Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

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

Dydd Iau, 17 Mai 2012
Thursday, 17 May 2012

Cynnwys
Contents

Cofnodir y trafodion hyn yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir cyfieithiad Saesneg o gyfraniadau yn y Gymraeg.

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

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Angela Burns	Ceidwadwyr Cymreig Welsh Conservatives

Christine Chapman	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Keith Davies	Llafur Labour
Jocelyn Davies	Plaid Cymru The Party of Wales
Suzy Davies	Ceidwadwyr Cymreig Welsh Conservatives
Julie Morgan	Llafur Labour
Lynne Neagle	Llafur Labour
Jenny Rathbone	Llafur Labour
Aled Roberts	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Simon Thomas	Plaid Cymru The Party of Wales

Eraill yn bresennol
Others in attendance

Dr Jennifer Calvert	Neonatolegydd Ymgynghorol, Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro Neonatal Adviser, Cardiff and Vale University Local Health Board
Andrew Cottom	Prif Weithredwr, Bwrdd Iechyd Lleol Addysgu Powys Chief Executive, Powys Teaching Local Health Board
Dr Andrew Goodall	Prif Weithredwr, Bwrdd Iechyd Lleol Aneurin Bevan Chief Executive, Aneurin Bevan Local Health Board
Paul Hollard	Prif Weithredwr dros dro, Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro Acting Chief Executive, Cardiff and Vale University Local Health Board
Kath McGrath	Cyfarwyddwr Cynorthwyol Gweithrediadau, Bwrdd Iechyd Lleol Cwm Taf Assistant Director of Operations, Cwm Taf Local Health Board
Judith Paget	Dirprwy Brif Weithredwr, Bwrdd Iechyd Lleol Aneurin Bevan Deputy Chief Executive, Aneurin Bevan Local Health Board
Carol Shillabeer	Cyfarwyddwr Nyrsio, Bwrdd Iechyd Lleol Addysgu Powys Director of Nursing, Powys Teaching Local Health Board
Allison Williams	Prif Weithredwr, Bwrdd Iechyd Lleol Cwm Taf Chief Executive, Cwm Taf Local Health Board

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

Claire Griffiths	Dirprwy Glerc Deputy Clerk
Claire Morris	Clerc Clerk
Victoria Paris	Gwasanaeth Ymchwil Research Service

Dechreuodd y cyfarfod am 8.58 a.m.

The meeting began at 8.58 a.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **Christine Chapman:** Good morning and welcome to the Children and Young People Committee. I remind Members and witnesses that all mobile phones, BlackBerrys and pagers should be switched off, because they affect the broadcasting equipment. We have not received any apologies this morning. Given that this is a formal public meeting, Members and witnesses do not need to operate the microphones; they will come on automatically.

8.59 a.m.

Ymchwiliad i Ofal Newyddenedigol
Inquiry into Neonatal Care

[2] **Christine Chapman:** In our first evidence session today, we will take evidence from Powys Teaching Local Health Board. I welcome our witnesses this morning, Andrew Cottom, chief executive of Powys Teaching Local Health Board, and Carol Shillabeer, director of nursing of Powys Teaching Local Health Board. I thank you both for attending and for providing written evidence.

[3] We will go straight into questions, if that is that okay with you. I will start with the first question. How do you ensure that maternity and neonatal services for residents in Powys are adequately taken into account in the relevant action plans of hospitals in England and Wales?

9.00 a.m.

[4] **Mr Cottom:** Thank you for your welcome. Powys Teaching Local Health Board is obviously slightly different to the rest as we do not provide services directly and we access all the networks around Powys. To respond to your question specifically, our approach is to take a very individual management approach to cases that require those services, so the planning for services is done well in advance, and very rarely do we need to admit on an emergency basis a baby who would then go on to need specialist care. In our evidence, we refer to one such case, where there was a very successful outcome. The management of those cases during the period is well rehearsed. Our midwives have additional training to ensure that they can respond in particular cases. There is a regular review of the individual cases, which Carol can speak about more directly.

[5] With regard to taking a broader view, particularly in terms of Wales, we are involved in the arrangements around the Welsh Health Specialised Services Committee. We are a full member of that and we have sight of and participate in its discussions and decisions on investment. We have access to the reports of the networks in England, which, again, we review through our structures to ensure that the overall standard of care is developing and that, on an individual basis, the residents of Powys are getting the right services. That is a very high-level view. If you want an additional response, Carol can provide detail.

[6] **Ms Shillabeer:** I would just add that, for Powys, it is quite complex, because it is normal for us to utilise the services in England. A large part of our population lies on the eastern side of Powys, so their normal pathway is into England. So, we have to plan across the border, as well as with every part of Wales. We utilise the Aneurin Bevan Local Health Board service more than that of any other health board, but we also have flows going into north Wales and Swansea. We have to be in touch with everyone really, which is the benefit

of the neonatal network and WHSSC in Wales. As a health board, we link with the English networks in terms of the planning of the pathways.

[7] **Christine Chapman:** We have heard evidence recently about poor standards at times and things that we are very concerned about. You touched upon how you monitor the services, and, as you said, it is a very complex situation with your board because of the geography, but how do you actually monitor the services? In particular, if there are unsatisfactory standards, how do you ensure that that is put right? What systems are in place to deal with that?

[8] **Ms Shillabeer:** There are a couple of things, really. The first is that we had the national service framework for children and we assess the service annually with all our partners, wherever they are—complex though that is—against those standards. The outcomes of those reports are reported to our board. As I am sure you are aware, we have the role of lead director for children, which is a role that I play in the health board, and the role of lead independent board member. Under the Children Act 2004, we have a duty to ensure that we co-operate with others regarding the welfare of children. The processes that we have within the health board include a lead director for children's meeting, which happens twice a year, at which we look at all of the issues relating to children. We also have a board report approximately twice a year, or more frequently if there is an issue of exception to report to the board, to identify how we are fulfilling our duty to co-operate and to identify any concerns the board should be aware of.

[9] With regard to specific issues relating to maternity and the neonatal pathway, there are a couple of things that I would bring to your attention. One is that we have a maternity services liaison committee that involves users of maternity services. We have revamped it in the past few years and it is a virtual committee to try to involve as many people as possible. We are pleased to say that Healthcare Inspectorate Wales, when it undertook its review, found this to be a very innovative way of trying to plug people in. So, we use the feedback from that. In a couple of weeks we will have an event involving the supervisors of midwives who meet with women and families who have had what we would consider to be a difficult experience. We have a lady, for example, who is from the north of Powys and has had to have her baby cared for in a south Wales unit—not because there was no cot availability, but because that was clinically appropriate. We recognise that that is really difficult. Was there anything else that we could have done as a health board to enable that to be a smoother or better process—I cannot say a pleasurable process, because it would never be—for that individual? This is about person-centred care, and what it was like for the individuals. That is the best test of standards: how did it feel for them? The only other thing that I would add is that we have a head of midwifery who is very much part of the group of heads of midwifery across Wales. We rely on those professional networks to ensure that any issues of concern in relation to the standards are fed through.

[10] **Mr Cottom:** We also have a formal agreement with every provider of services to Powys, and that in itself allows for issues to be taken up in a formal sense with the organisation, through to the chief executive if necessary, and then through to their board. We do operate that from time to time, when there are concerns. What we look for is for those things to feed through from the individual reviews that we have into the more formal planning and management arrangements. We can then take them into the formal mechanisms between our boards if necessary. In this particular case, we have not had to do that in the time that I have been in Powys, but the mechanism exists.

[11] **Suzy Davies:** On this point about monitoring services and standards, I can see that when you are talking about the district general hospitals in Wales you use the electronic self-assessment. How much confidence do you have in that system?

[12] **Ms Shillabeer:** Ah—I am hesitating because it is a very large self-assessment tool. There are many standards and domains in there. We try to be quite vociferous with it. We want it completed because we want to see the progression year on year. It is quite a heavy tool to use. You may want to check with others how it feels for them to use it. For us as a health board that works with lots of different partners, we have to try to collate all of their information, so it does become a bit large. That is why, when we are reporting things through the system to the board, we really pick out the issues of exception, and we find that that is the best way to report. However, it is a fairly hefty tool.

[13] **Suzy Davies:** I presume that the English DGHs use a different tool.

[14] **Ms Shillabeer:** They have a slightly different system in England. Obviously, the national service framework for Wales is different to that in England, but the standards that we expect for the population of Wales are not very different from those in England, although they are expressed differently. We still ask those questions, such as, 'Do you meet this standard?' It may be that there are some local differences, but we try to keep true to that NSF for patients who are resident in Wales.

[15] **Suzy Davies:** So, it is laborious, but ultimately effective, you think.

[16] **Ms Shillabeer:** Yes, that is probably fair.

[17] **Jocelyn Davies:** This is a simple question, really. I wonder how you approach this service when you do not provide it yourself. Are you satisfied that the standards of neonatal care in Wales are high?

[18] **Ms Shillabeer:** I should say that, a couple of years ago, I managed neonatal services—not in Powys, but in another part of Wales—and there were certainly some real challenges in terms of people being able to access the service. My feel for it now is that strides have been made—standards are improving, cot availability has improved, there are fewer women and babies going outside the network area. There are still some challenges, for sure. My understanding is that there are still some issues around nurse staffing and releasing nurses for training. There are certainly some issues around medical staffing. So, I would not want to sit here and paint a rosy picture, but I would say that things are improving. From a Powys perspective, we do not have issues of concern raised with us by our clinical staff or by our patients and residents. We have small numbers, you need to appreciate that, but this is not an area that keeps me awake at night because my door is being knocked down by people with issues of concern.

[19] **Jocelyn Davies:** The reason that you do not offer the services yourselves is because your numbers are relatively low because of the sparsity of the population.

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

[21] **Mr Cottom:** In addition, the geographical distribution means that they are going to different places in order to get the right sort of access.

[22] **Aled Roberts:** Roedd un o'ch atebion yn sôn nad oedd llawer o wahaniaeth rhwng safonau Lloegr a Chymru yn y fframwaith. Beth yw'r gwahaniaeth?

Aled Roberts: One of your responses mentioned that there was not much difference between the standards in England and Wales in the framework. What is the difference?

[23] **Ms Shillabeer:** The difference is largely around wording. The standards are much the same. I do not know whether you have had an opportunity to look at the reports that we have put forward from the English neonatal networks, but you will see that they largely cover the

same areas as they do in Wales. So, the issues of access, family-centred care and those concerning training—that the networks publish their training—are important. It is in the description, really; it is a language issue rather than anything fundamental.

