepting of the need to travel 30 or 40 minutes or even an hour to Hereford County Hospital, for example. However, if that service were to move a bit further away, we would want to ensure that we could give clinicians that direct access on the telephone to specialist opinion rather than necessarily send the patient all of the time.

[139] So, there certainly need to be improvements in accessing that service. We are already having those conversations about patients who might come into our units, even into GP practices, and would like to get a specialist opinion over the telephone. Increasingly, our services are being developed to provide that rather than always providing a service in person. So, if there were to be a paediatric unit reconfiguration, there would need to be a whole host of different arrangements to support more local care and local assessment in order to make it successful.

[140] **Darren Millar:** Thank you for that. I am afraid that the clock has beaten us in terms of taking any more evidence from you. Thank you both for your attendance at committee this morning. We appreciate the oral and the written evidence that you have provided to the inquiry.

10.06 a.m.

Ymchwiliad y Pwyllgor i Ofal Newyddenedigol: Tystiolaeth gan Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
Committee Inquiry into Neonatal Care: Evidence from the Welsh Ambulance Services NHS Trust

[141] **Darren Millar:** We will now move to the next item, continuing our inquiry into neonatal care. We are being joined now by the Welsh Ambulance Services NHS Trust. Mr Richard Lee is the regional director, central and west, of the Welsh Ambulance Services NHS

Trust. We have received an evidence paper from you, Mr Lee, which we are very grateful for. We will go straight into questions on that paper.

[142] The Welsh ambulance service provides emergency transportation for any woman going into labour and requiring rapid transfer from home to their birth centre in a district general hospital. Do all paramedics receive newborn life support training or is it a select special few that get that sort of training in the ambulance service?

[143] **Mr Lee:** All of our staff, our paramedics and the ambulance technicians that work alongside them are trained in the delivery and immediate resuscitation of newborn babies. The training is provided initially at ambulance technician and ambulance paramedic training courses and is then refreshed for the paramedics at their annual paramedic refresher course or at a continuing professional development one-day course, which they all achieve annually. There is 100 per cent attendance at those courses.

[144] **Darren Millar:** That is excellent; that is very good to hear. Ann Jones has the next question.

[145] **Ann Jones:** Powys Teaching Local Health Board raised concerns that a cross-border service had not been factored into the current 12-hour neonatal transport service. Do you share those concerns?

[146] **Mr Lee:** We are quite reactive in the transport process in terms of transporting neonates because we will convey the mother and the baby to wherever the clinician requesting the journey wishes us to take them. In the case of the mother and a newborn baby, we will take them to the hospital that the mother was booked into to have the baby. The only time we would seek to influence that decision is if the mother were booked into a hospital at a far distance and if there were a nearer maternity unit that, for some reason, she was not booked into. The ambulance crew may elect to divert to that unit for support. That often happens if patients are away from home when they happen to have their baby, for example, if someone is visiting a relative or something.

[147] **Ann Jones:** Could you tell us a bit more about how the 12-hour transport service will function and what your role will be in terms of neonatal transfers once that service is up and running?

[148] **Mr Lee:** The work that has been done with Health Commission Wales on designing the 12-hour service is based on potentially two models. One model is on subsuming these journeys into our existing emergency and high-dependence ambulance fleet and looking at the resource implications of that fleet for undertaking the additional work. The second model is about establishing a dedicated ambulance in each area that will only make those neonatal journeys. We have provided information to HCW through the project group on how both of those services would look from our perspective as an ambulance provider.

[149] **Ann Jones:** Which is your preferred option?

10.10 a.m.

[150] **Mr Lee:** We have not specified a preference. We have provided a specification for both.

[151] **Darren Millar:** You say that you have provided a specification for both of these options. It sounds as though it is in the infancy of the planning stage, really, rather than being ready for implementation, which is what we have been hearing from other witnesses. Is it fair to say that it is a way off from being implemented at the moment?

[152] **Mr Lee:** Well, we undertake these journeys at the moment, of course, using our emergency and high-dependency fleet. I am aware that Health Commission Wales has visited the London Ambulance Service, which operates the dedicated service model with a ring-fenced fleet of vehicles that undertake neonatal transfers.

[153] **Darren Millar:** How long ago did you provide the two options for HCW to look at?

[154] **Mr Lee:** It was in October, I believe.

[155] **Darren Millar:** So, it is a fairly recent development. Thank you.

[156] **Andrew R.T. Davies:** Thank you very much for your paper and the evidence you are giving us this morning. It is very much appreciated.

[157] When the service is up and running, I assume that it will need to recruit additional staff. What problems do you envisage recruiting enough staff, particularly dedicated members of staff, to allow the service to operate?

[158] **Mr Lee:** Recruitment is not a problem for us. When we advertise vacancies in patient transport and in the emergency service we have a very healthy field of good applicants; we do not struggle to recruit people. It is probably worth pointing out that we provide in-house training for ambulance technicians and patient transport care staff. So, we are not looking for a qualified pool of applicants; we are looking for people whom we can train. That makes recruitment quite easy because we have a wide spectrum of applicants. So, recruitment is not an issue. Provided that the funding is there to do the recruitment, we can facilitate that process quickly.

[159] **Andrew R.T. Davies:** So, specialist staff should not be a problem; the issue is getting the funding in place, which is ever the case.

[160] You touched on the impact on the ambulance service in your response to Ann Jones. You have provided two models, and you said that you do not have a preferred option. However, I suppose that each model would have some impact on the ambulance service as currently constructed. Is there a dramatic difference between the two models with regard to the impact they would have on the service and its ability to take this forward?

[161] **Mr Lee:** No, not at all, really. The main difference is that, if we went for a ring-fenced service that did nothing but undertake neonatal transfers, a different type of ambulance vehicle would be required because it would only move neonatal patients. Therefore, if we took the approach of other ambulance services, using London as an example, the neonatal retrieval ambulances would not look like a normal ambulance inside, but like a bay in a neonatal intensive-care unit. The staff would either be rotated through the full range of ambulance duties, doing some time with the neonatal service, or they would be ambulance staff that received some additional training to assist the neonatal staff in conveying those babies.

[162] So, if we go for a model where we subsume this work into our current emergency and urgent workload, the impact on the rest of the service would be a slight increase in the number of calls. On the other hand, if we go for a dedicated service and that is all those vehicles do, the impact on the rest of the ambulance service would be that the current neonatal transfers that we undertake would come out of the emergency workload.

