Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

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

Dydd Iau, 25 Mawrth 2010
Thursday, 25 March 2010

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These proceedings are reported in the language in which they were spoken in the committee. In addition, an English translation of Welsh speeches is included.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Lorraine Barrett	Llafur Labour
Peter Black	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Andrew R.T. Davies	Ceidwadwyr Cymreig Welsh Conservatives
Irene James	Llafur Labour
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

Simon Dean	Cyfarwyddwr, Strategaeth a Chynllunio, Cyfarwyddiaeth Gyffredinol Iechyd a Gwasanaethau Cymdeithasol, Llywodraeth Cynulliad Cymru Director of Strategy and Planning, Health and Social Services Directorate General, Welsh Assembly Government
Dr Iolo Doull	Paediatregydd Anadlu Ymgynghorydd; Llywydd, Cymdeithas Pediatrig Cymru; a Swyddog Cymru, Coleg Brenhinol Pediatreg ac Iechyd Plant Consultant Respiratory Paediatrician; President, Welsh Paediatric Society; and Officer for Wales, Royal College of Paediatrics and Child Health
Stuart Fletcher	Cadeirydd, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru Chair, Welsh Ambulance Services NHS Trust
Dr Andrew Goodall	Prif Weithredwr, Bwrdd Iechyd Lleol Aneurin Bevan Chief Executive, Aneurin Bevan Local Health Board
Edwina Hart	Aelod Cynulliad, Llafur (y Gweinidog dros Iechyd a Gwasanaethau Cymdeithasol) Assembly Member, Labour (the Minister for Health and Social Services)
Rosemary Kennedy	Prif Swyddog Nyrsio Chief Nursing Officer
Elwyn Price Morris	Prif Weithredwr Interim, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru Interim Chief Executive, Welsh Ambulance Services NHS Trust
Rebecca Robson	Rheolwr Swyddfa, Coleg Brenhinol Pediatreg ac Iechyd Plant Office Manager, Royal College of Paediatrics and Child Health

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

Sarah Hatherley	Gwasanaeth Ymchwil yr Aelodau Members' Research Service
Marc Wyn Jones	Clerc Clerk
Sarita Marshall	Dirprwy Glerc Deputy Clerk

Dechreuodd y cyfarfod am 9.08 a.m.
The meeting began at 9.08 a.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **Darren Millar:** Welcome to today's meeting of the Health, Wellbeing and Local Government Committee. I would like to welcome any members of the public and witnesses who have joined us for today. I remind everybody that headsets are available for simultaneous translation and amplification. If anybody has any problems using these, they should indicate that to the ushers and they will be able to provide assistance.

[2] Committee members and members of the public may wish to know that simultaneous translation is available on channel 1, while channel 0 is for the actual language being spoken. I would be grateful if everybody—Members and members of the public—could ensure that mobile phones, BlackBerrys and pagers are switched off so they do not interfere with the broadcasting and other equipment. If it is necessary to evacuate the room and the public gallery in the event of an emergency, then everybody should follow the instructions of the ushers who will be able to guide you to the appropriate exit. Finally, I remind everybody that the microphones are operated remotely and it should not be necessary to press any buttons to activate them.

[3] We have not received any apologies for this morning's meeting. It is a delight to see Irene James returning to the committee after her absence. Welcome back, Irene.

[4] **Lorraine Barrett:** After very good NHS treatment.

[5] **Irene James:** It was exceptional NHS treatment.

[6] **Darren Millar:** She is looking very well. I invite Members to make any declarations of interest under Standing Order No. 31.6. I can see that there are none.

9.09 a.m.

Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru—Y Wybodaeth Ddiweddaraf am Faterion Gweithredol
Welsh Ambulance Services NHS Trust—Update on Operational Issues

[7] **Darren Millar:** This is a special scrutiny session on the Welsh Ambulance Services NHS Trust with an update on its operational issues. Members will be aware that the chief executive, Alan Murray, has announced his retirement, so I am delighted to welcome this morning Stuart Fletcher, chairman of the Welsh Ambulance Services NHS Trust, Elwyn Price Morris, the interim chief executive, and Dr Andrew Goodall, who is the chief executive of the Aneurin Bevan Local Health Board. Welcome, gentlemen, to the committee.

[8] We have not had a paper as such this morning, so if witnesses are content we would like you to make some opening remarks, and then we will open the floor to questions. I do not know who wants to start. Stuart?

[9] **Mr Fletcher:** Yes, thank you, Chair, perhaps I could make a few introductory remarks. The good news this morning is that I believe that the trust at the moment is very much on an upward curve and we are approaching the end of what has been, I believe, quite a successful year, particularly in performance terms. Our performance during the year has been consistently improving. September was the best ever month in the history of the trust, October the best October, November the best November, and December, despite the snow, the best December. January was the second best January. The February figures have not yet been published, but again are very good—we hit over 65 per cent—and in March, to date, we are about 70 per cent overall. As of today every local health board area, including Powys, I am pleased to say, is actually over 60 per cent.

9.10 a.m.

[10] So, I think that that represents quite a sustained improvement and reflects all the changes that the trust has been introducing over the past year—particularly changes to rotas and our control, and as a result of the benefits of new technology. Over the last two to three months, we have been able to introduce automatic vehicle location systems and mobile data in all our emergency medical vehicles. The process is not quite finished yet as regards our patient transport service vehicles; nonetheless, we are now seeing the benefits of the technology.

[11] During the year, we also had an efficiency review undertaken by an independent firm of consultants, Lightfoot, which I think is the premier firm in the UK on ambulance service performance. We agreed with our commissioners that both sides will be bound by the results and you may wish to discuss the findings later. In general terms, what the review showed was that the trust clearly needed to improve in a number of ways, but if it was to hit its targets consistently it needed an increase in revenue of about £4 million. During the year, we have also been able to purchase an additional £3 million-worth of vehicles.

[12] So, overall, we recognise that we still have a long way to go if we are to provide the people of Wales with a standard of ambulance service of which they can be proud, but I think that this year has seen, for the first time, an upward trend in the overall performance of the ambulance service.

[13] **Mr Morris:** I would like to add just two aspects to that. First, all that Stuart has described there is set in the context that the trust is forecasting financial balance for the end of the year. It is remarkable for the trust to have had that performance improvement and to have been able to manage its resources in such an effective way.

[14] The other part that I would like to add is that the Welsh ambulance service is obviously a partner in NHS Wales. Certainly, from my perspective, there has been increased and improved joint working between the trust and, latterly, the local health boards on key issues such as handover and unscheduled care.

[15] **Dr Goodall:** Just to clarify, I am here as a chief executive representative and I really support Elwyn in the way that he views the recent months. There have been changes to the new structures to try to create a different relationship, really recognising that the structures are irrelevant for the patient's experience and that, when people come into a hospital environment, we have a responsibility to make sure that crews are released quickly. So, I think that there are already lots of opportunities for us to work differently with the ambulance

service. In Aneurin Bevan Local Health Board, which is the area that I cover, I have certainly drawn the ambulance teams into my own team, so that they are working on a multidisciplinary basis. I have my own contact points with the ambulance service and I meet weekly with them to review the performance of the week before. Over the recent weeks and months, we have been able to demonstrate that the ambulance handover figures have improved, that we have been able to release crews far quicker, and that the average times that ambulances are waiting are now reducing.

[16] This is really just to represent that it is about getting the whole system lined up around emergency care and not just about what happens between an accident and emergency department and the ambulance service. Members may want to get into that more during the course of this discussion.

[17] **Darren Millar:** Thank you very much for those opening remarks. Peter Black?

[18] **Peter Black:** I will just ask a few questions about finance and, in particular, the efficiency review. You reported just now that the efficiency review identified that the ambulance trust needed just over £4 million to get back on track and to deliver all that was expected of it. To what extent has it now been agreed with either the Government or Health Commission Wales that you will actually receive that cash?

[19] **Mr Fletcher:** Elwyn, would you take that one?

[20] **Mr Morris:** This £4.2 million was identified as the residual financial gap needed so that the trust could move forward with the developments required to improve and modernise. That resource has been negotiated and discussed with HCW on behalf of the local health boards, and the finance teams of the trust, HCW and the health boards are working together now to ensure the mechanism by which that resource can be put into the trust's allocation for 2010-11. At this moment in time, I see no reason to believe that that will not be anything other than the case.

[21] **Peter Black:** Have you been told you can have that money?

[22] **Mr Morris:** The discussion is under way as to how that money will be put into the trust and, as I say, we have no reason to believe, from our discussions with HCW or with colleagues in the department, that that resource is not going to be made available at the start of the year.

[23] **Peter Black:** To cover the gap and to deliver on your targets this year and in previous years, I understand that you have also had to make savings of recurrent and non-recurrent items. What impact have those savings had on your overall budgets and what will the impact be for future financial years? Are there things that you are going to have to catch up on?

[24] **Mr Morris:** I think that it is important to recognise that the financial position of the trust is predicated on both income and efficiency, but for 2009-10 there was also the question of supporting the HCW service change and efficiency plan, and also the historic repayment to the Welsh Assembly Government. The trust was excused responsibilities against those in this year, which has certainly been helpful in allowing it to perform to the degree that it has. Clearly, into next year there is the £4.2 million that we have discussed, which is critical income for the organisation, but it also recognises that there will be a gap between the allocation by the Assembly, which is seen as 0.75 per cent, whereas in likelihood we are going to have to look at a 3 per cent CIP programme.

[25] Efficiency savings are already in planning and they amount to very nearly £5 million, so we recognise as an organisation that we have to be very clear about our secured income for

the year. If that secured income is not in place, obviously that will impact on our ability to deliver against our performance requirements. There is a link between performance and our relationship with the Welsh Assembly Government on funding, particularly in relation to the historic repayment. An arrangement has been made where the £2.9 million a year repayment will be abated by one third over the next three years to support the trust, providing that the headline performance figures are met. So, we have a jigsaw puzzle to bring together to secure financial information and planning.

[26] **Peter Black:** I was not asking about that particular aspect. I was talking about the savings you have made in this financial year and the previous financial year to try to improve your service. I understand that you have had to delay capital expenditure and that you may have had to delay training. Is that the case? If it is the case, what are the implications for future budgets?

[27] **Mr Fletcher:** It is a lot like any other health organisation: the trust has had to make efficiency savings over the years and we expect that we will have to continue to make those. No organisation is 100 per cent efficient and we will continue to make savings. As Elwyn said, we have already identified savings for next year. It will not be easy. Yesterday, the board had a development day when we went through, in great detail, the savings that we will be making over the course of the next year. We do not regard ourselves as different from any other health organisation in that respect. What the efficiency review did demonstrate, however, was that by and large the trust expenditure is in line with the standards that will be expected for that investment, except for the £4 million.