[24] **Mr Cottom:** The fact that we use different sites, including sites in a different country, is one of the reasons why we take this individual approach, focusing on the individual experience and getting it properly managed and reviewed in our board mechanisms.

[25] **Aled Roberts:** Rydych wedi sôn yn eich tystiolaeth ysgrifenedig ac yma eto'r bore yma eich bod yn ddibynnol iawn ar ddarpariaeth drawsffiniol, naill ai o fewn Cymru neu draw yn Lloegr. Mae nifer o adolygiadau yn digwydd yng Nghymru, ond rwy hefyd yn ymwybodol bod cynnig y bydd y gwasanaeth yn cael ei drosglwyddo o'r Amwythig i Telford yn Lloegr. Beth yw eich rôl yn y trafodaethau hyn ac a ydych yn hyderus ei bod yn ddigonol i amddiffyn buddiannau pobl Powys?

Aled Roberts: You have mentioned in your written evidence and again here this morning that you are very dependent on cross-border provision, either within Wales or over in England. There are numerous reviews being undertaken in Wales, but I am also aware that there is a proposal that the service may be transferred from Shrewsbury to Telford in England. What is your role in these discussions and are you confident that it is adequate to safeguard the interests of the people of Powys?

[26] **Mr Cottom:** In terms of our role, the first principle is that our responsibility is to our population and to ensure that it receives the best care possible. In this particular circumstance, we have engaged actively with Shrewsbury and Telford Hospital NHS Trust. It held a number of meetings for us as a health board and with our populations, which we attended. We were able to review the detail of its case and took some confidence from the fact that it was weighing up the location issue with developing a clinically robust and safe service.

9.15 a.m.

[27] We also have an ongoing operational dialogue with it as it moves to implementation, because it is over a number of years, to ensure that the right services are in place. That would include issues such as equipping our midwifery services to ensure that they are able to respond to a service that will be slightly further away. Also, the Welsh ambulance service has been part of the planning mechanism to ensure that it, too, is equipped and that the service is sufficient to respond to the fact that there is a slightly longer distance involved.

[28] **Aled Roberts:** Rydych yn fodlon â'r trefniadau yn Lloegr ar hyn o bryd, ond mae perygl, pe bai penderfyniadau yn cael eu gwneud i symud gwasanaethau ymhellach oddi wrth ogledd Powys, na fyddech yn fodlon gyda'r trefniadau wedyn. Sut y byddech yn delio â'r broblem honno?

Aled Roberts: You are content with the arrangements in England at the moment, but there is a danger, if decisions were made to move services further away from north Powys, that you would not then be content with them. How would you address that problem?

[29] **Ms Shillabeer:** In relation to the services in north Wales, we have some benefit from being a very large and sparsely populated county with a lot of pathways. That is, we can sometimes move pathways. For example, if we became very unhappy with the service at Shrewsbury and Telford, we could have a discussion with our population about generating more links with Betsi Cadwaladr LHB, for example. In fact, there are a number of women in north Powys who access services in Betsi Cadwaladr LHB.

[30] We are really clear about the fact that, as Powys, we have to link in with every health board, and future planning involves our population and some consideration of its needs. We

feel confident that Wales is small enough to take a whole-system view. There are seven health boards now, and dialogue is good between board members and between the heads of professions to ensure that pathways can be fully explored. There is already some work going on with Betsi Cadwaladr LHB, and it is aware of the types of population that we have in north Powys and the needs and some of the issues that exist with regard to England.

[31] I would like to just add something that relates to your previous question. I think that it is very clear—it has been clear in England also—that having a lot of smaller units is difficult to sustain. Therefore, the need to consolidate, particularly at the higher end of care, in terms of intensive neonatal care, is really important. That is where England is, and our job, as Andrew has said, is to ensure that the voice of Powys residents is heard and that they are being fully considered—even though the numbers are small, they are still an important part of that flow.

[32] **Jocelyn Davies:** I have a question on a technical point. You intervene earlier and you do this pathway planning. So, you take account of the geography—where the pregnant woman lives—and of her likely needs before you decide where you will commission the service. You mentioned earlier that you might have somebody in north Powys going to Gwent. I think you said Gwent.

[33] **Ms Shillabeer:** She would be going to Swansea, from the Machynlleth—[*Inaudible.*]

[34] **Jocelyn Davies:** So, you would not automatically go to the unit nearest to you geographically; it depends on your circumstances.

[35] **Ms Shillabeer:** Absolutely.

[36] **Christine Chapman:** I am going to move on to Lynne Neagle now.

[37] **Lynne Neagle:** I think that my question has been covered in the answer to Jocelyn.

[38] **Jocelyn Davies:** Sorry.

[39] **Lynne Neagle:** It is all right.

[40] **Jenny Rathbone:** I would like to follow that up. Could you tell me what the clinical protocol is for deciding who has midwife-led care or hospital care? How much is it down to patient choice, and how much is it down to the risk factors?

[41] **Ms Shillabeer:** When women book in, their general health and their history are assessed, and, if they are fairly low risk, we try to encourage them to stay within a low-risk service. I am sure that you have read the paper that says that, in Powys, we do a very good job at looking after people in the low-risk category. The important fact is that we know our business and we know what we can and cannot do. So, if women do not fall into the low-risk category, we have to plan their care with the relevant services. Now, there are some areas whose current service configuration means that they will not be able to take the women at highest risk, and those women may need to be referred somewhere else. There is a discussion between the individual woman, the obstetrician and the GP to ensure that the pathway is planned. Our midwives spend a lot of time trying to pre-plan the care, because we do not want to be in a situation where something unexpected happens and everyone is in a rather difficult position. The key issue is that, at any time, if a woman's situation changes, she can be transferred into more obstetrics-led care. That is where the careful monitoring takes place.

[42] **Christine Chapman:** Lynne, you wanted to come back in on this point.

[43] **Lynne Neagle:** Yes. It is great that there is a lot of planning, but there must be circumstances where things go wrong unexpectedly. Could you tell us a little bit about how that is managed locally when someone very suddenly develops problems, so you might not have a pathway for that in place? How effective is the support in such a case?

[44] **Ms Shillabeer:** Probably the most memorable example in recent years was a case in 2007 where there was a neonatal emergency relating to a lady who had been on the low-risk pathway. These things happen. We ensure that all of our midwives, every year, are fully equipped with the neonatal life support skills to ensure that emergency intervention takes place there and then. If it is a home birth, which it largely is in Powys, unless it is in a birth centre, there are two midwives and therefore there is support. I am pleased to say that, in the 2007 incident, the baby was given oxygen support by bagging, as we call it, and, when the baby got to the neonatal unit, the oxygen saturations were as good as if it had come from the ward next door. People feel very confident about that. They practise these skills for that one occasion that may arise. You do not know when it will happen. Sometimes, people will present with problems after absolutely no sign at all that there is something awry. However, the emphasis is on planning and on early intervention. Generally, women feel comfortable about being referred in for a general check-up if a midwife is feeling a little unsure.

[45] **Lynne Neagle:** That is very encouraging as well, but I imagine that there are also cases where a woman might go into labour very early. Does what you have said regarding the skills that allow the midwives to intervene on a short-term basis apply to the very young babies—those who are born at 25 weeks or so? Does that work for them?

[46] **Ms Shillabeer:** It is neonatal resuscitation; that is what they do. That is for those who are very small. As you know, the chances of survival will differ and travel time is important. That is why our relationship with the Welsh ambulance service is very important. The service is very good and very responsive in those situations. If there is a midwife in the middle of rural Powys with a baby who is not breathing on its own, the ambulance will get there as soon as it can. I do not want to tempt fate. We have been very fortunate. I must emphasise that we try to plan and intervene early and then deal with anything else that happens that cannot be planned for.

[47] **Julie Morgan:** Do you encourage home births for first babies?

[48] **Ms Shillabeer:** There is no reason why we should not, if they are low risk. There is every reason to encourage people to have a home birth. What we have in Powys, which is the equivalent of a home birth, is our birth centres, which are in community hospitals, but they are a home from home. So, if you choose not to have your baby at home, there is a homely environment. So, there is no reason why first babies cannot be born at home. We do face some challenges in that some women who are outside the low-risk birth criteria will still want to have home births. That is tremendously difficult to manage, because there is an element of choice, which someone mentioned earlier, and supporting women in their decisions. That is when we use the supervisor of midwives arrangement to ensure that the woman fully understands the risks that she is taking. It is very stressful, but some women will choose that. We have had a couple during my time in Powys. All sorts of things could happen in that circumstance, and we try to persuade women, where their health and the health of their baby could be at risk, to access appropriate services.

[49] **Mr Cottom:** From a board point of view, going back to our approach of managing these on an individual basis, every case like this would be reviewed, and there is a proper mechanism for learning from that and for developing our approach so that we keep ahead of the game and ensure that mothers and babies are safe.

[50] **Jocelyn Davies:** I want to ask you about multiple births, which we know are

becoming more common. You are getting your services for neonatal care from a number of district general hospitals outside your area, so, if there is a multiple birth, are you able to keep all those babies together in one place?

[51] **Ms Shillabeer:** In relation to the criteria that we have just talked about, a multiple birth would not be low risk, so we would not elect the babies to be born in Powys. They would be born in a unit that is obstetric-led and offers neonatal support. I have heard of situations where babies have been split up and have gone to different units. I have not had any such cases relating to Powys. It is a tricky issue, because I understand that clinical staff will be weighing up the issues around trying to keep the babies as close as possible but also ensuring that they get the right access to care. I was chatting with a lady in my community who had experienced neonatal care, and she said to me, 'I will go to the ends of the earth so long as they get the best care'. That was quite interesting, but, equally, we do not want Welsh women to have to go to the ends of the earth for it. So, there are some very pragmatic decisions to be taken, but it feels as though we must do better than splitting babies up.

[52] **Jocelyn Davies:** There are large distances to travel in Powys in any case. Do you offer practical support for families in that position?

[53] **Ms Shillabeer:** There has been a lot of emphasis on outreach services, which are really important. It would be a real challenge in Powys, particularly as we have so many of the pathways. We have a small community paediatric nursing team, which, because it works in a rural setting, probably has a broader set of skills and is much more generalist than you might find in other places. There is a very close link between the team and the specialist services. For example, if a family and a baby are discharged from a neonatal unit, the follow-up is undertaken by our nurses in liaison with the outreach nurses to a level that our nurses can manage. If the baby requires more intensive support, there is a discussion with the outreach nurses about how that will be delivered. We have ensured that our nurses are as skilled as possible. They are local and are already within Powys, and they will have a relationship with that family further on in the lives of the children.