[163] **Andrew R.T. Davies:** Given that it is going to be a 12-hour system to start with, how important is it to move, operationally, to a 24-hour service so that you can make the necessary

accommodations? If a 12-hour shift pattern is used, what would the best shift be? Would it be from 9 a.m. until 9 p.m.?

[164] **Mr Lee:** We have a very good demand analysis tool that we can look at when we are currently asked to provide these journeys and ensure that we get the most encompassing 12-hour system to start with.

[165] On the other part of your question about the delivery of the service, once there is a 12-hour service in place, I think that the current arrangements would have to apply outside of that 12-hour service with the journeys undertaken being either urgent or emergency transfers using our existing fleet. Clearly, we are always keen to move patients, particularly the sickest patients, by the most appropriate means possible. So, we would be very keen to see a 24-hour service up and running as quickly as possible.

[166] **Darren Millar:** What is the cost differential between the 24-hour service and the 12-hour service? If you have dedicated ambulances, they are going to be available 24 hours a day are they not? It is just that they are not going to be used outside of the 9 a.m. until 9 p.m. period. So, presumably it comes down to the staffing complement for the hours between 9 p.m. and 9 a.m., which would be relatively small would it not?

[167] **Mr Lee:** We need 12 staff to run every 24-hour ambulance. So, obviously, we would need six staff for a 12-hour ambulance. So, it is a really simple equation: 12 staff equals one ambulance 24 hours a day; six staff equals one ambulance 12 hours a day.

[168] **Darren Millar:** So, it is just about extra staffing costs.

[169] **Mr Lee:** Yes.

[170] **Darren Millar:** What size of fleet are you talking about in your proposal? Is it 10 or 15 ambulances dotted around Wales?

[171] **Mr Lee:** No, Chair, the proposal was for two.

[172] **Darren Millar:** Just two.

[173] **Mr Lee:** The proposal was to split Wales into two regions and have one for a north region and one for a south region. Because of the number of journeys involved, it is a huge amount of work.

[174] **Darren Millar:** That is a small number. So, to up it to a 24-hour service is going to be very cheap.

[175] **Mr Lee:** It is going to be double the cost of a 12-hour service, I suppose.

[176] **Darren Millar:** Well, not double because the capital—

[177] **Mr Lee:** Sorry, double the staffing side of a 12-hour service.

[178] **Darren Millar:** Yes. Thank you for that.

[179] **Lorraine Barrett:** Are you confident that the standards for a neonatal transport service can be delivered within the current levels of funding for these services?

[180] **Mr Lee:** I would say that I am confident that we currently respond to all the requests we receive for neonatal emergency and urgent transfers. We certainly cannot introduce either

a ring-fenced service or an enhanced service as part of our current service provision. The service that we provide now is the transfer of babies either in incubators or as patients with midwifery and medical escorts, and we are not able to provide any further service within our existing funding.

[181] **Lorraine Barrett:** Are you reaching the standards?

[182] **Mr Lee:** Yes. The babies are moved in appropriate incubators in vehicles that are designed to carry the incubators and that have the correct crews on them, and we move the babies in a timely manner.

[183] **David Lloyd:** Staying with the general theme of the all-Wales neonatal standards, the British Association of Perinatal Medicine highlights problems with the desegregation of maternity and neonatal services. Do you have a view on whether the integration of maternity and neonatal services might help to improve neonatal services for mothers in high-risk labour and for special care babies?

[184] **Mr Lee:** I think that it would be fair to say that, from an ambulance service point of view, we inevitably end up transferring mothers from midwife-led units to consultant-led units when complications arise. In terms of the desegregation between the units and the special care facilities, quite often, it is not the ill baby that we move when a problem arises. If a hospital specialist unit is full and they have a high-risk birth or they deliver a baby that is very unwell, quite often, our role is to move a more well baby to another centre rather than the very ill child.

[185] **David Lloyd:** Following on from that, in your view, what has been the impact, if any, of the NHS reforms on neonatal services in Wales and the way in which the Welsh Ambulance Services NHS Trust works with the new health boards?

[186] **Mr Lee:** From my personal perspective as regional director for central and west, which covers Abertawe Bro Morgannwg, Hywel Dda and Powys, I would say that it means I am liaising with three health boards, my colleagues in the south-east are liaising with their health boards, and my colleague in north Wales is liaising with one. So, we certainly have clear lines of liaison with the new organisations. With regard to neonatal services, I do not think that we have had any specific dealings yet, but we are not having any issues liaising with the new organisations.

[187] **Helen Mary Jones:** I am not sure of the extent to which you will be able to answer this, so if your answer is: ‘we do not hold that information’, that is absolutely fine.

10.20 a.m.

[188] We have had evidence of mothers and babies having to be moved very long distances, and it has been put to us that that is due to a lack of capacity in Wales for specialist neonatal services. Do you have a take on how frequently the ambulance service is required to travel long distances to transport mothers in high-risk labour and special care babies because of a lack of capacity within the service? Does that have implications for the ambulance service?

[189] **Mr Lee:** I would say that it is very infrequent that we take a mother or a baby what we would describe as a long distance, be that inside or out of Wales. I could certainly arrange for exact figures to be submitted to the committee.

[190] With regard to the impact, as I said previously, it is unusual for us to move a very ill baby or a very ill mother a long distance. It is much more the case that we tend to move a more well baby from the same hospital to create capacity for the very ill baby to stay where it

is. I can certainly arrange for exact numbers of those journeys to be submitted to the committee.

[191] **Darren Millar:** I think that the issue here is not so much the transfer of a baby once it has been born, but of a mother going into labour and there being no cot available. She may be very well during labour, but if the baby is premature we know that it will need specialist attention.

[192] **Mr Lee:** I would say that movement of a woman in that situation happens even less frequently than the movement of a very ill baby, but I will provide that information for you. As I say, quite often, our experience is that we have to transfer a well baby out to make way for an unwell or high-risk mother to come in to deliver or for a very unwell baby that has just been born.

[193] **Helen Mary Jones:** I think that my next question will be answered with that detailed information, Chair. I had a further follow-up question to that, but it will be answered by that written information.

[194] **Mr Lee:** I will arrange for that information to be submitted this week, Chair.

[195] **Darren Millar:** Thank you.

[196] **Val Lloyd:** My colleague said earlier that she was not certain whether you would be in a position to answer her question, and I think that that may apply to my question. The funding that the Minister announced for the establishment of the transport system was wrapped up with the establishment of a managed clinical network and an IT database for use across all the neonatal providers in Wales. In your view, to what extent is the success of the transport service dependent on the introduction of that clinical network?