[28] **Peter Black:** So, what is the impact of this delayed expenditure on your next year's budget?

[29] **Mr Fletcher:** I think that it is too early to say what the impact is going to be. I would fully expect us to continue to meet the standards.

[30] **Peter Black:** If you are delaying training and capital purchases, that means that you will have to do that training and make those purchases next year. Will that not cause you further problems in balancing your budget?

9.20 a.m.

[31] **Mr Morris:** I do not think that one can isolate the financial position without understanding the measures that the trust has taken to modernise and improve. If one looks at, for example, the training and recruitment process, there is now a very comprehensive programme in place in relation to new technicians, paramedics, specialist paramedics, and getting those people into posts. Those sorts of measures will help to release staff to go into training. We do recognise that training has been difficult this year because rotas have had to be filled. The level of overtime, in our view, is still too high and needs to be brought down. So, there has to be a rebalancing, and that has to be a combination of good financial housekeeping, being efficient and effective and modernising through programmes of work.

[32] **Darren Millar:** Stuart, on the Lightfoot report, when was it completed? How long have you had it in your possession?

[33] **Mr Fletcher:** The report was published by the Minister just before Christmas.

[34] **Darren Millar:** It was published just before Christmas, and you still have not been able to agree. We are now just a few days away from the end of the current financial year. I appreciate the confidence that Mr Morris has indicated that he has about having the extra £4 million for the next financial year, but we are a week away and you have not had agreement

since December, despite the fact that you suggest that there was agreement up front that everybody would be bound by the outcome of that report. Why is that agreement not already on the table? From an operational point of view you need to know now, do you not?

[35] **Mr Fletcher:** Yes, we do need to know and my understanding is that the directors of planning in the health boards have been informed that that money has to be made available through the commissioner to the trust. As Elwyn said, no decision has been reached. At the moment we have no reason to believe that that money will not be made available, but we cannot say that it will be.

[36] **Darren Millar:** Okay. Thank you.

[37] **Andrew R.T. Davies:** Thank you very much for coming in this morning. We are very grateful for that. I just have a point of clarification. You have been asked twice now about this £4.2 million, and what I am hearing from the witnesses is that you are working through the delivery of it. Stuart, I think that you have said that the commissioners in the LHBs have been told that they have to make this money available, but there does seem to be a little bit of doubt as to whether it is actually going to come in. You do not seem to be able to say, ‘We are having it.’

[38] **Mr Fletcher:** Well, I guess I was always taught that you never believe it until the cheque is in your hand.

[39] **Andrew R.T. Davies:** The commissioners have been told that they have to find it, and you are working out the route. Are you able to say that you will have that in your budget for next year?

[40] **Mr Fletcher:** Well, the answer is ‘no’, I cannot give you a categorical assurance at this moment in time. Like Elwyn said, the discussions are going on between the various directors of finance, and the planning directors have been told that money must be made available, but I cannot give the committee a categorical assurance this morning.

[41] **Andrew R.T. Davies:** We are seven days away from the end of the financial year. Going back to the ambulance service, it was good to hear about the progress the ambulance service has made. In particular, I was grateful when Alan, Marie and you, Stuart, showed me around the Cwmbran centre. To see the dedication of the staff there and their multidisciplinary approach to their work was heartening to say the least.

[42] Sadly, as politicians, we have seen figures not being hit, as it were, in particular in Andrew’s area in Monmouthshire, for example. I get letters time and again as shadow spokesman for the Monmouthshire area that talk about 42 per cent target rates being hit. It really is excruciating to see the work that has gone on not actually hitting the front line, as it were, and those figures not starting to be hit.

[43] You have talked about improvements in the service and the remodelling of the service. I think that you in particular, Andrew, talked about how you are working on a constant basis and the fact that you talk to your managers. Could you give us a taste, in order to give us confidence going forward, that this remodelling is happening on the ground? What specifically is going on to make that improvement?

[44] **Dr Goodall:** As I said, firstly I do not think that it is always just about the point where the accident and emergency department meets the ambulance service. I think that there are a range of different things that we have tried to do. Some of those have taken place over the last year and a half, but particularly over the last six months or so.

[45] One thing that really does support it is our out-of-hours service and recognising that for two-thirds of the week we rely on a different kind of relationship with the ambulance service and the links there. You mentioned going over to the centre in Cwmbran. We have co-located our out-of-hours service alongside the ambulance service, not least in the control room, so there are shared experiences there but also ways in which we can define different ways of supporting patients in the community, who often do not need an ambulance vehicle but do need access to alternative services.

[46] On an operational level, I think that we have really had to emphasise that this is a target for all of us, because the patient experience is the most important perspective. There is often a danger in relation to structures that people try to deny responsibility for targets. From my perspective, the responsiveness targets for my area, the ambulance handover targets and the accident and emergency targets are all targets that my organisation needs to meet and support. So, as a practical example, on any shift there is always a shift leader, who is a nursing member of staff who will take responsibility for dealing with the ambulance handover as people arrive into the system.

[47] We have also been trying to look at different ways of communicating, not least in the ways in which paramedics can liaise with some of our clinical staff, and changing some of those areas. The biggest challenge with regard to how you remodel the services is how, when that first call comes into the ambulance centre, you can get them to access the alternative service, whether it is a community-based service, whether it ties into district nursing or health visiting, and so on, and just finding a different way. On the ambulance service's statistics, we know that a lot of the patients who arrive in an accident and emergency department did not necessarily need that kind of care. So, a lot of this for me is about single call centres, triaging people and signposting them to the individual services. Those are the types of discussions that we are having about our plans.

[48] On the responsiveness, I had my board meeting yesterday, and we report the ambulance responsiveness times ourselves, of course, alongside all of the other measures. Obviously, we have similar concerns about where we are not hitting them in our individual areas. This month it is pleasing that we have seen that all the areas in Gwent have managed to demonstrate improvement. I would hope that a contributing factor there is that we have been able to focus on the four-hour target, have got our performance in respect of the responsiveness rate up in the region of 90 per cent and above during March, and have got very close to the target of 95 per cent, but our handovers particularly have really improved over the last four months or so. So, by getting ambulance vehicles back on the road, we are doing our part to help the ambulance service responsiveness.

[49] **Mr Fletcher:** The figures for February have not yet been published, but the figure for Monmouthshire was over 60 per cent in February and the figure for March, to date, is over 60 per cent. We have been able to put an additional RRV up in Abergavenny, which has helped. I did have a meeting last week with Mr David Davies, the Member of Parliament for Monmouth, and went through the issues with him. I am meeting him again this afternoon, as it happens, in Cwmbran and he is going out in an RRV this afternoon, so he will have first-hand experience of the service.

[50] **Darren Millar:** You were expecting to lamp him one or something; is that what is going to happen? [*Laughter.*] So, he is going to need the attention of an RRV.

[51] **Andrew R.T. Davies:** We have heard about the improvements that have gone on, which are welcome, because we all want to see a fast and responsive service. Elwyn touched on the £5 million worth of efficiency savings—which everyone seems to call everything these days when you are putting less money in. So, what sort of impact would the £5 million that you have taken out of your budget for next year have on sustaining these improvements that

the LHBs have worked with you on? Could you give us an idea of what has to go that is making up that £5 million in efficiency savings? Obviously, as a politician, it worries me that there was £5 million in the system that could be classed as efficiency savings. You wonder what it was doing in the last budget.

[52] **Mr Morris:** Clearly, any organisation has a statutory responsibility to balance its books. The allocation that is coming into the trust and, indeed, across NHS Wales next year presents an initial challenge in respect of the difference between the uplift and inflation and so forth. So, part of the process for the organisation is to look at efficiency measures, good housekeeping and so forth, and not to go towards front-line services but just behind the general management of the organisation in order to try to bridge that cost improvement gap.

[53] As for what could be done if a £5 million pot was available, the first thing to say is that the efficiency review did identify that there needs to be a three-year programme of development, because not everything can come on stream at one moment in time.

9.30 a.m.

[54] What is important for the trust working with its partners is to make sure that, for this coming year, we have a very clear set of service objectives and improvements that we want to put in place that we can resource. So, that is the approach that we will be taking, ensuring that we are secure in the income that we have, to make sure that all of the investment and expenditure that we make is justifiable and inescapable, and to then make sure that our modernisation programme is supporting that.

[55] If additional resources came into the organisation I am sure that our regional directors would look with great interest at that. The reality is, though, that we are working within a financial environment that means that the organisation will, of necessity, need to take some steps to tighten its belt, but that is not the same as to say that we do not intend to press forward with our plans for the year. A lot of things come together in that, and we have discussed some of them today.

[56] I go back to the point that Andrew and I are making about the importance of joint working, because working together releases resources for the Welsh ambulance service to put into front-line services.

[57] **Andrew R.T. Davies:** So, is the budget that you have—with your £5 million of efficiency savings and, hopefully, the £4.2 million that will come in as identified by the review—the budget that you, as the directors of the service, require to deliver a sustainable emergency service here in Wales that is comparable to other parts of the United Kingdom?

[58] **Mr Morris:** The challenge for the trust next year will be, with the resource that it has, to meet its statutory financial duties, and we will set out a programme of modernisation that we intend will maintain the positive improvement that we have had to date. That will be moved forward.

[59] **Andrew R.T. Davies:** I accept that, but the original question was this: will the budget that you have allow you to deliver on the improvements, and to sustain those improvements, to be a reliable emergency service comparable to other parts of the United Kingdom? Yes or no.

[60] **Mr Fletcher:** That is the challenge that we have. Clearly, in making savings, we will absolutely attempt to protect the front line. We intend to make major savings in the management of the trust. Our management costs are already low; I think that we are the second lowest in the UK. We intend to take further savings out of there.

[61] Elwyn mentioned additional staff. In fact, one of the difficulties that we have had in the past is that we have had to rely far too heavily on overtime. We have 19 per cent overtime, which is far too high. By appointing additional staff, we can reduce the costs simply by employing more staff at plain-time rates. So, again, we can make further savings in that way.

[62] I just repeat that the intention of the trust is to make sure that we protect the front line, the front-line service and the front-line standard of service.

[63] **David Lloyd:** I want to home in on some coalface-type operational issues. You have alluded to the handover and I will start off on that one, on the interface between the ambulance and accident and emergency departments, just to flesh out a little more of what is happening.