[54] **Angela Burns:** Thank you for your paper, which was very interesting. I have two questions. You talked earlier about your relationship with the Welsh Ambulance Service NHS Trust. Do you have any figures for the average time a patient and their child or baby may wait before they are transferred to a district general hospital neonatal service? The second question, the answer to which I suspect, after reading a lot of this evidence, will be, 'How long is a piece of string?', is whether there is a critical time for a neonate. We talk about people with strokes having a golden hour and so on, and I wondered whether that is applicable in this instance.

9.30 a.m.

[55] **Mr Cottom:** I am not aware of specific figures for neonates as far as ambulances are concerned. We have seen an improvement in the achievement of the eight-minute response time standard in Powys. It has been over 60% for some time. We keep an eye on the coverage of that because we do better in some parts of Powys than others. We have a regular dialogue with the ambulance service and it is part of our unscheduled care planning team, to ensure that we are keeping abreast of any issues. If there was a particular incident that we were concerned about, it would go through our review mechanism. The ambulance service would be a part of that and we would hope to learn from it.

[56] **Ms Shillabeer:** I will pick up on the golden hour. You are absolutely right. How long is a piece of string? It clearly depends. The first thing is that you want to get that baby to the district general hospital—ideally, the right one—as soon as possible. It is important to ensure that treatment starts early. It goes back to the question that I answered earlier and about our

midwives being able to instigate life support. At a basic and fundamental level, it is about keeping the heart going and ensuring that there is oxygen going into the baby and being able to sustain that. Having two midwives is very helpful. That continues on the ambulance, so the midwives travel with the baby. We clearly want to get the baby to the nearest and most appropriate DGH. It is very different. If you are in Welshpool, for example, you are not that far from Shrewsbury, but if you are the other side of Newtown or in Llanidloes, you have to travel a bit further. So, it is not an easy question to answer with a definite time.

[57] **Christine Chapman:** We have talked a lot about ambulances and the midwives being appropriately trained. What about the ambulance crews? Do you have any thoughts on that?

[58] **Ms Shillabeer:** I have only one comment, which is that there is a need for ambulances to have neonatal equipment on board. It is a rare event to have a baby born in Powys that has not been planned, but we need to ensure the right equipment is always there, rather than saying that we do not need something as it has not been used for a while, so let us take it off. We need to ensure that it is there. It really is a very small piece of kit, and it is just to be able to strap the baby in so that the resuscitation can continue along the way. It is those practical things. Our dialogue with the Welsh ambulance service at a clinical leader level is to make sure that it is always there and just because it has not been used for a little while, they must not think that it is not needed. It is a just-in-case bit of kit, really.

[59] **Suzy Davies:** I have a straightforward question. The response times and the travel involved for Powys are just ridiculous, in my view, so do you use the air ambulance if you need to?

[60] **Ms Shillabeer:** Oh, I am glad that you thought it was a simple question.

[61] **Suzy Davies:** I did not think it was a simple question at all.

[62] **Ms Shillabeer:** There are occasions when we can use an air ambulance. I am not an expert on air ambulance and I probably need to know a bit more about it, but there are issues to do with flying at night and in bad weather and so on, so there are limitations. There have been occasions when we have used it, but it is not a routine mode of transport.

[63] **Suzy Davies:** But you do use it. That was my question.

[64] **Ms Shillabeer:** We do, yes.

[65] **Julie Morgan:** You have covered this question to some extent, but do you think that neonates are disadvantaged in Powys by not having one DGH to relate to—for example, you could be relating just to one all the time and building up links? If so, how can you get over that?

[66] **Ms Shillabeer:** I cannot think of any practical solution that we have not tried to put in place. Powys is so sparsely populated and its geography so large that even if we put a neonatal unit providing intensive care right in the middle of Powys, our numbers would still be so small that there would be some real challenges in attracting the right medical and nursing staff, maintaining skills, and so on. It is far better for women and babies who need specialist care to go to a unit that has the expertise at hand, and it is a broad range of expertise, as neonatal services continue to develop, with new therapies being brought forward. Our mums want the same for the babies as I want for them: the best care. We have overcome some of the challenges by working in quite a complex way with those different pathways. It adds complexity for us, but we try to ensure that, by planning individually, it is straightforward for the individual. They do not feel that level of complexity. If you are in

Brecon, for example, and you need obstetrician-led care, your nearest place is Nevill Hall. That is a fairly straightforward relationship. It is only we who have to think about five or six different systems, as service planners.

[67] **Mr Cottom:** So, based on our experiences, the answer is probably 'no'.

[68] **Jocelyn Davies:** I do not know whether you have read the transcript of our previous inquiry into neonatal services, but I will just remind you of something that was said when we had Dr Barr here. I imagine that some of your women might recognise this:

[69] 'I have no cots at all and there are babies who are now well enough to leave my unit, but the other units are full. That means that there is a baby who will be delivered today with complex medical needs who will have to be managed on a paediatric ward, because I do not have space for that baby.'

[70] Sometimes, these women are probably coming from Powys. Does it ever happen that a baby with complex needs from Powys is placed on a paediatric ward?

[71] **Ms Shillabeer:** A handful of women and their babies each year are transferred outside the normal pathway. That is in Wales and in England. They go to places that you would not want them to go to, because there was somewhere suitable closer to hand but cot availability was an issue. They are a handful. Largely, the transfers outside the normal pathway relate to surgical complications. For example, we had a baby that we knew, in utero, needed some spinal surgery, and we put them into Liverpool. So, that was planned, but there are occasions when a small number—and it is a smaller number than it was two years or so ago—are going to places because of cot availability. I did read the earlier evidence, and it was a difficult read, because we still do not have this completely right.

[72] **Aled Roberts:** I am just wondering what happens in one of these pathways if a decision is taken internally to close a special care baby unit. That has happened in north Wales on a number of occasions—in Wrexham, for example. The SCBU is closed for a period of time and the patients are transferred to Ysbyty Glan Clwyd. Would your arrangement still be with the Betsi Cadwaladr University Local Health Board, or would you have to rethink which pathway to choose?

[73] **Ms Shillabeer:** Our arrangement would still be with Betsi. The clinical lead for the service in Powys tells me that, rightly or wrongly, what tends to be a consideration is how far the resident, the mum, has come. If she is from Powys, that is a consideration in moving that baby yet further away. It may be that someone from that population would move if there is a problem with cot availability. I am not saying that this happens all the time, but consideration is given to how far away the family is from the unit, and how many miles they have already travelled.

[74] **Aled Roberts:** Is that consideration by you?

[75] **Ms Shillabeer:** It is consideration in the neonatal unit.

[76] **Aled Roberts:** How does that work if the north Wales neonatal service decides to close Wrexham, which means that Glan Clwyd is the nearest alternative? How would they take into consideration the needs of that woman and her family, and the problems that they face, when making their decision? I do not follow that.

[77] **Ms Shillabeer:** We must remember that the vast majority of this—and the example that we gave you from 2007 was an emergency—is planned. You gave an example of a high-risk woman who is perhaps on a maternity ward and who may well give birth later that day,

and a decision will be made in that unit between the obstetricians and the neonatologists—or paediatricians, often in the case of north Wales—about where to place that woman. Is she placed in another unit in north Wales or do we transfer her out? What I am saying is that I am told that there is a consideration about how far that woman has already travelled.

[78] **Jenny Rathbone:** Can you tell us about caseload? You have 1,200 births a year in your population, and 300 of those are in Powys. What is the caseload of each midwife? How many midwives have you got and what is their normal expected caseload?

[79] **Ms Shillabeer:** The first thing that I would say is that, although there are 300 births in Powys, there is antenatal and postnatal care in Powys, so we try to provide the preparation and the aftercare there. We base the caseloads on 1,200 women, with around 300 births. We have something in the order of 44 midwives, which means that the caseloads are reasonable. We also have to consider that our mode of delivery is a home birth, so we have a named midwife and then a second, and we have to try to arrange that. We use a system called Birthrate Plus to ensure that we meet the standard on midwifery staffing levels, and I am pleased to say that we do, so there are no difficulties with that. Increasingly, over the last few years, we have been introducing new roles, such as the maternity care assistant, to support some of that as well.

[80] **Jenny Rathbone:** If you had more women opting for your excellent community-led midwifery service, how would you cope? Do you have a vacancy problem?

[81] **Ms Shillabeer:** No, we do not have a vacancy problem. We are very fortunate that midwives like the model of care that we provide within Powys. It is back to their roots, if you like, so we manage to attract midwives in. We are always aiming to try to increase our in-county births. Up to about 40% would be ideal. Anything above that tends to be medium or high risk. So, we have a few more women to encourage to use the low-risk pathway. Birthrate Plus is a system that we review every few years, just to check that we have the right staffing, so we would have to modify it.

[82] **Christine Chapman:** On that note, I thank you both for attending today. We will send you a transcript of the meeting to check for any factual inaccuracies, but thank you both for attending.

9.45 a.m.

Ymchwiliad i Ofal Newyddenedigol
Inquiry into Neonatal Care

[83] **Christine Chapman:** I invite our next panel of witnesses to the table, from the Cardiff and Vale University Health Board and Cwm Taf Local Health Board. Will you all introduce yourselves for the record, please?

[84] **Ms McGrath:** I am Kath McGrath. I am assistant director of operations at Cwm Taf Local Health Board. I have 30 years' experience as a nurse and midwife.

[85] **Ms Williams:** I am Allison Williams. I am chief executive of Cwm Taf Local Health Board.

[86] **Mr Hollard:** I am Paul Hollard. I am interim chief executive of Cardiff and Vale University Local Health Board.

[87] **Dr Calvert:** I am Jennifer Calvert. I am a consultant neonatologist at Cardiff and

Vale University Local Health Board.

[88] **Christine Chapman:** Welcome to you all. Members will have read the evidence that you have presented. If you are happy, we will go straight to questions, for which we have a maximum of one hour.

[89] We have received evidence about challenges in relation to staff shortages. At what development stage is your workforce plans and how do you envisage that those plans will address the nursing staff deficit within your health boards?

[90] **Mr Hollard:** Thank you for the question. We have undertaken a review of nurse staffing levels within our neonatal service. We have a gap of around seven whole-time equivalents between the current provision and the standards that we are trying to achieve. The nurse director is currently undertaking a review, which, as you will see in our action plan, is due for completion at the end of this month. The division has completed its draft report. We are looking not only at numbers, but at skills, competencies and the skill mix of staff. That will be presented to the executive board at the end of this month and then we will take action to address those gaps. We fully recognise the gaps.

[91] We also provide a community outreach service and we are looking carefully at that. At the same time as developing our internal and acute service, we are moving to a community midwifery service. We are looking at how the interface between neonatal services and community midwifery works together. That will happen at the end of this month.