[197] **Mr Lee:** I think that it is important, for this caseload and many other caseloads, that the ambulance service is aware of where the available beds are for a whole range of patients so that we do not take a patient to a hospital where there is no capacity to deal with their condition.

[198] With regard to the neonatal service, with the dedicated service model where we have neonatal transfer ambulances doing nothing but that workload, because they are based at the neonatal unit that is on call for that period for retrieval, the ambulance crew are aware as part of being based at that unit of where they are going from and where they were going to. So, we would be reacting to a request to go to collect a neonate from X and bring it to Y, and that decision would be based on capacity. Therefore, for that part of it, as a stand-alone organisation, we would not really need to be aware of that.

[199] We have very good links with all the district general hospitals in Wales, and our three control centres are regularly updated when maternity units are full. We are aware, for example, if the maternity unit at one hospital is full and would like its patients to be taken to another maternity unit for a set period of time. Those arrangements are already in place.

[200] **Peter Black:** I think that you have probably already answered this. When will the 12-hour transport service be up and running?

[201] **Mr Lee:** I am informed by HCW that a proposal for a preferred model will be made this month.

[202] **Darren Millar:** That is about a proposal being made, but when will the service actually start?

[203] **Helen Mary Jones:** That depends, does it not, on when the Minister signs it off?

[204] **Darren Millar:** Wait a minute. With regard to the proposal, how long will it be from the time that a ministerial decision is made to the implementation of that decision?

[205] **Mr Lee:** We would look to implement our part of the service as quickly as possible. With regard to getting a team of staff together and using existing vehicles to facilitate a service, we could do that within days. However, this case mix is moving through our existing arrangements at the moment. We are currently undertaking these journeys. If the preferred option is to order specialist vehicles and recruit additional staff, there will obviously be a lead time.

[206] **Peter Black:** How long would that lead time be?

[207] **Mr Lee:** For delivering ambulances?

[208] **Peter Black:** If you went down the specialist route.

[209] **Mr Lee:** For new ambulances, you are talking months rather than many months. It probably takes three months to get a new ambulance.

[210] **Peter Black:** So, if the Minister took a decision tomorrow, would we still be looking three months down the line?

[211] **Mr Lee:** Well, the service could be operated in the meantime using our existing vehicles, which are perfectly safe and compliant with regulations for incubator moves and so on.

[212] **Andrew R.T. Davies:** In response to my question a little earlier, Richard, you said that you have very good data to show the peaks and troughs in demand. That could well be because the people who are commissioning your good selves to transport the babies understand the limitations of the service as currently constructed, without the 12-hour specialist transport. Is it possible for you to provide those data to the committee so that we could see what the pattern is over a normal day, shall we say?

[213] **Mr Lee:** I can provide the data broken down by day of the week and hour of the day, so that should answer both questions.

[214] **Darren Millar:** That would be very helpful. I think that brings us to the end of our questions, Mr Lee. Is there anything else that you want to cover before we draw this part of the session to an end?

[215] **Mr Lee:** No, thank you.

[216] **Darren Millar:** Thank you for your attendance at the committee and for your written evidence. We look forward to receipt of the other information that you have said you will pass on.

10.27 a.m.

Ymchwiliad y Pwyllgor i Ofal Newyddenedigol: Tystiolaeth gan Gymdeithas Meddygaeth Amenedigol Prydain a Choleg Brenhinol yr Obstetryddion a'r Gynaecolegwyr

Committee Inquiry into Neonatal Care: Evidence from the British Association of Perinatal Medicine and the Royal College of Obstetricians and Gynaecologists

[217] **Darren Millar:** We will move on to item 4 on our agenda today, continuing with our inquiry into neonatal care. We are now going to take some evidence from the British Association of Perinatal Medicine and the Royal College of Obstetricians and Gynaecologists. I am very pleased to be able to welcome Dr Jean Matthes of the British Association of Perinatal Medicine, and Dr Andrew Dawson, a fellow of the Royal College of Obstetricians and Gynaecologists and chair of the National Specialist Advisory Group on Obstetrics and Gynaecology. Welcome to the committee today and thank you very much for the written evidence that you have already provided. Because we have had an opportunity to look at that written evidence, we will go straight into questions if that is okay.

[218] We have heard pretty strong evidence that neonatal units in Wales are not meeting the all-Wales neonatal standards, and the nursing and medical standards in particular. To what extent are workforce and financial constraints impeding the delivery of those standards here in Wales?

[219] **Dr Matthes:** I think that all the units strive for the standards, but the problem is that we do not have enough staffed cots in the units in Wales, particularly in the lead centres and particularly in the high-dependency sector. Intensive care is perhaps also a problem, although to a slightly lesser degree than is the case with the high-dependency sector. The pressure on the high-dependency sector has increased over the past five to 10 years because of changes in the way that neonatal care is delivered. We have more pre-term babies surviving and we have had changes to the way that we care for babies, which means that we deliver much more high-dependency care.

10.30 a.m.

[220] I have discussed this with colleagues in England and the rest of the UK, and it is mirrored throughout the whole of the UK. So, we find that we have pressure on the cots in the lead centres, which means that sometimes the lead centres are closed or they cannot accept women in threatened preterm labour from further afield, or even that they have to transfer women in threatened preterm labour from their own labour wards out to other units. It is a significant problem.

[221] **Darren Millar:** What has caused the increase in the number? You mentioned medical advances.

[222] **Dr Matthes:** Yes.

[223] **Darren Millar:** The birth rate has gone up, has it not?

[224] **Dr Matthes:** That is right, and another factor is the increasing birth rate. It has gone up about 20 per cent, I think, since about 2000.

[225] **Darren Millar:** Has the number of those high-dependency beds increased or decreased over the period? You mentioned the staffing problems.

[226] **Dr Matthes:** Yes. In relation to the numbers of staffed cots, there has perhaps been a very slight increase, but not in keeping with what we need.

[227] **Darren Millar:** Thank you for that. Did you want to add anything, Dr Dawson?

[228] **Dr Dawson:** Yes, if I may, Chair. First of all, my royal college wishes strongly to

endorse the evidence that Dr Matthes has put before your committee. I would also comment that any pressures placed on the neonatal service are inevitably transferred to obstetricians and midwives on the basis that, if we then have to start trying to move mothers, either delivered or undelivered, from one hospital to another, that takes staff away from providing care in the labour ward. We are under pressure to reduce caesarean section rates, and we know that a major factor in that respect is one-to-one midwifery care, which we cannot provide if we have midwives escorting mothers in ambulances to other hospitals.