[64] I am pleased to hear about improvements. In my days as a junior hospital doctor, long ago in the last century, patients used to arrive at hospitals and go into hospital straight away. It was the duty of the junior hospital doctor on call to find the beds, and we did not have ambulances sitting outside accident and emergency departments. Then, in recent years, with the establishment of trusts, we had a change of responsibility, if you like, so that responsibility ends up with the ambulance service if there is no capacity within accident and emergency departments.

[65] I realise that there is an issue about liaison nurses and liaison ambulance officers and all the rest, but what talks are going on about having a rethink about whose responsibility it is at that interface? In general terms, patients are better off inside a hospital than just outside it. So, what talks are going on about the possibility of reviewing whose responsibility it is for the care of patients just outside an accident and emergency department? That is the first point.

[66] My second point applies both to local health boards and to the ambulance trust, on the whole issue of what patients do when they are ill out of hours. People seem to think that they should know what to do, but, in a panic situation, people do not know what to do and they tend to ring an ambulance inappropriately, one might say. So, what work is going on? Even if it is just advertising the number of NHS Direct or your combined call centre number—all that sort of combined work is the way forward—people need to know how to access that in a panic situation, on bank holidays and weekends, and in the middle of the night. Akin to that is any work that you are doing as regards the still quite high percentage of unwarranted 999 calls.

[67] My final point is about what work is going on to free up ambulances for GP admissions—not routine GP admissions but when a GP requests an urgent ambulance. It sometimes takes several hours to find an ambulance for a GP urgent admission request. So, how do you focus different parts of the ambulance/health board interface?

[68] **Darren Millar:** Do you want to start, Dr Goodall?

[69] **Dr Goodall:** Yes, perhaps I could start on a couple of those and then Stuart can pick up the last two in particular.

[70] On responsibility, I found it fascinating looking at the targets, because I am quite clear on it. It is our responsibility as an organisation to ensure that, when patients arrive at the hospital, they are taken in, that they receive the appropriate services and that we move them to the available bed as soon as possible.

[71] The issue that people sometimes worry about is where there are some professional concerns around that, but that is why I have tried to abandon any concerns around the

structures. For me, the ambulance service staff are part of my multidisciplinary team. They are part of my formal weekly meetings. They are part of the daily operational set-up and the meetings that occur. I am reliant on them to also support the discharges that I need to send out into the community, where we liaise proactively. If you are asking at what point that responsibility kicks in, I have been very clear in my time to say that I have the responsibility when that vehicle arrives on my site. I think that we need to continue to monitor it and make sure that performance, therefore, reflects that perspective.

[72] As for the out-of-hours situation that you described, where people will revert, if you like, to calling 999 because they do not really understand the full range of services, this is where combining some of our call centres and the triage approach linking into the way our out-of-hours service facilitates issues is the way of providing support. Across Wales, what we are all doing is developing a range of community-based services, where care co-ordination is at the root of it. These are people, of course, who have illnesses and conditions that will deteriorate, but, in the more traditional way, they would probably end up ringing 999 for support. What we are trying to develop, and we are doing this ourselves within Aneurin Bevan, is the single point of contact—the care co-ordinating role—so that, if somebody does ring and we feel that they just need to have a district nurse visit maybe, or some specific kind of support, we can target that support. However, importantly, if it is an emergency situation, we need to recognise that and make sure that they can access the 999 vehicles when appropriate. It is not just my area in Wales that is developing those plans. I am aware from my chief executive colleagues that they are now comprehensively being presented across Wales to deliver the community-based alternatives.

[73] I do think that the co-location of out-of-hours services in itself is one of my big opportunities in Aneurin Bevan, because people are literally looking at each other over their consoles. We can make sure that communication works more effectively there.

[74] **Mr Fletcher:** There is no doubt in my mind that what we have in Cwmbran is the nucleus of a future clinical contact centre. We are working with Andrew Goodall and others to try to achieve this because, at the end of the day, the ideal situation would be to have one point of contact. In the call centre, we have call takers who are employed by the Gwent out-of-hours service and we have our call takers. Our vision is that we will move towards having generic call takers.

[75] In the short term, when people phone up and it appears that it is not an immediate category A or B call, calls that are not life threatening or serious, rather than immediately send an ambulance, they are triaged by the nurses in NHS Direct Wales. That has shown in recent months that they are triaging well over 1,000 calls a month and only sending back a very small percentage to the blue-light service.

9.40 a.m.

[76] Obviously, if the patient does not need an ambulance but may need a doctor, they are also able then to fairly quickly transfer that call over to the out-of-hours service.

[77] So, I think that building on that is the way forward to make sure that the ambulances are available for only those calls that do need them. The other issue for us is making sure that when we do get to calls, that we transport as few patients to hospital as necessary. At the moment, we transport about 72 per cent of patients to hospital. In some trusts in the UK that figure is in the high 50s. So, in fact, what we need to do is to continue to skill up the workforce to make sure that we take fewer patients to hospital. We are doing that at the moment through our specialist practitioner programme, so we are now transporting fewer patients to hospital, but clearly that does depend, as Andrew said, on the whole-systems approach and making sure that there are additional care pathways available. They are

gradually coming on stream. In Powys now, for example, we do use a falls pathway that has stopped patients from going on very long journeys unnecessarily, say, from Builth to Hereford. So, that again is coming on stream.

[78] To answer the last question, which was about the GP urgent calls, one of the standards that we do have is to get GP urgent calls to hospital within 15 minutes of the time that the GP has requested. So, we would have contact with the GP and the GP might say, 'I would like this person in Merthyr within the next two hours'. Our standard is to get those patients in within 15 minutes of the agreed time. At the moment, we achieve that between about 75 and 80 per cent of the time.

[79] We are doing that by trying to make sure that the high dependency service vehicles and other vehicles are kept for that type of service, which we do recognise as a priority. It is sometimes said to me by the crews that, in fact, the GP urgent calls, by and large, involve patients who are often more unwell than the patients that they transport under the category A 999 call. So, we do recognise the importance of that category of patient.

[80] **Mr Morris:** We spend an awful lot of time concentrating on the front door of the hospital because of the accident and emergency question. One of the things that the trust is very mindful of is the supporting role that it can provide to hospitals in discharge so that the system is actually released up. That has to be a part of our core business in support.

[81] On the very important point about how we get the message across to the public about alternative pathways, there is no point in the NHS putting these pathways in place if we cannot get the message across to the public that they are there. There is certainly a public engagement programme now that we need to put in place that communicates this because we are making alternative pathways available.

[82] Finally, on the patient care service, as a general point the trust recognises the importance of getting the right model here and a director is now in place who has lead responsibility for developing that in partnership with the hospitals and the health boards.

[83] **Helen Mary Jones:** I have three sets of questions, one predominantly to the ambulance trust itself. One of the issues identified as a problem in previous inquiries relates to what some front-line staff have described as a fairly aggressive, bullying management culture related, I think, to a lack of capacity in front-line managers. There was a time when those front-line managers were being promoted, but then not given any management training. Anecdotally, it seems to me—because I am not getting unhappy paramedics in my surgery—that that is beginning to move on and change, but I would be interested to hear your comments on that.

[84] To both sets of witnesses, one of the issues that have been identified as a problem when it comes to handover and so on is that the separate services are working to different targets that are sometimes not compatible. So, there is the four-hour accident and emergency wait, and you can understand how if you are the admitting manager and you know that you are not clearing people out within the four hours and that you have people in an ambulance, it could be tempting not to clear them as fast as you might. I am not saying that anybody is doing that deliberately, but we know that that does happen. Conversely, the ambulance service targets are about turnaround times and getting back out on the road. Would you both feel that there was any merit in the Government doing some work to ensure that when it is setting new targets that they are compatible across the services?

[85] Finally, you mentioned, Dr Goodall, having the ambulance service staff sitting round as an integral part of your team. Would it possibly be simpler if they did just work for you? The other half of that question is to the ambulance trust. Could you set out for us what the

advantages are of having a national service? The ambulance service is one of the few services that have not yet been integrated into the local health boards and yet, of course, when it did work as part of the previous health authority regime there were some issues. So, I am slightly playing devil's advocate here. Would it not be better for you, Dr Goodall, if they did actually work for you but, on the other hand, what are the advantages from the trust's point of view of being able to run a national service?

[86] **Darren Millar:** I ask witnesses to be brief in their answers. We are up against the clock now, but it is important that we get this evidence on the record. Stuart, do you want to start?

[87] **Mr Fletcher:** I will start off in relation to the issue of aggressive and bullying management. We have recently undertaken a staff survey. I think that we are the only trust or health board that has done it in the last year. I wish that I could say that the situation had improved considerably. It has not, so there is still, as far as I am concerned, an issue of concern as regards how staff perceive things.

[88] Having said that, we are working very hard to attempt to improve matters. We have the NHS Centre for Equality and Human Rights working with us. We now have a values document and a staff charter. We have put a considerable amount of effort into training our managers. We now have clinical team leaders in place who are mentoring the staff. So, if there are any issues for the staff, they can be raised with the clinical team leaders directly. The majority of the staff now have personal development reviews, which they have not had in the past. So, this is an issue that we are taking very seriously. There are some indications of improvement, but we still have a long way to go. It is an issue that the board takes very seriously indeed.

[89] **Dr Goodall:** In respect of the four-hour target and handover, I think that there may have been a danger of them running into each other in the past. From my personal perspective, if I am able to meet the four-hour target, it means that the ambulance handover target improves too, because it means that I have capacity and flexibility in my department. So, I actually see them as complementary rather than opposed.

[90] As far as the structures are concerned, I think that the most important thing is how you get the operational front-line staff working together in the teams. To be quite honest, the structural issue over and above that should not really matter, and that is what I have been focusing my own time on.

[91] **Helen Mary Jones:** What are the advantages of a national service?

[92] **Mr Morris:** I think that I would answer that in two parts. The first part is that as a national service it can provide a focus on ambulance services and a very clear national voice on a very important subject area that might otherwise be lost in the generality of NHS services. I think that it can also provide leadership across Wales on the development of unscheduled care, which is a helpful position to be in because of the locality dimensions that the other health boards will be working on. I think that the trust needs to take that forward.

[93] I think that it also allows for there to be some standardisation of standards, conditions, outcomes and so on. We talked about postcode variation and so on. Working on an all-Wales basis, there is now a record developing of the trust being able to apply plans locally against nationally set standards, which I think is an advantage, too.