[92] **Ms Williams:** I will start and then ask Kath to give some details. Cwm Taf also has gaps in the establishment of neonatal services in line with the standards. We have a system of bank nursing and we are working on a rotation system of midwives to ensure that we always have the right number of staff working in the unit, depending on the needs of the babies at the time. While there are gaps in our establishment, our working practices are such that we are able to ensure that the gaps are covered and that we are not left with a deficit in clinical care at the time of need of babies.

[93] **Ms McGrath:** We have just completed an establishment review, which went beyond neonatal services; it was across the health board. It looked at acute paediatric services and midwifery services in line with the neonatal service. There was a shortfall of six full-time equivalents in the neonatal service. Two people have recently been appointed, which leaves us with a gap of four. We are looking at the opportunity to rotate midwives into the neonatal unit to address some of the gaps within the neonatal service. That will upskill midwives from the postnatal ward area by developing their transitional care skills. We hope that this will improve the competence and confidence of midwives to provide transitional care in a postnatal setting, thereby releasing some of our special care capacity.

[94] **Christine Chapman:** I will not ask at this stage about the impact of training, about which there have been some issues, because I know that other Members will want to come in on that subject.

[95] To both LHBs, how are you working together as a health community? How are you collaborating with other health communities to address the nursing staff shortage?

[96] **Ms Williams:** We are delighted to be here together. It gives a clear message to you about our joint working. Cwm Taf recognises that Cardiff has a clear partnership with all heath boards in south Wales and beyond for the delivery of specialist care. That relationship is particularly important for the south-central population, which is very dense. Our working together is critical. You may be aware that there used to be a level 3 unit in the Royal Glamorgan Hospital. However, three or four years ago, because of medical staffing

challenges, an active decision was taken that it was no longer viable or clinically safe and sustainable to keep the service in that way.

[97] That was the start of a significant strengthening of the relationship between Cwm Taf and Cardiff in managing the transition from level 3 services to level 2. It is the level 2 plus service that we have in Cwm Taf that you may want to hear a bit more about later. There is a strong relationship, which has strengthened further as a consequence of the network arrangements. We have joint meetings between our key staff so that we work and plan together. We are working to equalise the systems and guidelines for care between the relevant units. We are also exploring rotational programmes for our nursing staff between our two units, which is particularly important because we have a history of nurses in our neonatal service who are skilled and competent at delivering level 3 care because that is what they were doing before and we do not want them to lose those skills. The only way we can ensure that we are able to maintain those is by very close working, training and rotation programmes through Cardiff. It is a growing and developing relationship, but a very strong relationship for our population.

[98] **Mr Hollard:** I would echo that. The advent of the network has made a huge difference to us in terms of understanding neonatal services across the whole of Wales, but particularly in south Wales. South-central Wales, as Allison said, is really important in terms of the type of births we have in that population, which can be quite complex, and we need to work together. One of the things we have recognised is that, sometimes, the numbers of cots and the levels of care between the two units are not balanced, and something we are working on together is how to map those cots appropriately across the south-central region rather than just looking at the individual units. It needs to be done together.

[99] **Julie Morgan:** I want to ask you about the training issue. The committee has had some evidence that it has been difficult for some nurses to access training and education. What action has been taken to implement the all-Wales framework for neonatal nurse training?

[100] **Ms McGrath:** From a Cwm Taf perspective, each member of staff has a training programme. Somewhere in the region of 75% of our neonatal nurses have attended neonatal courses. It is funded by the health board and through local universities, so we do not have a significant problem with releasing staff for training. It obviously comes with its challenges, but it is important that we maintain those skills

[101] **Julie Morgan:** So there is not a problem releasing people for training in your health board.

[102] **Ms McGrath:** No.

[103] **Ms Williams:** If I may add to that, it is also important that we recognise that training takes a number of forms. There is formal training, which is what Kath has just been talking about, but there is also clinical supervision and on-the-job training, which are as critical for maintaining skills. That is a very important plank of our training and development strategy. As we said earlier, the potential for the rotation of staff between Cwm Taf and Cardiff is a further development and training opportunity, which works both ways because there are different experiences in both units. This is not about traditional attendance at study days and courses but very valuable training and development opportunities, which we need to look at as a very significant element. This side of things is not about releasing staff but giving them on-the-job training and experience that complement the formal training.

[104] **Julie Morgan:** So training takes many forms.

[105] **Ms Williams:** Yes.

[106] **Mr Hollard:** From Cardiff's perspective, as a specialist centre, we do not have difficulties recruiting staff. We do not necessarily have difficulties training staff. As Allison said, training takes a broad range of forms. As technology advances and we are able to care for neonates of shorter and shorter gestation, that is the skills base we are concentrating on. It is about how we ensure that those intervention skills increase as those levels of care increase as well. With regard to medical staffing, we have had some difficulties in the past. That has enabled us to work with the deanery. Jenny might want to say something about the medical staffing issues. That is being resolved and we are in a much better place than we were previously. So, from a clinical care perspective, we do not have significant problems in Cardiff and Vale.

[107] **Julie Morgan:** The Royal College of Nursing said that it found it difficult, in that nurses were asking to be released for training but were unable to do the training. It said that nurses had to do training in their own time and, I think, even pay for it themselves. Do you have any comments on that?

[108] **Dr Calvert:** I am not aware of that situation. In Cardiff and Vale, our practice education team runs intensive care and high-dependency care modules, which are open to other health boards. Staff from Cwm Taf attend those modules, and, as part of that training programme, we have started to set up some staff rotation.

[109] **Julie Morgan:** So, you are basically saying that there is not a major problem in relation to releasing staff or in relation to receiving training on the job?

[110] **Mr Hollard:** I do not know what the RCN raised with you, but there is a difference between the internal supported training that we undertake and the formal neonatal education. I do not know what it was talking about, but, as Jenny said, we run our own training modules within Cardiff and Vale. We take staff from within Cardiff and Vale and from our partners. As far as I am aware, we do not particularly have a problem.

[111] **Christine Chapman:** Perhaps we could send you the transcript of the evidence given by RCN, given that it was quite clear on that, because it is important that we get this situation clarified.

[112] **Mr Hollard:** Yes, that would be helpful.

[113] **Christine Chapman:** So, if we send you that transcript, perhaps we could get your comments on that. Angela?

[114] **Angela Burns:** I appreciate that you will be sent the RCN evidence, but when I read the RCN paper, I got the impression that the place to go to get trained is pretty much the University of Glamorgan, which offers two specialist neonatal courses. It also states that, outside Wales, an advanced neonatal nurse practitioner course is also offered. What are the training routes? Is it only that you can go to university to train to be a neonatal nurse or can you really do it on the job? You sort of answered that for Julie, but I was not clear—perhaps I am just being dense.

[115] **Ms McGrath:** There are varying levels of neonatal training. We expect most of our neonatal nurses, particularly those working at high-dependency and intensive care levels, to have followed a recognised neonatal course module to support them in the delivery of that type of care. If midwives are rotated into a neonatal unit, they would be working at the lower end of the special care spectrum of care delivery. They would not therefore particularly need the neonatal courses, but they would need some in-house training and competency-based

training. So, there are different levels and routes of training within the specialty.

[116] We are lacking in relation to training for advanced neonatal nurse practitioners in Wales. So, yes, those nurses have to go outside of Wales for a year's training.

[117] **Mr Hollard:** I just want to confirm that the modules that we were talking about are accredited and overseen by the university.

[118] **Ms Williams:** I have two comments to make. First, our staff in the neonatal service have a mix of skills, as we do in any other nursing team. We would not necessarily prohibit recruitment at the entry level into neonatal care if nurses did not have the training, but there would then be a requirement on staff in their early time in the unit to undertake that training. We would pay for that training and release people to undertake it.

[119] I read the RCN information in preparation for today. I do not recognise what it states in terms of my organisation, but we will follow it up directly with the RCN, because we need to know whether any of that relates to our unit. We certainly would not condone people paying for their own training. The only circumstance in which I could imagine a situation where someone may have to do something in their own time is if there was a fixed study day on their scheduled day off. So, they may attend that study day, but we would give them the time back in lieu. So, they might technically undertake that training on their day off, but time off in lieu would be reflected in their rota. That is the only circumstance in which I imagine that would happen in my organisation.

10.00 a.m.

[120] **Jocelyn Davies:** I want to ask you about the European working time directive and whether it has had an impact on the compliance of the neonatal capacity? I appreciate that you have said that you have looked at the evidence—I am not sure that all of you have done that—but there did seem to be an issue with capacity. We heard from Dr Barr at that time that she had eight babies and only three nurses the week before. These babies were very sick, and sometimes there were cots but nobody to staff them, so patients were being turned away. Is this as a result of the working time directive? Is what you have described to us new, or is this ongoing?

[121] **Ms Williams:** The European working time directive would not have a direct correlation with nursing staff levels. Our shift patterns and our systems of working in nursing have been compliant with the European directive for a long time. The European working time directive has had a significant impact on medical staffing, which was one reason why we had to review the sustainability of the level 3 service at the Royal Glamorgan several years ago—we could not secure compliance in having separate medical rotas for paediatrics and neonates, which is what is required of the high-acuity level. We could not sustain that at middle-grade level, because of European working time directive guidance. However, that is not a factor at all in our nurse staffing levels or in our working practices in nursing.

[122] **Jocelyn Davies:** How do you for account for the eight babies and three nurses in a high-dependency setting? In fact, I think that the doctor told us that she had six very sick babies, ventilated and on different drugs and having different procedures. There should have been six nurses, but there were only four. She described two different situations: in one, she had eight babies and not enough nurses, and in the other, she had six babies and not enough nurses. In the picture that she painted for us, she said that they were sailing close to the wind.

[123] **Dr Calvert:** Shall I comment on that?

[124] **Jocelyn Davies:** Yes, please.

[125] **Dr Calvert:** This relates to the British Association of Perinatal Medicine standards for nursing in intensive care and the all Wales neonatal standards. You have heard lots of evidence before that, for neonates in general, we do not meet the standards. The nursing in intensive care should be 1:1—when there are six babies receiving intensive care in an intensive care unit, there should be six nurses looking after them, one-to-one. In daily practice, unfortunately, we cannot meet the standards, and that is what we have been talking about—how we are going to attempt to meet the standards. At the moment, however, we cannot meet the standards, so what you have heard before happens on a daily basis. That is not acceptable, but we would always ensure that the care that we provide is safe, so that the babies have the care that they should receive. However, it does make it a very stressful environment for people to work in, because they have to provide more care than they would if we were meeting the standards.