[229] Historically, if Jean will permit me to say so, we have seen a huge difference in the technical ability of our neonatal colleagues. From that point of view, we are now transferring babies at much earlier gestational ages than we used to. When I started in my career, the idea that a 28-week-old baby could survive was almost miraculous, and we have now reached the point where we are transferring babies to level 3 units at 22 and 23 weeks on the grounds that they might survive. So, the expectations that we have of our colleagues in neonatology are absolutely enormous.

[230] One further point is that we are also now delivering babies in cases where at one time mothers perhaps would have had a termination of pregnancy as a result of abnormality because of conditions such as gastroschisis, diaphragmatic hernia and a variety of other conditions that require immediate surgery at delivery, which in Wales—certainly in the most southern parts of Wales—will only be in Cardiff. We have a situation, not infrequently, where mothers who are booked to deliver in Cardiff at the last minute cannot be accepted there because there are insufficient intensive-care cots and, therefore, we end up with a mother being transferred to England to a unit that she does not know, which does not know her, and where no preparations have been made at all. That has a huge effect not only on the woman but on her family and on the unit that she is being transferred to.

[231] **Darren Millar:** On the first point that you made about staff being tied up with the transfers as well, that is just not efficient use of staff resources, is it?

[232] **Dr Dawson:** It is appallingly time-consuming. That may be anecdotal, Chair, but I think that that anecdote would be repeated at every consultant maternity unit in Wales.

[233] **Dr Matthes:** If I could just elaborate a little bit, in my own unit in Swansea, in February of this year we were shut 18 days out of 28. In March, so far, we have been shut three days.

[234] **Darren Millar:** So, for 18 days out of 28 days in February you were shut to new admissions because you did not have the capacity.

[235] **Dr Matthes:** Yes, that is right. We were operating a 36-week model, which meant that our labour ward could only deliver at 36 weeks and above because we only had one flat space for an unexpected flat delivery, that is, a baby who is born and who unexpectedly needs care.

[236] **Darren Millar:** This is remarkable evidence. We have just heard from your health board that capacity is perfectly adequate.

[237] **Dr Matthes:** Capacity is not adequate. We try to staff the cots safely and within the funded levels, but the capacity is in no way adequate.

[238] **Darren Millar:** That is totally at odds with the evidence that we have just received.

[239] **Helen Mary Jones:** Just for clarity, I think that what we were told in the previous session was that the existing cots were staffed to the standard. I do not think that that then necessarily means you have enough cots. I think that the emphasis may be different but I do

not think that it is completely contradictory. The record will show that.

[240] **Peter Black:** She was asked about the number of cots.

[241] **Darren Millar:** She was, yes. How many mums and babies would you have to transfer over that period of 18 days?

[242] **Dr Matthes:** I really could not say. I do not have the data on that. I know that, when we audited this in March 2009, we just collected data from all the units in Wales for a month to see the extent of the problem. For that month I think that there were something like 70 refusals of either in utero or postnatal transfers. In my own unit, there were something like 12 in that month who needed to be delivered in the unit but had to be delivered in units further afield, which perhaps could not offer the intensive-care facilities that may have been needed. Obviously, this does have an effect. In fact, in two of those cases, we subsequently had to retrieve the babies and take them to other units, so we do end up all the time having to deal with situations that are not acceptable.

[243] In February, when we were shut, we still had babies needing to be delivered and brought to our unit. In fact, we had one extremely preterm baby brought to our unit because there was nowhere else for that baby to go. We did not have a cot, and we ended up admitting that baby and then having immediately to take another baby, who was in better health, to another unit. The mother lived in Swansea, and we took the baby to another unit and wanted to transfer the mother to be with the baby. We thought that the ambulance would be able to transfer her, and then the ambulance could not transfer her. So there was this awful anguish, with the mother and the baby being separated, which I feel is totally unacceptable. It is just an example of the pressures that the units are under. Everybody tries to do their best but we do not have enough cots.

[244] **Lorraine Barrett:** Looking at the average rate of cot occupancy, do you recommend a rate of 70 per cent?

[245] **Dr Matthes:** That is the BAPM standard, yes.

[246] **Lorraine Barrett:** We were told by the neonatal expert group that workloads exceed this capacity, and the rates are sometimes around 130 to 140 per cent. Do the data collated by the Welsh Neonatal Committee confirm that? It follows on from what you have just been saying.

[247] **Dr Matthes:** Yes. The data are from the Welsh Neonatal Committee.

[248] **Lorraine Barrett:** What is the impact on the quality of care, would you suggest, on mothers and babies requiring special care of having this high level of occupancy?

[249] **Dr Matthes:** What I think is happening, certainly in Swansea and Gwent, is that units are trying to deal the best they can with the intensive-care cases and their overcapacity in the intensive-care cots, and then the babies who perhaps ought to be admitted to special care are being nursed on postnatal wards. So, that is one aspect of it.

[250] Another aspect of it, of course, is that we cannot admit, and so babies are being delivered maybe in units that do not have the capacity for intensive care or do not have the standards to provide intensive care—not only nursing standards but medical standards. The standards for intensive care are that there should be a medical rota of first on, second on and consultants in neonatology. So, obviously, that is not met anywhere outside of the lead centres.

[251] **Lorraine Barrett:** Are you saying that to achieve medical and nursing staffing standards we need a further 24 intensive-care cots in Wales?

10.40 a.m.

[252] **Dr Matthes:** No, not a further 24. I think that we need a total of 24 intensive-care cots in south Wales.

[253] **Lorraine Barrett:** Can we check on that, Chair?

[254] **Darren Millar:** How many are there at present?

[255] **Dr Matthes:** There are about 17 or 18.

[256] **Lorraine Barrett:** So, we have 17 or 18 and we need 24.

[257] **Dr Matthes:** Something like that.

[258] **Lorraine Barrett:** Do you think that this can be achieved within current levels of funding?

[259] **Dr Matthes:** No, not unless we reconfigure the service, but that would be difficult. It might be achievable in the intensive-care sector, but it certainly would not be achievable in the high-dependency sector.

[260] **Lorraine Barrett:** Where would they be needed in a spread across Wales? Are there pinch points or particular areas?

[261] **Dr Matthes:** I think that they are needed in the lead centres, because that is where the standards are met for medical care. That is where the pressure is, and that is where the high cot occupancies are. That is where the centres of population are, too. So, that is where I think that they should be.

[262] **Darren Millar:** Can you just clarify that there are around 17 to 18 beds at the moment?

[263] **Dr Matthes:** They are funded in the intensive-care sector.