[94] The efficiency review points to the economics of a large Welsh organisation, but the second part of it, for me, is that the criticisms of the past were levelled justifiably at the organisation not delivering on performance. Over the past two to three years, the performance

in modernising and improving is now showing results and those results are being delivered on a national level.

[95] **Darren Millar:** Thank you for that. Val Lloyd is next.

[96] **Val Lloyd:** I will be quick, Chair, because Dai Lloyd asked much of what I was going to ask. It is on the same material that has arisen from casework and delays. I think that my question is for Dr Goodall at this stage.

9.50 a.m.

[97] You gave us some interesting data on how you are approaching the delays. I would like to also put on record that when I do get casework issues, which is quite often, people always start off by commending the quality and kindness of the ambulance staff. I would like that on record. Of course, the delay is the issue.

[98] You gave us the instances of good practice that you are taking forward. Obviously, I do not work within your area, so how much is that shared across all LHBs?

[99] **Dr Goodall:** I meant to give you some reassurance. I am here representing my colleagues, although, of course, I can refer to the position in the Aneurin Bevan area. These are all relationships and good practice that we are sharing with each other. We have a national programme around unscheduled care that we are setting up to make sure that we share that with all of us. We will be monitoring it, so I and my chief executive colleagues have plenty of time to make sure that we share the information on where some of us have met the targets and improved it, and we bring it back to our local patch. We can give you those reassurances as we move forward.

[100] **Darren Millar:** That is good to know. I have just one final question as we bring this evidence session to a close. To what extent are delays in decisions further up the tree having an impact on your service? You mentioned the fact that, obviously, the automatic vehicle location system is now in place, which is excellent news and should lead to further improvements in response times. Of course, you waited for a long time for a decision on that. We know that the annual operating framework last year was signed off a long time into the year, and that has been a common issue. Now, of course, you have the delay in waiting for this decision about the £4.2 million. To what extent does that hinder opportunities for improvement in performance in the Welsh Ambulance Services NHS Trust? Stuart, can you give us some closing remarks as well in answering that question?

[101] **Mr Fletcher:** Obviously, we would have liked to have had the automatic vehicle location system a long time ago. Its benefits really are now being shown, frankly, in spades. At the moment, the only business case outstanding is one in respect of the north-east Wales make-ready depot. So, all our other business cases, including the vehicles, have been approved.

[102] Looking forward, as far as the trust is concerned, we now need to work with the new local health boards. Once we get performance to a sustainable level, we will need to look more widely at the whole issue of unscheduled care because I think that is where the key gains are going to be in the future. That means making better use of NHS Direct. Working with Chris Jones and the primary community care strategy is where I think the real improvements are going to be made.

[103] As far as the ambulance service is concerned, I think that we are moving more and more towards being a clinical arm of the NHS. I see our having more highly trained and highly skilled paramedics making a major impact on the delivery of unscheduled care in

Wales.

[104] **Darren Millar:** Excellent; okay. With those closing remarks, we will bring this part of the meeting to an end. Ann Jones, did you have something to add?

[105] **Ann Jones:** I just wanted to say, because of shortness of time perhaps we could write to you as individuals. I have a set of questions that would have taken at least half an hour.

[106] **Mr Morris:** By all means.

[107] **Darren Millar:** Okay. Thank you very much for your time this morning. We know that this meeting was arranged at pretty short notice, so we appreciate the fact that you have attended.

9.54 a.m.

Ymchwiliad y Pwyllgor i Ofal Newyddenedigol: Tystiolaeth gan Goleg Brenhinol Pediatreg ac Iechyd Plant yng Nghymru
Committee Inquiry into Neonatal Care: Evidence from the Royal College of Paediatrics and Child Health in Wales

[108] **Darren Millar:** We will now take evidence from the Royal College of Paediatrics and Child Health in Wales. I am delighted to be able to welcome Dr Iolo Doull—I hope that I have pronounced that correctly, but correct me if I am wrong—who is the Royal College of Paediatrics and Child Health's officer for Wales. You are also the Welsh Paediatric Society's president and a consultant respiratory paediatrician, if I have that right. I also welcome Rebecca Robson, who is the office manager for the Royal College of Paediatrics and Child Health in Wales.

[109] Welcome to our meeting and thank you very much for the evidence paper that you have already provided. The paper has been circulated to Members and we have had the opportunity to look at it. We will go straight into questions based on the evidence paper.

[110] You make reference in your paper to the increase in the birth rate and the impact that that is having on neonatal services. How effectively or ineffectively has the service been able to respond to that extra demand?

[111] **Dr Doull:** There is no real option but to respond to the birth rate. It seems to be a UK-wide phenomenon. Certainly, from the nadir in the late 1990s and 2000, the birth rate has come up, and that has had an effect. There are also societal effects in our expectations of what can be done for sick newborn infants. The changing demographics given the age at which mothers are now planning their families also has a knock-on effect on neonatal care.

[112] So, within the UK there has been this increase in demand and there have been major advances, such that when I was training as a junior doctor in paediatrics, our expectations of what we might see from a baby born, say, at 25 to 26 weeks' gestation are completely different to what we would expect now. That has a major knock-on effect on the workload.

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

[114] **Ann Jones:** Fifteen months ago, the Minister announced funding for a clinical network, but it is still not up and running. How important is the clinical network in helping to maximise cot occupancy?

[115] **Dr Doull:** I think that it is very important. As a college, we really welcome this. We are conscious that there are challenging financial times ahead, so to have £2 million of new money is clearly very important. As yet, the network is not up and running, but the process has been gone through. When times are challenging, people always try to fight for their unit, and perhaps that has not been good for network development because everyone is trying to maintain their service. I think that the establishment of the network has been very important because among the first things it has done is to concentrate people's minds on the fact that they have to work with their colleagues. I think that, in the last year or two, that has been a major development. So, though the network has not started yet, I think that some of the benefits are already there.

[116] **Ann Jones:** The British Association of Perinatal Medicine told us that an increase in high-dependency as well as intensive care cots is needed in Wales. Do you agree with that view and, if you do, where should those extra cots be placed?

[117] **Dr Doull:** As an individual, I am not a neonatologist, so I think that it is outside my remit to say how many cots there should be or where they should be. I would actually put the question back to you and ask where you see neonatal services being delivered in Wales. I think that that is a broader picture.

[118] **Ann Jones:** I know what I want, but that will not be what the Government wants.

[119] **Dr Doull:** There are major challenges. From a college point of view, I think that we want to highlight the challenges. We recognise that the £2 million is great and that there have to be more intensive care cots in Wales. The important point is that high-dependency cots are perhaps being underutilised because the baby is in the wrong place, but as to where and how many high-dependency cots there should be, I think that that is a broader question.

[120] **Ann Jones:** So, you do not agree that there should be an increase. Is that right?

[121] **Dr Doull:** No, I did not say that. I just said that I did not feel that I was capable of answering that properly.

[122] **Ann Jones:** All right. Thanks.

[123] **Peter Black:** You say in your written evidence that difficulties in transferring infants between units has often resulted in a blocking of intensive care cots by infants requiring high-dependency care. To what extent might the 12-hour neonatal transport service help to address these problems?

[124] **Dr Doull:** We have to welcome the 12-hour transport system. I am not diverting, but one of the questions that has been asked is whether this should be a 24-hour service. I think that having the 12-hour service in place will change things dramatically. I think that it will allow babies to be cared for in the right position hopefully. Once the 12-hour service is up and running, we will have a clearer idea as to how much more provision is needed and whether babies are being cared for in the right places, not just in the level 3 units. The problem is that level 3 units get blocked by high-dependency children.

[125] **Peter Black:** Would you like to see a 24-hour service now, or would you prefer to wait and see how it develops?

[126] **Dr Doull:** I think that, as a college, we would feel that it should be a case of waiting and seeing. If you look at the rest of the UK, there is not unanimity on the best model of transport for neonatal care.

10.00 a.m.

[127] It is purely anecdotal, but I was speaking to people from Wessex where they have a 12-hour service. They felt at present that the 12-hour service probably met most of their needs. I have not seen the official data, but I think that the fact that there is not unanimity within the UK suggests that this is an area of uncertainty.

[128] So, as a college, I suppose that we would say that 12 hours is vital and we really welcome that. I think that once the 12 hours is running, if there was funding available would we say that for a very large sum of money we want 24 hours or would we be better off investing in the high dependency and intensive care cots?

[129] **Peter Black:** The issue that has been raised with us is that you cannot determine when babies are going to be born and it is a 24-hour cycle, if you like. The transport service may need to reflect that.

[130] **Dr Doull:** I would agree with that. Anecdotally, from talking to colleagues in Wessex, they said that with planning you can actually transfer out in utero. That is the ideal. I think that the ideal is still to transfer out in utero. If that is done in a strategic way, that can avoid many of these issues. There will still be infants born in the middle of the night unexpectedly, but for a newborn infant there is often a sort of honeymoon period in the first 24 hours of life. So, some neonatologists have said to me that, for a few hours they can cope; the important thing is that they know that the cavalry will arrive. That is very important in the smaller units.

[131] **Peter Black:** Health boards have told us that improvements are needed to the ways in which parents with special care babies are supported, particularly accommodation facilities. To what extent might transitional units be used to better support parents prior to discharge and to maximise critical care cots through early discharge?

[132] **Dr Doull:** Again, it is moving babies to the most appropriate place for their care. Anything that can move babies from intensive care to high dependency and from high dependency to special and then transitional care has to be welcomed. The needs of parents have to be paramount. It is a very stressful time for them, and if you look at other countries where there is a much more national service for neonatology, one of the paramount things is provision for the parents.

[133] **Irene James:** In your written evidence you state that there are significant pressures facing paediatric and neonatal care in Wales. Can you tell us more about your specific concerns and why you think that the current model of delivery is not sustainable?

[134] **Dr Doull:** The European working time directive has had a huge effect on hospital services. I am sure that, as a committee, you are well aware of these issues. I think that it is worth highlighting that the issues are probably greater in paediatrics and are greater in Wales. You will be aware that the number of hours that the junior doctors are allowed to work has come down from 56 hours to 48 hours. There was the option of derogation where some rotas were allowed to remain at 52 hours. I think that it is noteworthy that of the 200 rotas for derogation in the whole of the UK, 40 per cent of those were in paediatrics and a large proportion was in Wales. Nearly 10 per cent of all the rotas in the whole of the UK that got derogation were paediatrics in Wales. Paediatrics in Wales stands out by a long way in these issues.

[135] If you look at the number of in-patient units per 100,000 children, Wales stands out as being an outlier. We have more in-patient units per 100,000 children than comparable areas of the UK. Even Scotland, which arguably has greater geographical pressures, has fewer in-

patient units. So, we have a large number of in-patient units.