[126] **Jocelyn Davies:** Is that a new situation, or is it something that is historic?

[127] **Dr Calvert:** It is historic, unfortunately. The other issue that makes it increasingly important is that the demand for neonatal services is increasing. The birth rate in Wales is going up, particularly in the Cardiff area, where it seems to be increasing more than in other areas. So, the demand on our service is ever increasing, hence this is an ongoing problem that is going to get worse if we do not address the staffing issue.

[128] **Mr Hollard:** I agree with Jennifer. The other issue for us in Cardiff and Vale is that we are a surgical centre as well. So, we have surgical neonates as well as medical neonates, and that places us under additional pressure when there is peak demand.

[129] On the European working time directive, which I was talking a little about earlier, the situation has improved through our work with the deanery. It does not affect nursing staff levels, although we do have a challenge during peaks in demand.

[130] Another issue, on which we are working with Cwm Taf, as I have mentioned, is the level of cot cover for babies, as it can sometimes be out of balance across Cwm Taf and Cardiff and Vale. That has an impact on our staffing levels and on the acuity of our neonates.

[131] **Lynne Neagle:** You said that you make sure that the services are safe. Presumably, however, when you drew up the guidance for one-to-one nursing, it was done on the basis of clinical safety. How can you be sure that the services are safe when we have heard that there is such a significant shortfall of nurses in that situation? How can you be so confident that they are safe?

[132] **Dr Calvert:** On a daily basis, we assess the acuity of the babies we have on the unit and the care that they require in order to ensure that we have sufficient nurses on the ground to deliver the care that they need. However, it is an ever-changing service; it changes on a day-to-day basis. Babies come in unexpectedly very regularly and we have to adjust to that. However, we would always hope that we are providing a safe service.

[133] **Lynne Neagle:** So, you hope that you are providing a safe service.

[134] **Mr Hollard:** To follow on from that, it is not just the number of neonates that we have in the unit but the acuity of those neonates. Sometimes, there will be a greater number but less acuity and other times, there will be a smaller number with greater acuity. Therefore, the way that we manage the staffing will depend not only on the number of neonates but the acuity of those babies. Sometimes, we have to put in additional staff above and beyond what would be recognised because of the acuity of the babies that we have. So, it is not just a simple correlation between the number of neonates and the number of staff, it is also about

acuity. We have to watch that very carefully. Given the tertiary nature of our service, we will sometimes have a quick increase in demand, particularly from a surgical perspective.

[135] **Christine Chapman:** Allison mentioned bank nursing and, obviously, you rely on this from time to time, but you cannot rely on it to the same extent, because it depends on who is available. Would you like to say something on this, bearing in mind the service that we are looking at?

[136] **Ms Williams:** One of the challenges in a service like this is that it fluctuates in terms of demand, as you will have heard previously. As a result, we have to have the ability to flex our staff up and down according to what is happening in the unit at any one time. We have a small cohort of bank staff who are very well known to us, who are highly trained and who work flexibly to support the unit. Our situation is slightly different to that in Cardiff, because we are not providing the very high-end acuity of care on a regular basis. We have the ability, with the one intensive care cot that we have, which acts as a bit of back up to the situation, to flex the staff according to changing need.

[137] As Paul mentioned earlier, one thing that we are trying to do between us—some of this will be resolved as some of the physical constraints in the unit in Cardiff are improved—is to look at whether that intensive care bed needs to be in Cardiff with the other intensive care beds. However, there is probably a need to swap and have more high-dependency beds in the Royal Glamorgan so that we will be balancing the type of care between our two units.

[138] **Christine Chapman:** A number of Members want to come in at this point. Aled, is your question on this point?

[139] **Aled Roberts:** It is on another point.

[140] **Christine Chapman:** Okay, I will bring in Simon as he has a question on this particular point.

[141] **Simon Thomas:** I will ask a specific question, because I appreciate your assurances that the care is safe. You have said yourself that this is a very stressful situation for the nurses concerned. Do you undertake an analysis of the sickness rates or rates of absence from work? Can you give us any information about how that affects the service?

[142] **Mr Hollard:** To come back to the point about bank staff and overtime, in a week, we use between no shifts and up to three, on average, where staff will either work through the bank or increase their hours. In terms of sickness rates, it is a stressful environment, but the biggest challenge for us is maternity leave. We have a very high level of maternity leave in that area. We have just appointed additional staff to cover the maternity leave absence. Sickness rates are not that high. We have a very dedicated team of nursing staff who support each other well. However, our challenge is maternity leave. While we have time to plan for that, there are issues about filling that gap on a regular basis. There seems to be a particular trend in neonatology.

[143] **Jocelyn Davies:** Chris, may I make a point? Are staff coming into work when they should be home sick?

[144] **Mr Hollard:** I would say not, because staff are very mindful of the vulnerability of those babies, so they will not come to work, and we do not encourage them to come to work. It may be acceptable if a member of staff in one of the other wards has a cold, but it is not acceptable in the neonatal unit. Our staff are very mindful of the risk that they pose to those babies if they come in when they are unwell.

[145] **Ms Williams:** In response to your question, most of our critical care areas are recognised as being very high-pressure areas for our staff. As a consequence, in relation to the infrastructure within the teams, the team support and the external support that we put in to help then, whether it is in a tragic situation where they lose the baby or where they have been under a prolonged period of high acuity and pressure, we have specific staff support infrastructure systems within and outside of the team that we utilise to ensure that we manage that as best we can. In fact, we probably do it better in some of those areas than we do in others.

[146] **Ms McGrath:** Again, to give you some reassurance about the high fluctuations in acuity and activity within these areas, we are trying to rotate from other areas, such as midwifery and acute paediatrics, so that you do not have to wait for someone to come in via the bank. Individuals who have experience in the lower end of special care are releasing more experienced staff to deliver the high end of care. They can also move around the organisation so that they are not an isolated area.

[147] **Aled Roberts:** I am not sure whether I have read the evidence correctly, but were the standards brought in in 2010?

[148] **Dr Calvert:** They were brought in in 2008.

[149] **Aled Roberts:** Is there any expectation from the Government that you would reach those standards by a certain time, if you say that you are not currently meeting the standards? Part of the evidence in support of the neonatal review in north Wales says that standards are poor by international comparison. What is the position with your health boards?

[150] **Dr Calvert:** We benchmark—[Inaudible.] Our situation is unique within Wales because of our surgical responsibilities, so there is no other unit in Wales that we can benchmark against. So, we benchmark across the UK and the wider world, which allows us to compare our service with other services. We benchmark very well within that system. In some areas we are slightly outside where we would like to be, and we have taken steps over the last few years to try to address those areas, and the situation has improved.

[151] **Aled Roberts:** Do you still have areas that are outside where you would expect to be?

[152] **Dr Calvert:** Very slightly, but not in terms of overall outcome.

[153] **Aled Roberts:** What about the other board?

[154] **Ms McGrath:** With regard to the standards, over the period of time that we have monitored our service against the standards, there has been an overall improvement in our ability to meet those standards. We also benchmark, and our perinatal and neonatal mortality rates compare well and are within what would be expected for our area of delivery.

[155] **Julie Morgan:** Jennifer, you referred to a rise in the birth rate, particularly in Cardiff, and the extra pressures that that is bringing. How do you include that in your planning? How significant is it? I suppose that it particularly affects the health boards that you represent.

[156] **Dr Calvert:** There has been a 20% increase in births in Cardiff over the last 10 years, which is very significant. The evidence is that the birth rate is going up year on year; it is not stabilising—it continues to rise. So, that has to be taken into account with our future planning. We have lots of evidence from the neonatal capacity review from across the neonatal network to show the shortfall in capacity and cots, and we are looking as a healthcare community at how we will address those cots in our area. However, we need to take the rising birth rate into account as well, so that, as we address the current shortfall, we also take into account that

that shortfall will be greater in future.

[157] **Julie Morgan:** The evidence seems to be that this is an upward trend.

[158] **Dr Calvert:** It is, so our planning has to take that into account so that we create the capacity that we need now, but also the capacity that we anticipate needing in future.

10.15 a.m.

[159] **Mr Hollard:** May I add to that? This is not just about the birth rate, but for us, again, it is about the type of population that we have in Cardiff and the Vale in that it is a very mixed population. Some of the cultures are challenging in terms of how babies are born, which brings another challenge. So, we are not only looking at the population increase and the birth-rate increase because this also relates to the type of population in Cardiff, which is expected to grow. So, we are taking that into account, particularly in our medium to long-term plans, which will include working across the network. However, in terms of our particular responsibility for our population and some of the tertiary services, we need to be mindful of the type of population that we are servicing as well as the number.

[160] **Julie Morgan:** Are you reaching out to the ethnic minority population?

[161] **Mr Hollard:** We are; we have done quite a lot of work with Somali women recently. The director of nursing and other members of the team have met with some groups of the population that may be hard to reach or who perhaps do not take up health services for a number of reasons. Some of our asylum-seeker population can also be difficult to engage. So, we are taking such steps, particularly through the third sector, which often provides us with a pathway to those populations that, as a statutory organisation, we sometimes have difficulty engaging with.

[162] **Christine Chapman:** I am conscious that quite a few Members want to come in on this section on medical staffing, but we need to move on. Could you all be as brief as possible so that we can cover everything?

[163] **Lynne Neagle:** I have a follow-up question to Jocelyn's question on the pressures on staff. When I visited the unit at the Royal Gwent Hospital, I was struck by how much reliance there is on the goodwill of staff, who will come in on days when they are meant to be off. To what extent is that an issue in both your health boards? Is pressure put on staff to come in when they are meant to be resting on their days off?

[164] **Dr Calvert:** I would say that, yes, it does happen. If there has been unexpected sickness or sometimes, nurses are expected to be on a particular shift, but not all of them are available. At such times, staff will ring around people who are on their days off to see if they are able to come and help. So, we do rely on the goodwill of staff and we recognise that they provide that quite frequently.

[165] **Mr Hollard:** As I said, because of the type of service that staff provide, it is a close-knit group that will support each other well. So, if there is unexpected sickness or perhaps if we have had an unexpected increase in neonates coming in, either surgically or medically, they will often call on their colleagues and ask them for help, even if it is only for a short time, and they are flexible. The important issue for us is to ensure that those staff then have a rest period so that they are not in a state of tiredness when they are back on shift in their normal shift patterns. The unit manages that really well because it is self-supportive.

[166] **Ms McGrath:** It is a similar picture across Cwm Taf health board. It is a workforce that is used to working flexibly because of the high peaks and troughs in the service. If we

anticipate that there will be longer term issues, then we will put longer term planning in place—we would not expect people to keep losing their rest periods on a long-term basis. We would put planning in place to cover those deficits.