[264] **Darren Millar:** So, that needs to increase by eight, which is a 50 per cent increase in terms of current capacity.

[265] **Dr Matthes:** Six or seven.

[266] **Darren Millar:** Okay; pardon me.

[267] **Dr Matthes:** Give or take a bit, that is the ballpark figure.

[268] **Darren Millar:** Okay, but it is a significant increase, and well above the increase in the birth rate.

[269] **Dr Matthes:** Yes, but then it was never funded properly anyway.

[270] **Darren Millar:** So, it has never been adequate.

[271] **Dr Matthes:** No. Look at the Health Commission Wales report of 2005, which shows a £10 million deficit.

[272] **Darren Millar:** Okay. Thank you for that. Peter Black is next.

[273] **Peter Black:** The expert group highlighted particular concerns about the lack of high-dependency cots in south Wales. Do you agree that an overall increase in high-dependency cots is needed in Wales and, if so, do you have any views about where they should be located?

[274] **Dr Matthes:** There is certainly a deficit in high-dependency cots. My personal view is that I would wish them to be in the lead centres, because that would be where you would get the maximal efficiency from them.

[275] **Peter Black:** In terms of how many, maybe not percentage-wise—

[276] **Dr Matthes:** Ten to 12, something like that. I am looking at south Wales now. I do not know whether you are going to ask me about north Wales later.

[277] **Peter Black:** Ten to 12; is that 50 per cent, 10 per cent, or what?

[278] **Dr Matthes:** I will just check my figures, because I cannot remember how many we have funded.

[279] **Darren Millar:** While you are doing that, Dr Dawson wants to make a point.

[280] **Dr Dawson:** The point that Jean was just making is that we would like to point out that in one sense at least, the definition of a consultant obstetric unit is that it at least has high-dependency neonatal support available. My royal college president would want me to point out that any reconfiguration would need to consider how that service would be provided, and that in turn has knock-on effects on other services such as gynaecology, intensive care, surgery and so on. None of these things really operate in isolation.

[281] **Darren Millar:** Thank you for that point. Yes, Dr Matthes.

[282] **Dr Matthes:** The shortfall in high-dependency cots according to the calculations of the Welsh Neonatal Committee is 12, based on the 2008 figures for south Wales.

[283] **Peter Black:** How many are in south Wales?

[284] **Dr Matthes:** About 30 are funded.

[285] **Peter Black:** Okay, that is about 40 per cent, then. That is quite a lot, yes. Obviously, increasing the number of cots in Wales is going to mean an increase in nursing input and appropriate ratios and staff nursing standards. It is also going to mean costs for accommodation, equipment and consumables.

[286] **Dr Matthes:** Exactly, there will be issues of space.

[287] **Peter Black:** Have there been any estimates as to the cost of increasing the number of cots to your recommended levels?

[288] **Dr Matthes:** No.

[289] **Peter Black:** None at all?

[290] **Dr Matthes:** I do not have a cost that I can give you.

[291] **Peter Black:** Okay. Can you explain why the 2005 Health Commission Wales calculation of the number of cots required is no longer valid?

[292] **Dr Matthes:** It is because it was based on activity in 2001 and, as we have heard, a lot has moved on since 2001.

[293] **Peter Black:** Yes. Has the health commission not done a recalculation?

[294] **Dr Matthes:** Not to my knowledge.

[295] **Darren Millar:** Did you want to come in on this point, Helen Mary?

[296] **Helen Mary Jones:** No.

[297] **Darren Millar:** Well, over to you, Helen Mary, anyway, as you have the next question.

[298] **Helen Mary Jones:** This is probably a question more for you, Dr Dawson, but Dr Matthes might have a view. It is something that you did mention, Dr Matthes. Dr Dawson, are you aware of incidents where service pressures mean that some babies who require a level of special care, perhaps not the most intensive care but special care nonetheless, are being looked after on postnatal wards? If that is happening, what are the safety implications and the implications for the mother and baby of this?

[299] **Dr Dawson:** I could not produce for you anything other than anecdotal evidence to support that, but I have no reason whatsoever to disbelieve it. I was smiling earlier because in the case of one of the families in question that was affected by care in Dr Matthes's unit, the woman ended up in mine in Abergavenny. So, I am certainly aware that these sorts of rather bizarre exchanges of patients and babies do occur.

[300] Our biggest concern, really, is that, for women who in some cases might deliver in a more local unit—Nevill Hall where I work has about 2,300 deliveries, so in Welsh terms it is about middle sized—the unit should be able to provide a reasonable level of high-dependency/low-dependency ventilation for a couple of days for a baby. However, we sometimes end up having to send babies out, sometimes quite long distances away, simply because we cannot sustain that.

[301] The other thing that I do not think either Jean or I have mentioned is that a lot of these babies are now having such incredible care at such early gestations or following such incredible surgery that they then get returned to the level 2 unit for very lengthy, ongoing care for nutritional and developmental purposes. That then blocks the high-dependency unit's ability to provide the acute care that we might need.

[302] **Darren Millar:** So, are you saying that the average stay is longer?

[303] **Dr Dawson:** I do not know whether Jean agrees with that, as we have not discussed it before. [*Laughter.*] It is certainly a phenomenon that we see.

[304] **Dr Matthes:** It is true that some of the babies go back to their local units, and they are there for a very long time.

[305] **Helen Mary Jones:** Are these babies that perhaps would not have survived even 10 years ago?

[306] **Dr Matthes:** Yes.

[307] **Dr Dawson:** They might not even have been born, because the women might have had a termination of pregnancy.

[308] **Darren Millar:** Thank you for that. Andrew R.T. Davies.

[309] **Andrew R.T. Davies:** Thank you very much for your evidence so far. One of the strands that is coming out of the evidence that we have had from other witnesses concerns the importance of parental support in any packages that are put together to try to strengthen the service. Bliss has a charter that has seven key planks to it, trying to strengthen obviously the ability and facility for parents to have the best support possible. Are you confident that the aspirations of that charter are being delivered in neonatal units, either across Wales or in your particular areas? It might be a bit unfair to say 'across Wales', because your specialty is in your own areas.

[310] **Dr Matthes:** Yes. Bliss has very high standards, as you would expect. I think that everybody certainly tries to achieve the standards. There are some areas where there may be some room for improvement. What it is like across the whole of Wales I really do not know. I think that it, too, is probably a bit patchy, and it would be very good to have an all-Wales audit.