[136] We also have fewer junior doctors. So, comparatively, we have fewer doctors on our rotas. There is now an acute shortage of many middle grades, particularly in paediatrics, so it has been very difficult to maintain middle-grade cover. Ultimately, hospitals run on middle grades. The consultants tend to be more consultative and they may not be resident. The SHOs, the most junior doctors, will have some training, but the middle grades will have had at least three years' training. They are the core of many paediatric services. We do not have enough of them when we are trying to run so many units, so it is very difficult.

[137] I am not suggesting this was ideal, but when I was a middle-grade registrar I was the only registrar for a hospital of, say, the size of the Royal Glamorgan, with about 2,500 deliveries. There was one SHO and we did one in two. Between us we got a lot of experience and we did a lot of out of hours, but you could run the units. Currently, you probably need eight middle grades, so the number of junior doctors ideally will be huge to maintain the number of rotas that we have. The maths of where you get these people from and what you do with them at the end just does not stack up. So, I think that trying to maintain the neonatal services that we have in Wales is just impossible.

[138] **David Lloyd:** I want to follow up on that point. You mentioned that there are more neonatal and paediatric pressures in Wales from the patient, mother-and-baby perspective, yet you seem to be advocating cutting the number of services available to them, if you go by this 'per capita there are too many paediatric and neonatal units in Wales' line, regardless of need. Do you not think that it is a bit rash to try to redesign a service because we do not have enough doctors, rather than, as a royal college, trying to get to grips with the training issues and the European working time directive issues, which have been in the firmament for many years now? Instead of penalising the patients, if you like, by redesigning a service because there are not enough doctors, how about, as a royal college, grasping the nettle and—because this is all at UK level—sorting out the mess that has been medical training over the last few years?

[139] **Dr Doull:** I am sorry; it is not for me to defend medical training and that is not my responsibility here today. It is not a matter of too few doctors; whichever way you do the maths, it is not sustainable. It is fine to say 'patient need', and quality, safety and sustainability have to be our fortes, but whichever way you do the maths, if you want to have middle-grade cover, how it will work is not conceivable.

[140] To briefly go through the maths, Wales currently has 12 paediatric in-patient units with middle-grade cover. We then have three level 3 British Association of Perinatal Medicine units with middle-grade separate cover. The University Hospital of Wales has a paediatric intensive care unit as well and it has a specialty grade. So, you are trying to maintain 17 middle-grade rotas across Wales. Everyone seems to think that the minimum number of doctors with which you can run a service is eight, but you cannot train with eight and therefore if you want to have training, you probably need 11. So, you are looking at 160 to 170 middle-grade doctors in paediatrics to maintain the current Welsh provision. If you want to train them, you probably need 200. Most of them will be on training for five years, so you are going to produce 40 doctors a year in Wales who will be ready to become consultants. There are roughly 180 to 190 consultants in Wales. If they work for an average of 30 years and you have about six retirements a year, you will be producing 34 doctors, but where will they go?

[141] So, the middle-grade model of sustaining services is just not viable. We are not being rash; we have been saying this all along. We have said that the current system is not sustainable. We have addressed this, but I would put it back to you that we have been saying this for a long time, but we have not really been listened to.

[142] **David Lloyd:** Fair enough, but it is Modernising Medical Careers and the European working time directive that have got us to here. Obviously, it was routine for me in my younger days, as it was for you, to do 100 hours a week. So, obviously, if you are going to say that doctors cannot work any more than 48 hours a week, the simple mathematics is that you need twice as many doctors just from that point of view.

[143] **Dr Doull:** No, you do not need twice as many; you need probably five times as many.

[144] **David Lloyd:** Exactly, but that has been foreseen for many years. What has gone on top of that is the fact that MMC complicated things and took the flexibility out of the situation so that people could not start on one specialty and then have a change of course. We now no longer have that flexibility, so people decide to go in for, say, paediatrics and they have to stay with paediatrics come what may. Then we lose those people if they do not actually make the grade either.

[145] So, what steps are you taking as a royal college? It is expensive to train doctors. We have hundreds of kids out there who are trying to become medical students who are rejected every year. So, it is not as though medicine has become unpopular overnight. Loads of people want to be medical students, want to be doctors, and yet we end up not training enough. That has always been the situation.

10.10 a.m.

[146] On top of that, we have an additional foul-up now in that there is no flexibility in the current regime of training, so that if people do not make the grade—that is, ideally, they want to stay at some sort of sub-consultant grade—they are no longer allowed to do so. So, we end up losing people who are very experienced and highly trained. As a royal college, do you not have a view on that?

[147] **Dr Doull:** We support the fact that there has been a massive increase in the number of medical students. MMC has had an effect but, sorry, I come back to the fact that to have the number of middle grades to sustain the rotas, you have six retirements a year in Wales, but you have 40 trained people coming off the conveyor belt. That is not a model that can be sustained. MMC has had an effect, but we are talking about the working time directive. That is the major effect.

[148] You could double the number of medical students, but what are they going to do at the end? You are putting people into a middle-grade rota to sustain services and, at the end, they are going nowhere. I think that MMC has had an effect but it is the working time directive that is going to change services.

[149] **Helen Mary Jones:** I am quite struck by a factual point. Is there an expectation that, if you become a middle-grade doctor, you are going to be a consultant one day? If you are a front-line nurse, there is not necessarily an expectation, and not all school teachers become headteachers. So, why does it matter if middle-grade doctors get stuck as middle-grade doctors? They are certainly not living on bread and potatoes, are they?

[150] **Dr Doull:** No, they are not. Dr Lloyd is correct that one of the difficulties with MMC is that you come on at the start and you come off at the end, and if you come off at the end, where do you go? You cannot go into a training post, so you are looking for a career-grade post. Currently, consultant is what you are aiming for. There is no guarantee that you will get to be a consultant and the fluctuations in medical demands are that sometimes there are no jobs; sometimes there are too many jobs. There is no expectation. If you want people to go into paediatrics, they have to have an expectation of where they are going to go. Now, if you

are going to be in your 60s still up at night working long shifts and you are going to do that for the rest of your life, that is probably not a career that many people are going to be jumping to do; they will probably want to go into primary care or whatever.

[151] So, from a paediatric perspective, we need a model to go to. I accept that, as a UK system, the consultant is the career-grade level that people would be aiming to get to if they became a registrar.

[152] **Darren Millar:** It seems to me that the main point that you are making here, regardless of the people coming into the system, is that there are not enough doctors in Wales in this particular service. Is it right that there are not enough posts?

[153] **Dr Doull:** There are plenty of posts; it is that they cannot be appointed to. If you look at the modelling for how you want a service to run, the bottom line is that, if you want to maintain it on middle grades, that is not sustainable. As a college, we would advocate that we should be moving towards more of a consultant-delivered model. There are good examples of that; Salisbury, Hereford and Dorchester are used as examples where, rather than having middle grades, you will have consultants delivering. You are moving then towards a consultant-delivered service. The current model of neonatal and paediatric care based on middle grades is not sustainable.

[154] **Lorraine Barrett:** I will ask my question now if that is okay, because you have started talking about middle-grade rotas, leading towards consultant-delivered neonatal services. In north Wales, there are currently no dedicated consultant neonatologists. Do you have anything to say about how that works or does not work?

[155] **Dr Doull:** There are paediatricians whose major interest is neonatology, but it is correct to say that none of the three units in north Wales have a full BAPM level 3 unit with separate middle-grade and consultant neonatologists. Thought needs to be given to how best to deliver services there. The unit of currency for paediatrics is the number of deliveries. If you look at the three units across north Wales, they are all comparable—at between 2,000 and 2,500 deliveries—so there is no easy way out of that. One of the strengths of north Wales is that Betsi Cadwaladr University Local Health Board has a unified child health strategy across the three locations, so they can make decisions. I would compare that with west Wales, where the three units have been forced to act as silos, almost. So, I think that north Wales is more advanced and I am aware from the clinical director there that there are plans to take that forward for level 3 care.

[156] **Lorraine Barrett:** With regard to the consultant-delivered service, how long would it take to achieve what you feel is the right way for this service to go? When a medical student qualifies as a paediatrician, what is the expected timescale before he or she becomes a consultant? How long would it be?

[157] **Dr Doull:** The current model is that they will come off as medical students and will do F1 and F2. Once they get on the conveyor belt, they will do three years before they do their exam. After that, they will be middle grade and they will do five years as middle grade. So, it is effectively eight years. Our college, among others, has argued that perhaps the length of training could be increased. It is very clear from the Postgraduate Medical Education and Training Board that that is what we are left with. So, it is eight years, effectively.

[158] **Lorraine Barrett:** Under your preferred, consultant-delivered service, particularly in north Wales, how long would it take to get the right number of consultants? You are saying that it is not sustainable—

[159] **Dr Doull:** It is not sustainable at present. I think that if we went to a consultant-

delivered model, it is sustainable. There are enough junior doctors coming through to move towards that model. We are, in a way, producing too many trainees for just retirement at present. If the number of consultants in the UK stayed exactly as it is, we are producing too many trainees. If we were to move towards a consultant-delivered model, those trainees could go into those posts, but in probably between five and 10 years we would need to decrease the number of trainees, because otherwise we would be training too many people. I am not an expert on medical manpower planning, but it does seem incredibly complex to be planning things for 10 years down the line.

[160] **Val Lloyd:** I want to take you back to your assertion about the need to decrease the number of in-patient paediatric and neonatal units. Is the lack of doctors the only reason that you assert that, or are there any other benefits to a reduction?

[161] **Dr Doull:** We are trying to have safety, quality, sustainability and access, but I believe that quality and safety are more important than access. In moving towards a consultant-delivered model of care, there are huge advantages for patients and their families. That is not going to be resource-neutral, though it probably is not going to be as resource-terrible as you might imagine, because you could then decrease the number of middle grades and trainees. As a country, we need to work out what is important for the care of our children. I would argue that a consultant-delivered model would be better for the children and their families.

[162] **Val Lloyd:** Would it lead to women and babies needing to travel further and a lot more?

[163] **Dr Doull:** People will need to travel if there is less provision. I think that Wales is still haunted by the Bristol heart inquiry, but a number of parents involved in that said they would have travelled if the quality and safety was better. Ease of access is important, but if you look at, say, the Princess of Wales and Royal Glamorgan hospitals, they are not that far apart and the travelling time is not that great.

10.20 a.m.