[167] **Suzy Davies:** You say in your evidence, Paul, if you do not mind me asking you, that the number of junior doctors in training in neonatology is a significant issue. Are you able to offer a view as to why junior doctors are not choosing this discipline?

[168] **Mr Hollard:** Jenny might be better placed to answer that, but there is an issue about the pressure of the role. Neonatology, for all staff who are involved in it, is a high-pressure area. As I said, we have seen an improvement in our medial staffing because of our discussions with the deanery. There is a wider issue about how we maintain that across the whole of Wales, which you will be aware of. I do not know whether Jenny wants to add to that.

[169] **Dr Calvert:** There is an overall shortage of junior doctors in paediatrics as a whole and within neonatology. The working time directive has had an impact on medical staffing in paediatrics in particular and in neonatology because we have to run full-shift rotas. To provide the neonatal service in Cardiff, we have a separate junior medical staffing rota and a middle grade, as well as the consultant cover. Those rotas are compliant with the working time directive, but that has necessitated an increased number of doctors on those rotas because their working hours are now shorter than they used to be. So, in order to fill those rotas, we need a greater number of doctors than we had previously. A few years ago, we had a major problem with gaps on the rotas, which made it very difficult to staff the neonatal unit. At that time, we had to reduce the number of cots, because it simply was not safe. Since then, we have worked with the deanery and we have been very fortunate that our rotas have been much better staffed. However, it is an ongoing problem.

[170] **Suzy Davies:** How are you planning to address the problem?

[171] **Dr Calvert:** I think that you are aware that the deanery is looking at a further shortfall in doctors in the not-too-distant future and at a reduction in the training numbers over the next few years up to 2020. So, we need to address that.

[172] **Suzy Davies:** Do you all foresee a drop in the number of beds?

[173] **Ms Williams:** You may have seen the evidence published last week around the case for change in response to ‘Together for Health’. One of the big challenges in there is that there are certain specialties in which the workforce configuration and the workforce number will experience a reduction over the next few years. That will require us to look significantly at the configuration of services. That will be about looking at alternative workforce models, a mixed-economy workforce model, and at how we use senior consultants, junior doctors, middle-grade doctors and advanced practitioners in specialist nursing fields in a way that we have not, perhaps, in the past. It is an exciting opportunity for us in Wales. We may also have to look not necessarily at the numbers of cots that we can sustain specifically in neonatology but at how and where they are located together, so that we can make the best use of the capacity that we have. For example, between Cardiff and Cwm Taf, the higher acuity activity and the lower acuity activity will perhaps be distributed differently in future. This applies not only to neonatology, but to paediatrics more generally and to some of the other high-pressure specialties as well.

[174] **Suzy Davies:** Are you saying that you are expecting the beds, even if they are differently distributed, to be clustered in areas of high concentration, so that you would draw all the ICU beds together in one central place and all the level 2 beds together in one place, even if it is not the same place?

[175] **Ms Williams:** If you look at the experience that we had in Cwm Taf, we took the active decision that the level 3 service was not sustainable. We still have one intensive care cot, but we are all in agreement that that needs to move to Cardiff in the medium term. So, we would be concentrating the intensive care level in Cardiff, but that might mean an expansion of the high-dependency level in the Royal Glamorgan Hospital. It is not a one-way street, but it has to be about a partnership where we make the best use of the staff. Then it will be about having very sophisticated mechanisms of rotating our staff so that we keep them all skilled. That is something that our workforce is very positive about, because it is seen as a more effective way of delivering care to a wider population. We will inevitably see some of these changes over the next couple of years and that has to be about safety and sustainability coming first.

[176] **Mr Hollard:** One of the issues for us is around how we engage with the public and with our mums. We have been talking about how we manage that capacity across the two units and what that means for a mum who is going to deliver. A local mum in Cardiff might deliver in Cardiff, but might need high-dependency care in Cwm Taf for us to free up an intensive care cot. So, we will have to have quite a lot of dialogue with expectant mums about what the service might look like as we go through some of these changes. That will be difficult for some to understand.

[177] **Keith Davies:** I ddilyn yr hyn a ddywedodd Allison, rwyf wedi clywed am system sy'n cael ei weithredu oherwydd prinder meddygon, sy'n cael ei alw'n *hub and spoke*. Clywais fod eich dau fwrdd chi yn gweithio ar system o'r fath, lle bo arbenigwyr sydd yng Nghaerdydd, efallai, yn gallu gweithio mewn ysbyty ym Mhontypridd, Llantrisant neu Ferthyr Tudful. Ai dyna beth oeddech yn sôn yn ei gylch yn gynharach, Allison? Pan oeddech yn sôn am hynny, nid sôn am yr adran *neonatal* yn unig yr oeddech, ond adrannau eraill hefyd, rwy'n credu.

Keith Davies: Following on from what Allison was saying, I have heard of a system that is operated due to a shortage of doctors, called hub and spoke. I heard that both your boards are working on such a system, where consultants who may be in Cardiff can work in a hospital in Pontypridd, Llantrisant or Merthyr Tydfil. Is that what you were talking about earlier, Allison? When you mentioned that, you were talking not only about neonatal units, but other departments as well, I think.

[178] **Ms Williams:** We like to call it a bicycle model, rather than a hub and spoke, because we like to think about the two wheels as being equal partners, rather than being big brother and little brother. So, across a number of specialties, we are encouraging two-way movement. Historically, it used to be that the consultants from the tertiary centre went out to work in the district general hospitals. We feel that it is equally important that the consultant, medical and nursing staff move the other way so that we are up-skilling across the whole workforce. We are seeing that increase year on year across all our specialties. That is seen as a very positive thing. Where we have actively taken the opportunity to make joint consultant appointments between our organisations, it has assisted in recruitment as well. So, there are a number of opportunities that we are pursuing actively, which will be advantageous in ensuring that we keep the skills in all of our units together.

[179] **Christine Chapman:** Angela, you have the final word.

[180] **Angela Burns:** I want to come back to the question of the deanery, because you have spoken about what you are going to do to mitigate the challenges you will face in future. Do you think that there is a case for the deanery to review how it deploys people around the country and its working practices? Maybe the issue does not hit you quite as hard, but I know that in west and north Wales it is exceptionally difficult to recruit junior doctors. Of course, it

strikes me that they are at a time of their life when they are looking to settle down and doing six months in a hospital for Betsi Cadwaladr health board, six months in Withybush hospital and then shooting over to Newport, simply does not build that kind of life. Do you think that there is a case for that whole issue of deployment to be looked at? That may alleviate some of these problems, because it seems to me that it is all about how we solve a problem, but we could stop the problem arising, to some degree.

[181] **Dr Calvert:** I think the deanery is aware of it. The forecast is that there simply will not be enough doctors to staff all the rotas across the whole of the network. So, there will need to be some sort of configuration to address that.

[182] **Mr Hollard:** From an organisational point of view, we work really well with the deanery. The deanery is working with us across all the health boards, because this is a problem that affects all the units in one way or another, whether that is the need to transfer babies between units or whether it is a need to share medical staffing and expertise. The deanery is very aware of that issue. We also need to recognise that the deanery is concentrating on the training experience of doctors. We have a responsibility to ensure that training is appropriate and attracts junior doctors to Wales. It is a two-way conversation. There is one issue about how we, as health boards, provide the experience for junior medical staff, but there is also the issue of how we support training and education and make it a good experience.

[183] **Angela Burns:** Allison, before you answer, forgive me, but I have to understand this, so speak to me in simple terms, if you like. All the university places are oversubscribed. There are children and young adults leaving education now who desperately want to be doctors. We had reports, not many years ago, that we had doctors falling out of our ears. What has happened? Have they all beamed off to Mars? I do not understand it. We talk about this and it is in every discipline. Is the problem particular to Wales? Is the problem particular to the UK? What is happening? Why do we not have these doctors? I can understand that there may be some unfashionable specialties, but there just seems to be this critical lack of junior doctors.

[184] **Ms Williams:** If we talk about the issue more generally, rather than the specialty, for a moment, it may be something, to be fair, that the dean needs to answer himself, because what I am able to give you is third-hand information. We are aware that there are challenges with recruitment to the junior doctor posts in the Welsh deanery. Some of that is because of the way the rotas are configured. We have some low-intensity rotas with high on-call type commitments, which are less attractive to some trainees than high-intensity, low on-call rates for their training experience.

10.30 a.m.

[185] This is a particular challenge for rural communities, where you may be on a one-in-three on call, but the frequency and intensity of your work when you are on call is very low. As part of a training experience, that can be incredibly challenging. That is why the deanery has to look much more fundamentally at how we deliver training. There is an argument that the training for working in rural communities may in the future need to be bespoke, because there may be a different training requirement. There has been discussion about the need for rural practitioners, almost as sub-specialty training. So, the deanery is grappling with many issues and working with us to address them.

[186] One challenge that you quite rightly raised is that of moving around for young people, particularly women, given that they now comprise the greater proportion of the junior medical workforce—and they are women who have babies during the time that they are training and who have ongoing commitments. However, if you want to be a neonatologist or a

paediatrician, your training has to cover the whole spectrum of care requirements. Other than the University Hospital of Wales, and Swansea probably, there is nowhere else in Wales where you can get the whole training experience in one place. Different hospitals in different communities offer different experiences. For example, Merthyr Tydfil gives you a very rich experience of deprived communities while Aberystwyth gives you a very different and rich experience of rural medicine. It is a dilemma. It is a bit of a Welsh phenomenon and we are working very closely with the dean to try to address that.

[187] **Christine Chapman:** It would be useful for the committee to write to the deanery. We will pick up some of these points because there are issues to be addressed. I want to move on as we have very little time left.

[188] **Lynne Neagle:** I want to go back to some of the cot issues that we spoke about earlier. Can you tell us how the South Wales Central community is addressing the current deficiencies, particularly for the one intensive care cot and the three high-dependency unit cots that are needed, and can you give us some idea of the timescale for when you expect that to be in place?

[189] **Mr Hollard:** On the intensive care cot, we currently have the joint working group. We need to bring that cot to Cardiff as soon as possible. The issue that we are discussing is the high-dependency unit move out. We also find that our infrastructure in the Cardiff and Vale local health board is very difficult in respect of neonatology's current footprint. So, we are working through a three-phase programme, which you will have seen in the evidence that we submitted, to try to address the constraints of the unit itself, including space in the unit, between cots. The transfer of high-dependency cots out to Cwm Taf Local Health Board, where the infrastructure is very good, will help us to address some of those issues. Through the second phase, which will be completed in June, we will have an additional two cots for low-dependency care, which, again, will help the whole network. The intensive care cot that is currently at Royal Glamorgan Hospital needs to be transferred to Cardiff.