[311] **Andrew R.T. Davies:** In your evidence, you clearly identify the need for such a review, or you think that it would be a good move. Is it possible without the review to get a handle on what the facilities are across Wales, or is that why you have identified a need for the review? The danger is that if you commission a review, you will just be building one house on top of another house as such, is it not?

[312] **Dr Matthes:** We have to have some sort of prioritisation of the problems as well. While the parental issues are clearly very important, if we could address the cot issues, we would help to address the parents' issues as well.

[313] **Andrew R.T. Davies:** The point that you made in your evidence—and to be honest, I had not looked at it on that basis—is that with the reconfiguration of units, particularly if there is the ability to increase the number of cot spaces, you could actually be knocking out parent accommodation that is currently in existence.

[314] **Dr Matthes:** That is the very real danger, and it is important that the parent accommodation is protected. It does need to be increased, but I would say that the priority should be to increase the cot numbers.

[315] **Darren Millar:** Is it fair to say, though, Dr Matthes, that if you increase the cot numbers, then parents will probably be treated closer to home anyway, so there will be less of a need for accommodation?

10.50 a.m.

[316] **Dr Matthes:** If you increase the intensive-care or the high-dependency cots in the lead centres, you would probably need more parent accommodation. The danger is that you would increase the cots by taking away the parent accommodation.

[317] **Andrew R.T. Davies:** What would the standard of accommodation be like at the moment? We had a taste of it this morning in that your own board area said it was satisfactory. Would it be fair to say that it is satisfactory and no better, but certainly no worse?

[318] **Dr Matthes:** In our trust, we have four parent rooms. There is a double bed and a sink

in each room and that is about it. They are very pleasantly furnished, but if you are staying there for a week on end, they are not really family friendly if you are bringing children. There is a television on the wall as well.

[319] So, we have four parent rooms, and these are for the parents of a very sick baby who may be living a distance away, or it may be a parent who is getting ready to take the baby home when the baby is rooming in. The English toolkit for commissioning neonatal care—this is a toolkit for commissioners that lays down standards—recommends that there should be one parent room per intensive-care cot. It is interesting that the Department of Health published a report on 16 March called 'Maternity and Early Years—Making a good start to family life'. One of the promises in that document states that,

[320] 'we will aim within five years that parents with babies in neonatal care can be confident a bed will be provided for them so that both mothers and fathers can stay close to the baby.'

[321] So, that commitment has been made in England, and it would be fantastic if that could be replicated in Wales.

[322] **Andrew R.T. Davies:** Is there no such aspiration, shall we say, in Wales?

[323] **Dr Matthes:** I think that it is left very much to individual units and individual local health boards.

[324] **Andrew R.T. Davies:** Could I ask, Chair, that we do our own sample of the boards, in a simple letter to ask them what standard of accommodation they have at the moment, to give us a snapshot?

[325] **Dr Matthes:** Are you referring to the number of rooms?

[326] **Darren Millar:** That ratio is obviously not being met in Wales, is it, in terms of one room per cot?

[327] **Dr Matthes:** I very much doubt it, but I do not know. I have not done my own survey, so I really do not know. I imagine that it is pretty good in Cardiff. I do not know what it is like in the Royal Gwent; I do not know what it is like in north Wales.

[328] **Andrew R.T. Davies:** I think that that is a piece of work for us. We need to ask, do we not?

[329] **Darren Millar:** Thank you for that. We now turn to Ann Jones, who has questions about north Wales.

[330] **Ann Jones:** I will return to north Wales, if you do not mind, and direct questions at both of you. Again, Bliss has highlighted concerns about the neonatal services in north Wales. In fact, it has asked us to pay particular attention in our inquiry to that on the grounds that currently there are no dedicated consultant neonatologists at any of the three units in north Wales. To what extent is the shortfall in such consultants in north Wales putting increased pressure on neonatal services?

[331] **Dr Matthes:** Well, there is, I believe, a birth rate in north Wales of about 7,000 per annum. There are staffed intensive-care cots, from the nursing perspective anyhow, in the Glan Clywd and Wrexham units, and there are also high-dependency cots staffed in those units. I believe that we have paediatricians with an interest in neonatology who look after those patients. There is no dedicated middle grade rota or dedicated first-on rota for

neonatology and, again, those aspects of the service are provided by paediatricians who have many other calls on their time. It is not the same standard as in the Welsh standards. It is not meeting those standards, and it is not the same standard as in south Wales.

[332] **Dr Dawson:** Obviously, our aspirations necessarily must follow those of Dr Matthes's colleagues. To that I would add that, increasingly, because of the complexity of care that obstetricians must now provide for mothers who are likely to deliver early or whose babies have the potential surgical problems that I have already mentioned, it is important that wherever the neonatal expertise is sited, it is also matched by consultant obstetricians. We are ourselves going some way down the line in training and in appointments in Wales at the moment with a degree of sub-specialism, because it is very difficult for generalist obstetricians and gynaecologists now to learn all that there is to know and to keep up to date with everything there is to know.

[333] In particular, it is absolutely vital that doctors like Dr Matthes and I are in good communication. That is something we still need to have a lot more work done on. That would be eased, however, by making sure that any reconfiguration—and my colleagues in Wales are not against reconfiguration, I should add—should look very carefully at the impact on the people we serve and on the quality of the service that we end up providing.

[334] **Ann Jones:** So, really, you are saying that you feel that better integration between maternity and neonatal services will help to address some of the issues.

[335] **Dr Dawson:** Dr Matthes knows this because we have worked together in a couple of different groups over the last two years. I feel very strongly that we need to see ourselves as a maternity service in which neonatology is absolutely a leading part. I just want to emphasise that good obstetric care and good midwifery care will underpin the quality of babies that end up under the care of Dr Matthes and her colleagues. If babies are spending time in an ambulance while the mothers are in labour then those women will not be getting good care and neither will their babies.

[336] We really need to make sure that whatever service we arrive at is one that is truly responsive and—I feel it is becoming a jargon expression these days—fit for the purpose it is intended for.

[337] **Dr Matthes:** We have been co-ordinating the activity of the units in terms of intensive-care days, high-dependency days and special care days for all the units in Wales over the past few years. We were rather puzzled by the activity coming out of north Wales for 2008, because it looked quite low for the population. In fact, in 2009, the figures look much more as one might expect for the population. I just wonder whether there was a problem with the data collection for 2008 in north Wales.

[338] **Darren Millar:** Just returning to this consultant neonatologist post, do you think that securing a post for north Wales should be a priority?

[339] **Dr Matthes:** That is in the business case for the transport and the network.

[340] **Darren Millar:** It is, is it?

[341] **Dr Matthes:** Yes.