[164] So, if it was a question of going to a unit where you would see a consultant rather than a junior doctor and would get very good, high-quality care, or seeing a junior doctor somewhere locally, I think that it is important to ask people the question.

[165] **Val Lloyd:** Would any reduction in neonatal units have a knock-on effect on maternity and obstetric services in the lead centres and DGHs?

[166] **Dr Doull:** Clearly, and I think that one of the reasons for highlighting that is that we are not an island. We have to be aware of other services. I understand that obstetricians are having exactly the same discussions and have come to the conclusion, again from the point of view of the working time directive and sustainability, that the current model is not sustainable. It is the same for emergency services and for anaesthesia services. As a service, one of the problems that paediatrics have is that while there are 'hospital at night' arrangements for most aspects of medicine, we are a standalone service. The only people who can do middle-grade paediatrics are either middle-grade paediatricians or consultants. You cannot get other people to do it. It is the same for obstetricians and anaesthetists, and I think that they are having the same discussions that we are having.

[167] These are difficult issues, but I would highlight this, because unless this happens in a planned way it will lead to a crisis.

[168] **Helen Mary Jones:** My first question is one that may not be fair to put to you and, if

not, then fair enough.

[169] **Dr Doull:** I will tell you.

[170] **Helen Mary Jones:** Yes, indeed. Do you have an assessment of the level of investment that would be needed to enhance the role of community paediatric nursing and community paediatric services in response to the changes that you propose? It is the question about resourcing that I think may be a bit difficult to put to you.

[171] **Dr Doull:** Sure. As a college, and this is not just in Wales, but in the rest of the UK, we feel that we have to decrease the number of in-patient units. That is not just a Welsh perspective, but a UK perspective. If you do that, there have to be other factors in place: a transport service both for neonates and for children to a PICU is vital. As I say, anecdotally, speaking to consultants in Salisbury, they say that they are happy being a consultant-delivered service. The level of morale among the consultants there is very high, but it is important that they know that if they have a sick child someone will come and take it away to sort it out in an appropriate environment.

[172] The knock-on effect is that they need community nursing, because that is very important. Certainly, from a paediatric perspective, I think that quite a lot of children will be admitted who may not necessarily need admission but who need some observation or some degree of follow-up. So a proper community nursing service will keep children out of hospital, which I think would be a good thing.

[173] I would not be able to quantify the resources, but I think that there are costs to be saved in addition to outgoings.

[174] **Helen Mary Jones:** Thank you. This question again relates to nursing roles. The British Association of Perinatal Medicine highlighted to us the important role of advanced neonatal nurses developing their skills to enable them to work alongside the doctors. Its representatives said to us that they thought that those advanced nurses would be able to perform many of the tasks that are currently undertaken by junior doctors. Do you have a view on that? Do you think that investment in that role might be of assistance?

[175] **Dr Doull:** That has to be the way forward. That is a very appropriate thing to do with regard to many of the junior staff responsibilities. I think that it is worth emphasising, though, that they would not be able to do the middle-grade posts. The middle grade is separate, and I think that we are still left with that as an issue. However, for transport and for a lot of what the SHO level may have done, I think that it is the way forward.

[176] The flip side, of course, is that these are specialist nurses who then need more specialist training. Again, we are talking five years down the line. It takes a number of years to train these people and for them to get the experience. It is my understanding that, often, they are better remunerated in England, so some of the ones that have been trained in Wales have then gone to England. There is a desperate need for some form of training programme in Wales.

[177] **Andrew R.T. Davies:** Thank you very much for your evidence this morning. It is very thought-provoking and challenging. As someone who sits on the Petitions Committee of this institution, I am fully aware of the sensitivities involved. We currently have a petition on the status of the unit at the Royal Glamorgan hospital. As a politician, I am trying to reconcile reality and the public’s aspirations, and I think that you have touched on many of those points in your evidence this morning to us.

[178] In your written evidence you talk about suitable safety net cover and that a paediatric

middle-grade doctor is required, but if one is not available then a consultant is needed to provide that safety net cover. How many units in Wales would you say are unable to provide adequate safety net cover?

[179] **Dr Doull:** The bottom line is that consultant paediatricians are very committed to their service. We have not done a census recently, but we had an extraordinary general meeting last year, because we were all so concerned about these issues. The results of the census taken at that time were that in over half the units in Wales consultants had had to come in to be the resident on call to maintain the safety net. There were no middle grades available, so the consultants came in.

[180] That is fine, but there is a knock-on effect. If you have been up all night, it is unreasonable for you to be doing clinics and ward rounds the next day. It has a huge knock-on effect. So, ultimately, consultants will maintain that service, but if they are maintaining out-of-hours provision—and it is the out-of-hours provision that is the crucial issue—that then affects in-hours service.

[181] **Andrew R.T. Davies:** So, what is the knock-on effect for expectant mothers in such units?

[182] **Dr Doull:** If you are the consultant in, say, Glangwili in Carmarthen and there is no middle grade doctor available that night, what do you do? You will end up coming in and acting as the registrar overnight. So, the expectant mothers will have a superb service, actually; they will have a consultant-delivered service. However, the next morning, if the consultant has been up all night, he or she will not be able to do the ward round and clinic. So, the knock-on effect is not necessarily on the expectant mothers, but on your patients with chronic diseases.

[183] Chronic disease management is very difficult now. I run a cystic fibrosis and respiratory service, but the amount of time that I have a registrar attached to my unit decreases all the time, because they are being dragged off to cover out-of-hours provision. Out-of-hours provision is having a massive effect on the service delivery of everyday management of chronic disease and on training, because if they come to me to learn about cystic fibrosis and respiratory disease and they spend most of their night up and they are actually only doing one clinic in four, their training is affected.

[184] **Darren Millar:** Thank you very much for your evidence this morning. That brings this particular part of our session to an end. If there are any further points that you wish to make, feel free to drop us a note in addition to the paper that you have already supplied us with. Thank you very much indeed.

[185] **Dr Doull:** Thank you. I would just reiterate that we really welcome the investment. It has been very positive for neonatal care in Wales.

[186] **Darren Millar:** Thank you. That will be on the record.

10.28 a.m.

Ymchwiliad y Pwyllgor i Ofal Newyddenedigol: Tystiolaeth gan y Gweinidog dros Iechyd a Gwasanaethau Cymdeithasol a Chomisiwn Iechyd Cymru Committee Inquiry into Neonatal Care: Evidence from the Minister for Health and Social Services and Health Commission Wales

[187] **Darren Millar:** Continuing with our inquiry into neonatal care, I am delighted to

welcome to the committee the Minister for Health and Social Services, Edwina Hart, Simon Dean, the director of strategy and planning, and Rosemary Kennedy, the chief nursing officer of the NHS in Wales. Thank you very much for your paper, Minister. It has been circulated to Members. We will go straight into questions on that paper and some of the evidence that we have received so far as a committee during the course of our inquiry.

[188] We have been told that in 2005 the review undertaken by HCW estimated that to improve neonatal services in Wales around £10.4 million-worth of additional investment was required. Since then, we have heard that demand for neonatal services has increased by around 9 per cent because of the growth in the birth rate, yet you have put in only an extra £2 million in recent years. Do you think that that is enough?

[189] **The Minister for Health and Social Services (Edwina Hart):** I would not use the expression ‘only £2 million’. I think that it is welcome news that I have made an additional £2 million available for neonatal services. Of course, as part of looking at the issues that were raised all that time ago, I have now established a clinical advisory group to advise me on the priorities of the developments in this area, because when you are taking on such a large task you have to prioritise what you do first.

10.30 a.m.

[190] The first thing indicated to me by clinicians was, of course, a transport service—which I think that Members around the table will probably recognise as a key issue that has been raised with you already—a clinical information system, which they were also very keen on, and the managed clinical network to ensure effective service co-ordination and planning across Wales. Most of these developments will be in place shortly and, of course, this will recruit additional staff. As a committee, you already recognise the issues around staff in these units, and the needs, requirements and pressures, and I have asked the network to advise me on how I should deal with these issues and how the NHS needs to take this forward.

[191] When we talk about additional resource, we need to recognise that the NHS has had massive additional resources without any specific grants coming from central Government to look at what the service required over the years. I am looking at the NHS now to identify what further resources it has or requires to deliver a very effective service in Wales.

[192] **Darren Millar:** Obviously, the HCW report indicated that, in 2005—five years ago, now—£10.4 million in additional funding was required to improve neonatal services up to an acceptable standard. Of course ,we welcome the £2 million-worth of investment; in fact, every witness has welcomed the additional investment that has gone in, Minister, but it falls significantly short of the amount that was specified in that HCW report some five years ago. We have seen an increase in demand for services and yet there is an £8.4 million gap, is there not? Did you want to comment, Mr Dean?

[193] **Mr Dean:** Yes, if I may, Chair, just to add to the Minister’s comments. The Minister made available £2 million through Health Commission Wales, but HCW has never commissioned neonatal intensive care for the Gwent area because of the resource mapping when HCW was set up. I believe that I am correct in saying that the Gwent authorities invested an additional £1 million last year in neonatal care and there have been additional investments in neonatal services from other health boards including, if I recall correctly, the former Abertawe Bro Morgannwg health board. So, the £2 million is not the sum total of additional investment in neonatal care since 2005. That was a specific sum announced by the Minister about a year ago, but there have been additional investments on top of that. So, the gap is not quite as stark as it might appear.

[194] **Darren Millar:** What has the total additional investment been?

[195] **Mr Dean:** I believe that it is of the order of £4 million. It is not possible to track all of that in detail because it comes from disparate sources. So, Health Commission Wales, for example, spends money on placements in cots at individual providers, and we have had the £2 million announced by the Minister, plus additional investments by other health trusts and LHBs.

[196] **Peter Black:** Minister, I think that there was an announcement on the 12-hour neonatal transport service in December just gone. When is it likely to be operational and has a decision been made on the model of delivery?

[197] **Edwina Hart:** Yes. The clinical advisory group has decided on the model of delivery, so it is not me making the decisions, but those who are at the front end of it. I understand that the first appointments are due to be made in April or early May. Consultant appointments will take slightly longer, but that process is also under way. I think that you are aware of the issues around consultant appointments.

[198] Transport services should be fully operational by the autumn—that is what I understand from officials. We are working currently on the detailed plans for implementation and consultation with all the interested parties because the 12 hours is a key issue. Of course, we then have to move on to look at the issues around a 24-hour service, and what discussions the neonatal network will want to have in the future. Obviously, I would then have to look at anything that arose from that and how that could be prioritised in the NHS.