[190] **Ms Williams:** We must also look at the spectrum of care, and we need to pay as much attention to transitional care at the bottom of the acuity ladder as we do to intensive care at the top. A key efficiency opportunity for us would be to manage acuity down and upskill the midwives in postnatal care on transitional care, as Kath alluded to earlier, as that would enable us to discharge babies from critical care sooner and prevent readmissions. So, that re-balancing must take into account what we do with transitional care in the postnatal period, on the postnatal unit, as well as what happens at the high end of acuity.

[191] **Lynne Neagle:** When do you expect all these changes to be completed?

[192] **Mr Hollard:** We expect to have the additional two cots by the end of June, and that is when we can start some of the work. The long-term plan for Cardiff and the Vale is dependent on the children's hospital. When that is commissioned, it will release capacity in the existing building and we can then look at how we provide a longer term solution to neonatal care in the context of the infrastructure within which we are working. That will help across the network. It is a bit of a way off and that is why we have a three-phase plan to increase the capacity by two cots by the end of June.

[193] **Dr Calvert:** It is not just the intensive care cot in the Royal Glamorgan; it is the shortfall that has been highlighted by the capacity review. So, in addition to transferring that intensive care cot, we need to increase the intensive care capacity in Cardiff and Vale to address the shortfall and to meet the other standards of working at 70% occupancy to allow for the peaks and troughs and to meet the overall demands. We need to increase our capacity and, within the existing footprint, we cannot do that. We need to expand to provide the additional capacity that we require and to deal with potential further increased capacity that

may be needed in future. We have a plan for that but, as Paul has pointed out, it is dependent on the Children's Hospital for Wales.

[194] **Lynne Neagle:** Are you saying that the intensive care cot at the Royal Glamorgan is something that was not taken into account in this review and that there will be the move of the Royal Glamorgan cot and an additional intensive care cot?

[195] **Dr Calvert:** It has been included in the review and it has been agreed that intensive care will continue there for now, because there are neonatologists at the Royal Glamorgan and, as Allison has pointed out, it used to provide intensive care. However, it is recognised that intensive care should all be delivered centrally for the best outcomes overall across the network. So, we need to address those two things and that is what we plan to deliver.

[196] **Aled Roberts:** Yn ei thystiolaeth ysgrifenedig i'r pwyllgor ym mis Ionawr, dywedodd y Gweinidog,

Aled Roberts: In her written evidence to the committee in January, the Minister said,

[197] 'All Local Health Boards have neonatal action plans in place to address shortfalls in staffing levels for safe and effective care.'

[198] In further evidence that we received in March, the Minister went on to say that

[199] 'Addressing shortfalls in staffing levels and progressively achieving compliance with neonatal standards is a matter for individual health boards.'

[200] There is also the low-dependency workstream that was published in January. How are your boards complying with your current action plans? What is the level of challenge that the Welsh Government will face if you are not meeting the standards, as we heard has been the case for the last four years? There are concerns because, if we are not meeting current standards, what level of satisfaction or reassurance can we have about the quality of provision in the NHS in Wales following reconfiguration and change?

[201] **Christine Chapman:** Before you answer that, I will bring Jenny in on a similar theme, because we are running out of time.

[202] **Jenny Rathbone:** Most of Cwm Taf's action plans are rated green or amber, using the traffic lights system, while most of Cardiff and the Vale's action plans are graded amber or red. I am particularly concerned about the agreement in Cardiff's plan on the appropriate transfer between different levels of neonatal care. That seems to me to be fundamental because if you have people clogging up intensive care cots inappropriately, it is no wonder that there is a problem. How much progress are you making collectively before, as Aled quoted, the system collapses under the stress? Where is the blockage in relation to resolving where babies ought to be placed? Is it about consultation with the community, the patients, or the mothers, or is it about disagreements among health professionals about the appropriate protocols for moving from one level to another?

[203] **Ms Williams:** Quickly, in response to your question, the governance requirements and the accountability for monitoring and managing the delivery of our action plans sit firmly with the LHBs. Within our governance structures, we have a process to oversee that and to ensure that, within the health board, we deliver that within the timescales that we have set ourselves. So, that is part of what we do. Through our performance management arrangements directly with the Government, by exception, if we were not meeting the action plan, we would be required to report that. So, that would be discussed as part of our general performance management arrangements. However, I am satisfied that my board is on track with the action plan that we have agreed and set for ourselves.

[204] In response to your question—and colleagues from Cardiff may have a similar or different view—the issue, as we see it, is about culture and consultation with the public as much as it is with the professionals. As Paul said earlier, one challenge for us is repatriation, which is an important part of the pathway as you de-escalate the level of care. So, if a baby from Cwm Taf were transferred to an intensive care cot in Cardiff, as soon as they were back on high dependency, that repatriation process would be triggered and the baby would be returned to Cwm Taf.

[205] The challenge will potentially be for Cardiff mums. In future, if the high-dependency unit in Cardiff is chock-a-block and there is capacity in Cwm Taf, Gwent or anywhere else, in order to make the best overall use of capacity to meet clinical need, we may have to move babies from one unit to another when they are going from intensive care to high dependency. That is hard for the staff to do and for the mums and the families to understand, but it has to be a critical part of the work that we are now doing together and with the public. They have to understand that that is in the greater interest of the clinical care and safety of all the babies in our population. These distances, fortunately, are short and are within the M4 corridor area, but we do not underestimate the inconvenience to families of doing that. In addition, they will have become used to a particular nursing team looking after them and their baby, but it is an important part of our planning, moving forward. We must bite this bullet with communities so that they understand the necessity for that sort of change.

[206] **Jenny Rathbone:** Do you have a maternity services liaison committee in place?

[207] **Ms Williams:** Yes.

[208] **Mr Hollard:** On the clinical criteria for how you step down, I will leave that to Jenny. On the accountability, I agree with Allison that it firmly sits with the LHBs, but it is for both of us. We have individual accountabilities for our local populations, but we recognise that, with this service, as with many others, it is a network arrangement and we have to work together. The challenge will be how to ensure that the service is spread across boundaries and health boards and that the public understands that the service has to change in that way to accommodate everyone at the right level.

[209] **Christine Chapman:** I know that there were other questions from Members, and I apologise for closing the session, but time has caught up with us. If Members would like to feed in any extra questions that they had to the committee clerk, and if you would be happy for us to do so, we will write to you for a written response. I thank you all for attending this morning. It has been an excellent scrutiny session. We will send you a transcript of the evidence to check for any factual inaccuracies. I close the meeting now for a short break.

Gohiriwyd y cyfarfod rhwng 10.44 a.m. ac 11 a.m.
The meeting adjourned between 10.44 a.m. 11 a.m.

Ymchwiliad i Ofal Newyddenedigol
Inquiry into Neonatal Care

[210] **Christine Chapman:** We continue with our inquiry into neonatal care with evidence from Aneurin Bevan Local Health Board. I welcome both of you here today. Will you please introduce yourselves for the record?

[211] **Dr Goodall:** Good morning. I am Andrew Goodall, the chief executive of the health board.

[212] **Ms Paget:** Hello, I am Judith Paget, the director of planning and operations and deputy chief executive of the health board.

[213] **Christine Chapman:** Welcome to you both. Members will have read your written evidence, so, if you are happy, we will go straight into questions. We will start with a question from Angela Burns.

[214] **Angela Burns:** Good morning, and thank you for your written evidence. I will ask my question in one go and you can work your way through it. I am talking about the shortage of nurses and the capacity that is required. In your written evidence, you state that over the last 18 months you have appointed an additional 10 whole-time equivalents, because you had a shortage of 22, I think. Going forward, when do you think you will be able to fill the rest of the gap, how much investment do you think you will have to put in to be able to fill that gap, and what are your general plans? We are seeing that a shortage of specialist neonatal nurses is an issue for all the health boards, and this may be a difficult question to answer, but, over the last 18 months, when you had such a massive shortage—you refer to the last 18 months, but it could have been longer—how do you think that impacted on the quality of care and safety of care given to your neonates? Do you think it has affected the survival rates? I read your outcome table, but I found it quite difficult to understand, to be honest. If you did not have the specialists to look after all those babies because of the shortage, who looked after them, what was the calibre of those staff and what training did they have?

[215] **Dr Goodall:** I will start off by talking generally and then I will hand over to Judith to pick up on that. When the health board was established, it was quite clear that our neonatal services were having some struggles, and it was clear that there were some nursing deficiencies there. We were managing the situation by relying on bank and agency staff. Bank staff are staff very familiar to us and to the unit, and the use of bank staff will tend to be through local arrangements, but it is not an ideal situation to put additional pressure on nursing staff considering the workload within the department. We have also had a very flexible approach in the unit, and perhaps we will touch on this during the course of the evidence, in terms of ensuring that, as far as possible, we flex the capacity so that we are able to retain neonates, but also mothers, wherever possible, within the local area. I know that we will need to touch on that.

[216] It was clear that, although the use of bank and agency staff made sure that services were safe, it was not a sustainable solution for us and very early on we decided that we would be actively recruiting nursing staff. We have, as you have indicated in referring to our evidence, recruited 10 extra staff over the last few years, and we can see that our spend on bank and agency staff has come down, so we have been able to invest in those individual members of staff. We also have plans to recruit more moving forward. In fact, in March—in public, as part of reporting on our standards—the board received proposals that matched our compliance against each of the standards, but we highlighted to the board that our greatest concern was about moving ahead with the nurse staffing ratios. So, we have set out a plan for it for the next two or three years to recruit additional nurses and we are looking to recruit another eight or nine nurses, mainly qualified nurses, but also some nurses at the support level to try to move on with the support provided.

[217] I would genuinely say that one of our concerns is that, because there is a national shortage, to some extent, of nurses with this very specialist experience, there is a danger that, as all units in Wales start trying to recruit, all that happens is that nurses move between different sites and different hospitals; there is a broader requirement to ensure that we are able to retain the specialist nursing staff within Wales itself for all of the units. We found that we were training quite a number of staff, but that, as they looked to move up the structures, they ended up going for a position in Cardiff or in the Royal Glamorgan Hospital, because they wanted to consolidate their experience. That required us to change some of the nurse training

arrangements around. Historically, there was a two-year, very intense programme of training for nurses to get specialist experience, but we were able to reduce it to six months and tested it out to bring in lower-grade qualified nursing staff to ensure that we could start developing our own. That has been very successful for the unit.