[342] **Darren Millar:** Okay. Do you think that it should be treated as a priority?

[343] **Dr Matthes:** It is being funded and, hopefully, if they can recruit, that would be fantastic.

[344] **Darren Millar:** We talked about the high-dependency cots in south Wales earlier. What is the capacity like in north Wales? Is it adequate? Is there a shortfall?

[345] **Dr Matthes:** By the 2008 data, it did not look as if there was a shortfall. From the 2009 data, it looks as if the Glan Clwyd Hospital in particular has pressure on high-dependency services.

[346] **Darren Millar:** How many cots would be needed in order to match the demand?

[347] **Dr Matthes:** I regret that I have not done that calculation.

[348] **Darren Millar:** But there is obviously a pressure there.

[349] **Dr Matthes:** It may be that another couple of high-dependency cots would be needed there. In Wrexham, the activity looks as if it is reasonable for what is funded. In Glan Clwyd, it looks as if there is a huge pressure in high dependency. I would say that they perhaps need another one or two high-dependency cots, off the top of my head.

[350] **Darren Millar:** Thank you. Ann, do you have any further questions?

[351] **Ann Jones:** No, I am fine, thank you. I think that the questions have been answered.

[352] **Darren Millar:** Okay. We will turn to staff training. Val has questions on this subject.

[353] **Val Lloyd:** My questions are on staff training. I am not quite certain whether you would have detailed knowledge of my first question, so I do understand if you cannot answer it. The Neonatal Nurses Association and the RCN described situations where nursing staff were caring for very pre-term and vulnerable babies without the right medical staff support and training.

11.00 a.m.

[354] We were also told that staff frequently use annual leave for study days. Do you have a response to those issues and how they might be overcome?

[355] **Dr Matthes:** I cannot answer the second question, and I have forgotten the first question so can you tell me again?

[356] **Val Lloyd:** Basically, they say there are situations where nursing staff are caring for very pre-term and vulnerable babies without the right medical support and training.

[357] **Dr Matthes:** Without the right training?

[358] **Val Lloyd:** Without the right medical support and training. There are not sufficient doctors, they did not feel adequately trained and there was not the right medical support, if any.

[359] **Dr Matthes:** I cannot really answer that question. All I can say is that in the lead centres there would be the right medical support, one would hope. In terms of looking after babies without the qualifications, nurses are allowed to look after babies if they are not qualified in the specialty as long as they are supervised in doing so.

[360] **Val Lloyd:** We are simply taking that from evidence we were given. I did say I thought perhaps it was an unfair question for you.

[361] **Dr Matthes:** It is probably outside my area.

[362] **Val Lloyd:** Just as an extension of that, the nursing association has also told us that there is a lack of long-term planning and accountability in developing the neonatal workforce. Would you agree with that?

[363] **Dr Matthes:** I know that some units have recruitment problems and I am not sure why. In my own unit we do not have a recruitment problem. There seem to be adequate nurses, who are trained as nurses, wishing to come into neonatal care, and they are then developed.

[364] **Val Lloyd:** So, you can say with authority that at least the development takes place in the unit, even if they come in without the totally relevant qualifications in neonatal care.

[365] **Dr Matthes:** Yes. They will come in as a nurse who is qualified as a nurse and then—

[366] **Val Lloyd:** Yes, but for the specific neonatal qualifications, they are empowered in the unit to move towards gaining those qualifications.

[367] **Dr Matthes:** That is correct. Actually, over the last few years we have been quite pleased that a number of nurses have come in. We were a senior workforce and a lot of people have retired, so we have a lot coming in. I have to say that I am one of the senior ones.

[368] **Val Lloyd:** I am with you on that. [*Laughter.*] That gives us a clear picture of one level 3 unit, at least.

[369] **Darren Millar:** Absolutely, thank you. That is consistent with the evidence that we received this morning from a health board as well.

[370] **Peter Black:** Might an increase in advanced neonatal nurse practitioners help to tackle some of the problems?

[371] **Dr Matthes:** Absolutely. Advanced neonatal nurse practitioners are a very beneficial resource. They are nurses who are trained as neonatal nurses who then take on an extra year of training in order to develop their skills, including skills that enable them to work in the place of doctors on junior on-call rotas. They tend to be a permanent feature in the workforce as well, which gives a sense of continuity. They really are extremely valuable. In these days where we have uncertainties about medical staffing, in that we have already seen a middle-grade crisis in staffing, to develop ANNPs would really strengthen the service. It may be that we could use them on the first on-call rotas; it may be that we could use them later on, once they have become more expert, on the transport service; it may be that some of them will then be able to go on to the middle-grade rota. It takes time to develop, but certainly to have these people trained and working within the neonatal service in Wales would be a huge asset. We only have three or four in Wales at the moment. We certainly have a lot who are keen to train. If we can train more, then I think that would be very beneficial.

[372] **Peter Black:** I will ask you the $6 million question: how many more?

[373] **Dr Matthes:** We cannot train everyone at once. I would say let us train four, five or six this year, and then maybe we can continue that. To train one to get the qualification costs about £50,000, and then they have to be developed afterwards as well.

[374] **Peter Black:** So, are we talking about maybe between four and six a year over the next few years.

[375] **Dr Matthes:** That would be wonderful, absolutely wonderful.

[376] **Darren Millar:** Thank you for that. Dai Lloyd is next

[377] **David Lloyd:** I commend the presentation thus far and the written evidence as well. It is always a joy to see Dr Matthes because only a couple of years have elapsed since we were in the same year in medical school together. [*Laughter.*]

[378] **Darren Millar:** She looks a lot younger than you, Dai.

[379] **David Lloyd:** Absolutely. [*Laughter.*] I was about to say that one of us has gone on to greater things and the other has become an Assembly Member, but I thought I would cut that one out.

[380] In terms of neonatal transport services, we all remember the Bliss presentation here a couple of months ago in the Senedd. Fifteen months have passed since the funding for the 12-hour neonatal transport service was announced by the Minister, and it is not yet up and running. In your view, to what extent is the delay in implementation due to workforce constraints, and how confident are you that recruiting to these key posts will be successful? That is directed at you both, really.

[381] **Dr Matthes:** I am very frustrated by the delays as well. The business case was signed off by the Minister in December last year, so it is two or three months down the line. The body that is responsible for implementing the recommendations is Health Commission Wales, and it holds the purse strings.

[382] **Darren Millar:** The evidence we received from the ambulance trust said that the case was yet to be signed off. Clearly, the Minister has made a decision.