[199] To be frank with you, my entire budget is currently allocated for next year to the LHBs, but I do expect them to look at all these issues to deliver a sustainable service across the piece. I think that once the 12 hours is set, we will then have to have discussions on the 24 hours because that is an issue that has probably been raised across the piece.

[200] **Peter Black:** If we are waiting until, say, September or October for the 12-hour service, are there transitional arrangements being put in place to bolster the existing service until we get that up and running?

[201] **Edwina Hart:** Yes.

[202] **Mr Dean:** The detail of the transitional arrangements depends on the pace of recruitment because clearly we are dependent on the recruitment of an additional five consultant staff and 11 neonatal nurses. There is a timescale to achieving that so we will be working with the NHS and through the network to ensure that the service is put in place as quickly as possible.

[203] As the Minister indicated, what the network has said to us is that it wants to review the position once the 12-hour service has been in operation to advise on what the next priority should be, whether, in fact, it should be to move to a 24-hour service. It is not a clear-cut decision that a 24-hour service is the preferred model. Their preference may be to invest additionally in the existing units either through additional staffing or to support extra costs. So, the advice that the Minister has had from the clinical advisory group has been to put that 12-hour service in place, to assess the impact of that and then allow the group to provide further advice on the next priority steps.

[204] **Ms Kennedy:** May I come in here, Chair?

[205] **Darren Millar:** Of course.

[206] **Ms Kennedy:** The recruitment, particularly around neonatal nurses for the transport

service, is not something that we can rush into because the nurses that we need to support the transfer of very sick babies really have to be at the advanced level. They really do need to be well sound neonatal nurses and, at the moment, that means that they are likely to come from existing neonatal units. So, we have to be a little bit careful that in putting those people into place, we do not then strip out the key people that we need within the neonatal unit. It does need to be handled across the piece as a totality, rather than just taking bite-sized approaches to it.

[207] **Darren Millar:** Minister, if a recommendation does come back from the network to increase the service to a 24-hour service, we heard evidence from the Welsh Ambulance Services NHS Trust that the cost of that would be relatively small because the main investment is in the ambulances and to kit them out. I think that it was about £250,000 in order to double the shift patterns up to make it a 24-hour service. Is that something that you would be prepared to consider funding?

[208] **Edwina Hart:** I would obviously wait to see what advice I would receive from the network that I have established. As I have indicated, I know that there is a demand for the 24-hour service. We will have to prioritise according to what the clinicians are asking us to do and which they see as the key. I think that the chief nursing officer is quite right that we have to approach this in a very systematic manner because we cannot afford to 'rob Peter to pay Paul' in setting up one system and then find that we have an inadequacy in another part of the system. So, that is something that would have to be considered on its merits. I have been led throughout by the discussions with clinicians and I continue to be led by clinicians as to what they think are the most effective ways of dealing with matters and prioritisation.

[209] **Lorraine Barrett:** You mentioned the network, Minister. We had been told that the clinical network was not yet up and running. Is there any reason for the delay? When do you think it will be fully operational?

[210] **Edwina Hart:** It has been established now and obviously I am slightly disappointed that this was not done previously. I think that I have buy-in now from clinicians for the network, how it is to be designed and the type of approach that we are taking. That was inevitable. I have to say that there is a lot of information and detail that they have to get on with, and we are now appointing the lead clinician, which will be quite important, and the network manager. Of course, there is an issue as well of dedicated nursing time to identify protocols and access training requirements. I do not know if the chief nursing officer wants to comment on that.

[211] **Ms Kennedy:** We really have a problem with which comes first, the recruitment of staff or the development of the service. To date, I think that it would be fair to say that many neonatal nurses have not seen that there is a career structure for them and they need to see how the whole system is going to develop from end to end to give them good rewards from that point of view.

[212] The other difficulty that we have had in recruiting and retaining neonatal nurses has been an 'own goal', I will say, because about two years ago the Nursing and Midwifery Council advised midwives who were working in neonatal services that, in fact, they may have to come off the register if they did not put some time back into being midwives, which was extremely difficult because a lot of midwives are drawn very naturally into neonatal services. They have retracted that and we are working with them, but it did rather put a stop on things. I think that that affected the general state of recruitment.

[213] **Darren Millar:** On the delay, Minister, you did not give a full response about the reason for the delay in establishing the network. We know that it was a priority, which you indicated was there. Was the problem with officials not taking that priority seriously?

10.40 a.m.

[214] **Edwina Hart:** No, I think—well, you can comment if you wish, Simon, as the official concerned.

[215] **Mr Dean:** The Minister established a clinical advisory group to advise her on the priority developments. It provided that advice in November, and the Minister agreed all the recommendations in December. Included in that advice was a model for how the network would operate. Since December, the clinical advisory group has been working on the detailed plans and as part of that it wanted to look at some of the details of its proposed model, particularly how the clinical lead worked. So, it provided further advice to the Minister, which she signed off last week or the week before, if I am correct.

[216] **Edwina Hart:** Yes.

[217] **Mr Dean:** It has been the clinicians working through the detail of how the network would operate at a practical level that has led to further advice to the Minister, which the Minister has now signed off. So, the network is now progressing to a point—

[218] **Darren Millar:** Mr Dean, almost every witness that has been before us has expressed enormous frustration at the delay in establishing this clinical network. The Minister made it quite clear in December 2008 that she wanted this network established, and yet you are telling us that you were waiting for the clinicians to come up with some clear recommendations and a steer as to how the network would look. Those very same clinicians that you say that you have been waiting for have been saying they have been waiting for NHS Wales, effectively, to establish the network. They have expressed enormous frustration at that. I cannot understand. That seems very different to the evidence that you are giving us this morning.

[219] **Mr Dean:** What is important is that we generate an effective way, which is clinically owned, in which clinicians work together. If we were to impose a model on clinicians that they did not agree with or accept, we would not create an effective network. So, it is really important that we do the groundwork, because we need all of these units and services to work together effectively on an all-Wales basis. Bringing that about requires clinicians to work together and to write proposals that they can own, that make sense to them professionally and that will deliver the sort of services that they want. That is what the time has been spent on doing.

[220] What we have to do now is to bring the two things together: the clinical consensus about how the network should work and the funding that the Minister has made available to enable it to happen. That is the point that we are at now.

[221] **Edwina Hart:** I am sure, Chair, in the evidence that you have had from clinicians, you have probably seen a divergence of opinion on issues. So, we need to bear in mind that there is not necessarily unified agreement on how to take things forward. However, we are working towards that now. What is important is that we are absolutely committed to getting this working correctly and all the key partners are now engaging.

[222] **Darren Millar:** There was unanimity about the frustration expressed at the lack of establishment of the network. That has been pretty clear in the evidence that we received.

[223] **Irene James:** Minister, I want to move on to the set of standards for neonatal care that were published by the Welsh Assembly Government in December 2008. From the evidence that we have received, it appears that these standards will not be achieved within the current levels of funding. Are you confident that the vision set out in the all-Wales neonatal

standards can be achieved?

[224] **Edwina Hart:** Yes. It is the responsibility of LHBs to develop plans to improve service standards and to meet the standards, and the networks will be assessing the position now against the standards as a priority in their work. I expect the networks then to advise the LHBs through, of course, the new commissioning bodies that we will be utilising, on the next priorities for development. That is the key area there.

[225] As for confidence, I will be more confident about what I would say to you when I have the reports back.

[226] **Irene James:** Following on from that, you have stated who is responsible, but how do you intend to monitor that these standards are being met?

[227] **Edwina Hart:** This is monitored regularly as part of the issues that I have advice on. I have specialist advisers. Now, of course, I have my network established, so that will all form a framework to ensure that there is proper delivery. I do not know whether Simon or Rosemary want to add anything on that.

[228] **Mr Dean:** I will add two other components of that. One is the performance management system that we have in place, whereby we assess the performance of individual NHS bodies, and, in this case, we will be looking at the performance through the Welsh Health Specialised Services Committee. The other is the national clinical project, which the Minister has established to take forward developments in maternity neonatal services and paediatrics, because we need to see all of these services as inter-linked. I am sure that you will be aware of professional questions and concerns about the sustainability of services, given such things as the European working time directive and the recruitment issues that we face. So, we put in place a project that will be looking at a strategy for maternity services and a strategy for hospital-based paediatric services, and neonatal care will form a part of that project. So, that national piece of work will be going on alongside the network to ensure that progress is made on implementing the standards and to identify any key issues that need to be pursued, for example, around sustainability.

[229] **Edwina Hart:** Last week I had the opportunity with Holly Ferguson, my adviser on midwifery, to have a discussion with some of the leads within Wales about the management structures that currently exist, as the heads of midwifery oversee this. There are issues that the CNO might want to advise the committee about.

[230] **Ms Kennedy:** At the moment not every area has neonatal provision attached to the maternity services, and I think that that is a major step—sorry, I have to cough.

[231] **Darren Millar:** I remind witnesses and Members that we are up against the clock, so please keep questions and answers as brief as possible and to the point.

[232] **Ms Kennedy:** We need to see neonatal provision as part and parcel of maternity services and paediatric services. It cannot really stand alone, because when we are talking about planning, cot demand and so on we have to have a good relationship with the maternity services so that we can identify at-risk mothers and foetuses so that they are managed well.

[233] **David Lloyd:** Still on the all-Wales neonatal standards, we have heard from witnesses that neonatal units should aim for 70 per cent occupancy. We have also heard that the majority of Welsh neonatal units work above this level, and at sometimes very near to 100 per cent occupancy. Do you have any concerns about any potential risks to mothers and babies in that situation?

[234] **Edwina Hart:** Yes, I think that there are issues around this. I think that I referred in my written evidence to the national clinical project that I have established to develop a strategy for maternity and neonatal care and for hospital-based paediatric services. It is quite important that that is a focus.

[235] As part of that work, we will have to look at the professional advice that we have had from clinical staff from the royal colleges, because this is about safe and sustainable services. We have to look at their views and concerns, because we know that the recruitment of doctors, nurses and midwives is currently very challenging in this area. That was one of the issues that I discussed with the heads of midwifery last week.

[236] Occupancy rates in units vary over time. The transport service will, hopefully, enable the existing cots to be used more effectively. So, in answer to your question, I think that there are issues there and they are issues that we will have to work through with the professionals. As the CNO has indicated, in some areas, of course, the head of midwifery is responsible for the whole gambit of services within an area, but that is not necessarily the case for everyone. We will have to explore with the LHBs a common approach with the national strategy.