[383] **Dr Matthes:** No, I think that is a different issue.

[384] **Darren Millar:** Is it?

[385] **Dr Matthes:** The question of which ambulance service provider will provide the service has not been decided, but the business case was signed off by the Minister in December. Once Health Commission Wales gives the go-ahead to the LHBs that they can have the money to recruit, I am sure that everyone will be very happy to try to recruit.

[386] How successful will we be? I think that we will recruit the nurses. I think that we will recruit some of the consultants, but maybe not all immediately. In terms of ANNPs and middle grades, there may be local solutions to how we implement that. I think that everyone is raring to go, really.

[387] **Darren Millar:** If everyone is raring to go, what has been the problem? We still do not even have this formal clinical network set up either, do we? Again, this decision was made at the end of 2008. The Minister clearly wanted to push forward with this, but for some reason, somewhere along the line, it has not happened—either in terms of the transport, the development of the database or the formal clinical network. We know that there are informal arrangements, but there is nothing formal. Have you any idea as to what the delay has been caused by? It is obviously not ministerial inertia, because the Minister is making these decisions when things are presented to her, or it would appear that way to us. We will ask the Minister herself next week, but do you have any take on this?

[388] **Dr Matthes:** One of the difficulties with the service is that it has not benefited from investment over the years, and is under a lot of pressure. Trying to find a solution to

implementing a transport service took a bit of thrashing out in terms of how best to do this without destabilising everything. That took a while with the business case.

11.10 a.m.

[389] As I said, the business case was signed off in December. The ministerial funding was £2 million for the transport services for north and south Wales, plus the database and the network. One of the problems has been that the moneys have got tangled up with another £500,000 of moneys, which were to fund cots in Gwent and Swansea, which we thought were recurring but are apparently now non-recurring. So, we have had a little bit of a debate about what to do about that issue, which has taken a little while. We re-examined the business case to see whether we could deliver it in any other way or cheaper, but there was no way that we could do that. So, we still have the cost pressure of £500,000 on the cots.

[390] As I said, Health Commission Wales holds the purse strings. I understand that it will advertise the network posts imminently. With regard to the purchase of the database and equipment for the transport service, we are trying to achieve this before the end of the financial year because we would like to use some of the slippage moneys, of which there must be a vast amount. I have to say that the mechanisms for achieving some of these things do not seem to be very easy to sort out either. I think that everybody is frustrated by the delays. We just hope that things can start moving quickly now.

[391] **Darren Millar:** Thank you for that. I have one final question. Something that you both say in your evidence is that there are challenges and that they need to be risk-managed because we obviously need to provide safe maternity and neonatal services but you are not sure whether they are safe at present. Is that a fair assessment of what you have said? For example, I think that you note in your paper, Dr Matthes, that you have written to HCW on two occasions to say that there are shortages and pressures in terms of cot numbers and capacity. The Wales Neonatal Network sent letters in March 2009 and April 2009. What were the responses of HCW? You have mentioned this £500,000 for extra cots in Gwent and so on, but clearly you were concerned at that time about safety.

[392] **Dr Matthes:** I wrote on behalf of the Welsh Neonatal Committee because we perceived that we had a bit of a crisis. The problems were many and impacted one on another. We had cot shortages, we had middle grade shortages, and we lacked an effective transport service to get babies from one place to another. We also had pressure on the labour wards so that, sometimes, even if there was a cot available for a pre-term baby in, say, my unit you could not get the mother on to the labour ward. So, we had all of these pressures.

[393] Those letters were sent to flag up those issues. By the time of the second letter we had the results of the survey from March 2009, which I alluded to earlier, which showed that we had had 70-odd cases where we either could not accept an in utero transfer or a postnatal transfer at the lead centres in Wales.

[394] I had an acknowledgement of the first letter. I do not think that I had anything in response to the second letter. However, I have to say that, after that, I was told by one of the commissioners that the responsibility for neonatal services was being moved at that time from HCW to the Children and Young People's Specialised Services. So, we were sort of left in limbo but then, on the other hand, we had the ministerial announcement in December and then we worked on the business case.

[395] **Darren Millar:** You also make this point about 500 women or babies being displaced per annum as a result of the inadequate resourcing.

[396] **Dr Matthes:** That is just scaling it up from a month to a year.

[397] **Darren Millar:** Finally, what should the priority be? What clear recommendations would you like to see coming from this committee? If you can both answer that question that would be great.

[398] **Dr Matthes:** We want the business case expedited and money released. I think that the next priority is that we need to have more cots funded, particularly in the high-dependency sector. I think that we are looking at 12 high-dependency cots across Wales.

[399] **Dr Dawson:** I absolutely endorse what Dr Matthes has just said. Dr Matthes and her colleagues and I and my colleagues are working to keep maternity services as safe as they can possibly be at the moment. Nevertheless, everything that your committee is discussing is about reducing risk, and I think that we should be frank about that. Certainly, I know that my colleagues would welcome a more flexible and responsive neonatal service, one that we would like to work with, rather than one we find ourselves occasionally in dispute with. We want to work towards the benefit of the women and their babies, keeping that entirely as our focus.

[400] **Lorraine Barrett:** May I ask for clarification of one thing?

[401] **Darren Millar:** Yes, of course.

[402] **Lorraine Barrett:** Dr Matthes, you said that we are probably in need of 12 high-dependency cots. Would those be in addition to an extra six or seven intensive-care cots?

[403] **Dr Matthes:** We do need another six or seven intensive care cots as well. You can staff a high-dependency cot with three-and-a-half nurses, whereas an intensive-care cot requires five nurses. I suppose that, in a way, it is the same whatever you do. We need both, but what we can achieve with the amount of money there is I do not know. If I had to choose I would go for high-dependency cots. In an ideal world, yes, let us have it all.

[404] **Lorraine Barrett:** Okay. Thank you.

[405] **Darren Millar:** Thank you for your evidence today. We really appreciate the oral and written evidence that you have provided. We look forward to an exchange of information with the health board in your area just to clarify some of the issues that we heard about this morning.

[406] You will be sent a copy of the transcript of today's meeting. If you want to add anything further to that information to supplement it, please feel free to do so. Thank you very much.

[407] **Dr Matthes:** Thank you.

[408] **Dr Dawson:** Thank you.

[409] **Darren Millar:** Just before I bring the meeting to a close, I would like to note that our next meeting will start at 9 a.m.. We will close the meeting there.

Daeth rhan gyhoeddus y cyfarfod i ben am 11.18 a.m.
The public part of the meeting ended at 11.18 a.m.