[237] **David Lloyd:** In 2001, the British Association of Perinatal Medicine published recommendations on the minimum nursing and medical staffing standards for neonatal care. How confident are you that Welsh neonatal units are meeting those minimum standards, including one cot per nurse in an intensive care unit and so on? It is usually a nursing issue.

[238] **Ms Kennedy:** I think that that also refers back to your previous question. We have to be very clear that the cots that are designated intensive care cots are staffed and are used for babies who need intensive care. That might cause some difficulty sometimes, because it might mean that a baby in need of care who does not need that level of care perhaps needs to go to a high dependency unit or just a special care baby unit.

[239] We have an opportunity in special care baby units to start to look at the skill mix. The needs of those babies are much less than those of intensive care babies and I think, therefore, that part of the network's work around staffing must be around the skill mix.

[240] **Edwina Hart:** We have to look at the improvements from 2005. We have now gone up to 18 whole-time equivalents and I announced a further five consultants in December. There will be a further five middle-grade doctors within the system and an additional 11 nurses, together with four advanced neonatal nurse practitioners.

10.50 a.m.

[241] **Ms Kennedy:** There are also eight in training.

[242] **Edwina Hart:** So, there are improvements taking place on the back of the 2005 report.

[243] **Darren Millar:** It seems an awfully small number compared to the 500 nurses that we heard we were short of from other sources.

[244] **Ms Kennedy:** With respect, I do not think that we are short by 500. The overarching formula looked at around 500.

[245] **Darren Millar:** No, it was 180 short.

[246] **Ms Kennedy:** There are 400-plus nurses in there.

[247] **Darren Millar:** That is right, The figure is 180. Pardon me. However, it is in stark contrast to 11 posts—180 is quite a bit more, is it not? What progress has been made towards that?

[248] **Ms Kennedy:** That will be down to the LHBs, as the Minister has already said. They have to look at their services once they know what sort of provision their unit is providing—what the volume of intensive, high dependency and special care is—and then they can start to look at the numbers that they need. They might not all be neonatal nurses.

[249] **David Lloyd:** The previous witnesses from the Royal College of Paediatrics and Child Health alluded to issues regarding the training of middle-grade doctors. They said that we do not have enough, and were advocating that, as a consequence, we should have fewer neonatal units. I do not agree with that line, really, because we have increased needs here in Wales and the issue should be to tackle the difficulties that we have had over recent years as regards medical training and junior hospital doctor training.

[250] What sort of input do you have to that? Obviously, that is a UK-level issue but it applies particularly to us in Wales because we have lots of scattered rural units of whatever dimension, whatever specialty, and we always have this plea, because of the lack of middle-grade junior hospital doctors, to centralise everything millions of miles away. That will keep on happening, but it would not if we could sort out training. As I mentioned earlier, there are hundreds of people out there who want to be medical students and doctors, yet at the critical times we do not have enough doctors in the right place. So, what sort of input have we had to that at the UK training level?

[251] **Edwina Hart:** We discuss with the royal colleges their views on this issue. Their mantra to me is ‘safe and sustainable services’, and I think that that is something that I have to look at. We have to be realistic when we look at the advice from bodies like this. They want us to look very closely at the links between paediatrics, neonatal and obstetrics. There is a whole range of issues that we will have to look at if we are going to be able to provide safe and effective services. Of course, as medicine and technology move on there will probably be more centres that will be extremely specialist in this area.

[252] I appreciate that there is an issue for parents involved in this. Parents would like these matters to be dealt with closer to home, but I do not think that, even in an ideal world, we would have the level of expertise necessary to have everything where everybody would want it. I would be happier in my own mind knowing that we had safe, secure, well managed units with the appropriate staffing in Wales in key centres. I do not know if the CNO wants to add anything to that from a professional perspective.

[253] **Ms Kennedy:** It goes back to the need to build this into maternity services, because we need to identify those at-risk mothers and babies very early on to ensure that they are in the right place for the support that is there. We understand that we cannot have intensive care units in every hospital, but we can have special care cots and we can then work with that. Even having advanced nurse practitioners in neonatal services will not cover all of the work that middle-grade doctors cover.

[254] **Helen Mary Jones:** I want to ask a supplementary question to that, which is implied in your paper, Minister, but it is an opportunity to put it on the record. Rosemary Kennedy has just referred to the need to look at these issues about where the cots should be provided in the context of maternity services. To what extent will your maternity strategy for Wales, which you refer to in your paper, deal with and identify some of these issues? Can you confirm, for the record, that you expect to have that strategy and be able to publish it by December this year? I think that is what is stated in your paper.

[255] **Edwina Hart:** Yes, we are hopeful that the strategy will be published by December this year and it will cover the issues that you raise. As I was saying, we have to have that cohesive approach to service provision.

[256] **Andrew R.T. Davies:** Building on some of the evidence that we have had over the last two to three weeks, there has been an identifiable shortage of neonatal nurses that, combined with the high admittance and high activity levels in units, has resulted in the units having to close to new admissions and babies being transferred to England. Obviously, the ability to understand the level of demand is critical in gauging and providing the new service. What level of monitoring is undertaken to ascertain the level of transfer from Wales to England because units have to shut because of staff shortages or demand? What is the cost analysis of these transfers?

[257] **Edwina Hart:** There is no dataset available in England for us to utilise. There are some available data but they are not collected on a consistent basis, which is why we have introduced the clinical information system, which will enable us to collect the data on neonatal transfers between Wales and England. The network will drive consistency in the data collection process, which will allow us to answer some of these questions in the future.

[258] I have to say that data are sometimes collected on the basis of bed days or episodes, so there is no consistent approach and, therefore, no clarity in the system. That is why one of the priorities of the clinical network was to introduce the clinical information system to allow us to deal with the very points that you have raised.

[259] **Andrew R.T. Davies:** So, has the delay in getting the network up and running resulted in a delay in giving you quality information to allow you to shape the development of the service?

[260] **Edwina Hart:** I have agreed to the clinical information system. The clinical information system was recommended to me as a result of discussions with clinicians. Once I had that recommendation through, I agreed that I would ensure that that was established. It is not necessarily network-related.

[261] **Andrew R.T. Davies:** Is it correct that you, at the centre, have no overall understanding of the level of transfer out of Wales into English units or the costs?

[262] **Edwina Hart:** It is fair to say that we do not have the information that we would like to have, but we will in the future.

[263] **Andrew R.T. Davies:** That is being developed. We have also had evidence that has touched on the number of high dependency cots, or the lack of high dependency cots. Are there any plans currently in place to develop more capacity? What money has been allocated to develop that additional capacity, specifically for high dependency cots?

[264] **Mr Dean:** The key feature that we need in neonatal units is the ability to flex capacity depending on demand. That is why we need to see the neonatal capacity as a total pool, with the network orchestrating how that capacity is used, which will, of course, be heavily dependent on demand, availability of staffing and capacity.

[265] So, with the clinical advisory group, we are looking at what the next stage of development should be. At the moment we do not have the transport service in place. When we have that in place, the network will be able to better manage the flow of patients around the system. Together with the clinical information system, we will have much better information on occupancy in something closer to real time than we currently have. That, in turn, will allow the clinicians to advise on what the next priority should be, whether that

should be further cots, their nature and the units in which they are to be placed.

[266] **Andrew R.T. Davies:** So, there is a process going on. Is there nothing specific that you could tell the committee today, for example, in relation to an element of identified resource that will be coming in imminently to address the shortage of high dependency cots?

[267] **Mr Dean:** As the Minister indicated earlier, the vast majority of her budget is allocated to the local health boards for them to utilise to deliver service improvements. We need the network in place to provide that advice through the Welsh Health Specialised Services Committee to the LHBs about what the next priorities for investment should be. We need the transport service in place so that we can assess the impact that that will have. There is then a conversation to be had with the LHBs about the next priority for investment, when that investment should take place and where it should be targeted. That is what we will be working through with the network and with the Welsh Health Specialised Services Committee, as the improvements that the Minister has already announced come into place.

[268] **Val Lloyd:** I have a question about support for parents. We have been told that staff shortages can prevent care being delivered in a family-centred way and also that there is a shortage of accommodation facilities for parents with special care babies. Have you had any discussions with the health boards to review such facilities and support for parents of babies receiving neonatal care?

[269] **Edwina Hart:** We have had some involvement with Bliss, the charity, and we have discussed issues around shaping some priorities in this area of parental support. We are working with that charity to develop better information and a website to provide information for parents. I agree that the network will have to review the facilities that are available to parents as part of achieving the standards.

11.00 a.m.

[270] One of the key issues is that if you are away from your immediate family and friends and you have a baby that needs support, you want to be in the best position possible to stay with your child. So, I think that we have to look at that.

[271] In light of Dr Lloyd’s earlier comments that the move is coming from the royal colleges to look at how very specialist things have to be more centralised, we would certainly have to look at the facilities for parents in that context if we were to change anything about the delivery of services.

[272] **Darren Millar:** There was also some concern about the way that some of these accommodation facilities in particular were funded, some through charitable means, others by the NHS, some with a combination of the two. Obviously, the inconsistency there is difficult to manage.

[273] **Edwina Hart:** The voluntary sector is very good at providing cash and sometimes we do part-fund things with the voluntary sector. We now have Maggie’s Cancer Caring Centre in Swansea, with half charitable and half public money. So, I think that you are right, that it is nice to get a consistent approach, but what is important is not who funds it, but that parental facilities are available as necessary and are of the same quality.

[274] **Darren Millar:** Thank you. Are there any other questions from Members? I see that there are not. Are there any closing remarks that you want to make, Minister?

[275] **Edwina Hart:** No. Thank you very much, indeed. I look forward with interest to reading the evidence that you have had from clinicians.

[276] **Darren Millar:** Okay. Thank you very much for your attendance. I thank Mr Dean, the Minister and Rosemary Kennedy for the evidence that they have provided.

11.02 a.m.

Papurau i'w Nodi
Papers to Note

[277] **Darren Millar:** Just before we close the meeting, there are a number of different papers to note, which have been circulated to you all. I want to draw everyone's attention to the fact that there is a paper in there from what appears to be the Betsi Cadwaladr University Local Health Board, but it is actually a personal paper from Dr Cronin who works for the Betsi Cadwaladr University Local Health Board. Make a mental note of that when you read through it.

[278] There is also a paper from the Deputy Minister for Social Services further to our CAFCASS inquiry. I think that we will mop up a response to that as and when we look at the implementation of some of the recommendations from previous reports.

[279] With that, I close the meeting. Thank you.

Daeth y cyfarfod i ben am 11.02 a.m.
The meeting ended at 11.02 a.m.