[218] You raised some figures and asked how we know whether that has made a difference. We are able to measure it in a number of ways. Through the annual report, we monitor significant quality measures, not least of which are such things as mortality rates. The mortality rates for the unit compare well with other units within a UK context, not just within Wales. It is a high performer in terms of those comparisons. That has been true despite these staffing issues over the last two or three years. We also know that it has made a difference from a staff and morale perspective. We were concerned, when the health board was established, that there was a very high level of sickness and absence in the unit, which, I think, demonstrated the workload pressures on staff in trying to do the appropriate job in the area and feeling that they needed to give support. We have managed to reduce the sickness and absence levels in the teams, which was almost as high as 18% at one point. It has reduced to around 5% over the last year or so. That gives us a bit of a feel for how things are. I will ask to Judith to come in there.

[219] **Ms Paget:** In terms of compliance with the neonatal standards, it is important to note that, since the health board was established, we have been monitoring our compliance against the standards. At every reporting period, our compliance against the standards has improved. The health board has focused its attention on two areas, and will continue to do so over the next two years. The first, which we have just discussed, is to ensure that staffing levels meet the standard compliance recommended by the standards and the neonatal network. The second is to ensure a reduction in occupancy levels. The special care baby part of our neonatal unit, in particular, is running at quite high occupancy levels. In order to both address the standards and ensure that our occupancy level is appropriate, we have estimated that we need to recruit another 18 registered nurses and four to five unregistered nursery nurses.

[220] We are planning, over this year and next year and into the year after, a phased recruitment. This year, we will recruit six or seven registered nurses and two nursery nurses to help us ensure that our current cot configuration is compliant in relation to current nursing staffing levels. Over subsequent years, we will increase our cot numbers and staffing levels accordingly. We estimate that that, in staffing terms alone, will cost in the region of £800,000—I think that you asked about the cost. There will be additional costs in relation to training and so on. However, the staffing component is around £800,000.

[221] Alongside that, we also need to ensure that we have picked up on all the recommendations made by the network in relation to low-dependency care. The neonatal network has done an extensive review of low-dependency care. Although we already have transition beds at Nevill Hall Hospital and the Royal Gwent Hospital, which are well used, and although we have an extensive and well-resourced outreach team, we still think that, within the recommendations of the network, there is probably more that we could do to ensure that we have babies in the right place at the right time. We will be looking at that again to ensure that there is not any more that we can do in relation to that compliance.

[222] We have also, as Andrew mentioned, revamped our in-house training programme. We have three practice development facilitators who work with our nursing teams to ensure that the newly-recruited nurses, particularly the band 5 nurses, have really good on-the-job work experience, which is then supplemented by access to the two academic modules, mostly done at the University of Glamorgan, which they also participate in. We have a high take-up of those modules. You will see from the annual reports that we submitted in evidence that very many of our staff are qualified through those academic modules as well.

[223] **Angela Burns:** I just want to make sure that I completely understand this. The facts that, over the past 18 months, you have not been able to achieve the full-time equivalent requirement you need to maintain the standards and that, as you clearly state in attachment 1, you have been unable to provide a nursing ratio of 1:1 for neonatal intensive care—which, again, is a standard—and that you have been unable to provide evidence that the establishment is correct for the number of neonatal intensive care cots commissioned, have had no effect whatsoever on the life-expectancy rates of the neonates in your charge. Is that correct?

[224] **Dr Goodall:** The comparisons that we do and the audits of the team have consistently demonstrated that. It demonstrates the commitment of the team, irrespective of the general pressures, that it is able to stand comparison with the best in the UK in those arrangements. We are also monitoring this in various ways. We look at complaints, sentinel events and serious incidents, and the annual reports go to our quality and patient safety committees within the board's structure to ensure that the ongoing monitoring is not something that is left simply to the clinical teams but dealt with within the board's governance arrangements.

[225] **Jocelyn Davies:** Of course, I do not think that you would challenge the need for the standard just because you can currently rely on the goodwill of your staff. It sounds as though you are very lucky to have such good staff. Thank you for sending us the attachment. My copy is not in colour, so I cannot tell from that how good the compliance is. However, you had a plan prepared that was going to the board in January. You mentioned that in your introduction, Mr Goodall. Perhaps you can tell us the outcome of that. Attachment 2, which is a capacity review, also mentions the capacity shortfall. It says that the plan was updated in February and that you had a board meeting in March at which someone was going to seek additional investment in order to comply with the standard. Did the board agree the total investment asked for? If so, can you tell us why this is being phased in?

[226] **Dr Goodall:** This was to ensure that neonatal standards are a profile issue. I deal with the discussions in respect of specialist services. We deal with it as part of our daily conference calls in Wales around some of the emergency pressures when they are happening, but it is important that the board can discharge its governance perspective. Clearly, one of our concerns is that there is a difficult financial outlook for public services in general terms, but, inevitably, there are services that continue to need to develop and to meet standards. Although it is a difficult discussion, we wanted the board to understand the progress that had been made on neonatal services. I think that the board would have challenged this if we were looking to expand our staff base without having addressed bringing in temporary bank and agency staff as part of sustaining the service. Given that we were able to demonstrate that, we were asking the board to make the investment in these nine members of staff. As Judith and I have both outlined, it was a £300,000 investment, and, yes, the board has approved that on the basis of the progress we will make over the next 12 months.

[227] Whether that should be 10 or 30 members of staff goes back to what I was saying about developing staff and trying not to have a merry-go-round around different units in Wales as staff are able to move and make choices between different areas. We need to find ways of developing our own staff and we wish them to feel that they can progress within our organisation. There are probably two reasons for the phased progression. One is that we know that, although it would originally have taken two years to train nursing staff, it will now take six months with the accredited course that we have now. We have the experience of recruiting the additional 10 full-time equivalents over the past 18 months, and we are being realistic about the number of specialist nurses you can deal with at any one time with supervision and taking into account what the general market would look like for recruiting these members of staff.

[228] **Jocelyn Davies:** We just see this snapshot in time of the information you have sent

us. I do not know what the plan said before, but were any additional resources requested last year?

11.15 a.m.

[229] **Dr Goodall:** The additional resources were not necessarily requested by the neonatal team, because we felt that it had resources within its own use. There is a cost associated with bringing in agency staff, and our initial proposal to the neonatal service was that we wanted it to recruit substantively, not only because it would be better for the spread of the workload within the department, but because they would be able to resource it within their own spend. So, for example, we were able to reduce our spend on bank and agency staff by £700,000 in the prior year, which we will be able to reinvest in neonatal services. So, it was not about not listening to staff or not recognising the standards, but because it would not have been sustainable to push on with the ongoing use of bank and temporary staff. Having said that, part of our flexibility as a unit is that we have specialist nurses in our nurse bank. That is a good thing in itself, but particularly so when we need to increase by a cot or two, because it gives us that flexibility at the edges. However, it should not be a way of running the main service.

[230] The reason for us having a progressive plan is that we already have local proposals in relation to centralising our neonatal services in our specialist critical care centre. There is a plan to expand the number of cots further, because there are some limitations on the current accommodation. Developing that over a two to three-year period allows us to grow the staff for the specialist centre.

[231] **Julie Morgan:** You referred twice already to reducing the training and induction period for newly recruited nurses from two years to six months, which is a fairly dramatic cut. How have you achieved that, given that you say that it is successful?

[232] **Ms Paget:** Our senior clinical colleagues in the department reviewed the original training programme and spoke to staff who previously went through the training programme, and they managed to condense it to include the critical components, which allows staff to get the experience they need of working in the special care, high-dependency and neonatal intensive care components of the unit. So, they have compressed the training into a six-month programme, rather than the two-year programme.

[233] It should be stressed that the training has been well evaluated by the clinical teams and by the staff who have gone through it. So, we are confident that this model is sound in relation to providing a very good level of on-the-job training and experience for staff when they come into the neonatal service. That training is supplemented by the academic modules that staff go through. So, the training seems to be working well in terms of on-the-job experience and induction for new band 5 nurses who are joining us.

[234] **Christine Chapman:** You say that there are reasons why the training has gone from two years to six months. Are you therefore saying that the two-year course is not as good as the six-month course?

[235] **Ms Paget:** No, what I am saying is that the programme has been compressed to ensure that we can maximise the ability of staff to get through the programme and to maximise their level of competence at an earlier stage. That does not mean that one is any better than the other. It just means that the time it takes for a new member of staff joining the neonatal service to become able to work across the range of areas—in special, high-dependency and neonatal care—has been compressed into six months, rather than it taking two years.

[236] **Christine Chapman:** So, this programme is as good as the two-year course.

[237] **Ms Paget:** Yes.

[238] **Dr Goodall:** Yes, but it has required a particular focus, with a nurse development post alongside the programme and ongoing supervision from nurses who are higher up in the nursing hierarchy and who are prepared to oversee the training in that way. This approach was in fact proposed by the staff in their feedback, but we needed the accreditation and the academic rigour as well.

[239] **Christine Chapman:** Julie, did you want to come in on this?

[240] **Julie Morgan:** You have covered what I was going to ask, Chair.

[241] Basically, you are saying that the staff are able to have as much experience in that six-month period as they would have in two years?

[242] **Ms Paget:** They gain a sufficient level of experience in each aspect of care, which ensures that they are competent to work in those areas. They are clearly not spending as long in each area as they would in a two-year programme. However, it is about their level of competency and confidence to work in that area that is being measured, not how long they have been working in it.

[243] **Julie Morgan:** Has this been independently assessed?

[244] **Ms Paget:** It has been assessed by our own teams; not independently assessed.

[245] **Julie Morgan:** Should this approach be used elsewhere?

[246] **Ms Paget:** The senior nursing staff in our neonatal service have shared our experience with the nursing therapies group, which has been supporting the work of the neonatal network. So, it has been shared across Wales with colleagues in terms of our experience and learning and how they have been applied.

[247] **Jocelyn Davies:** I have a question about the European working time directive. We heard earlier that it did not have an impact. Is it the same for you?

[248] **Dr Goodall:** We have to ensure compliance with the European working time directive for all staff. Clearly, the focus tends to be on junior medical staff in particular. With regard to how the rotas are being organised at the moment, certainly for the August and September rotations, it currently looks as though we have a sufficient number of staff to deal with the rotas for the two sites that we operate, one of them being a level 3 unit and the other a level down from that.

[249] Having said that, I think that you heard earlier about the general pressures, so the extent to which this continues to be sustainable is a concern for all of us. We have had some examples of shifts, as recently as the past few months, where somebody was on maternity leave or on sick leave, and we had consultants who were prepared to provide us with cover for those arrangements. Obviously, that is not necessarily a sustainable way forward either, but for now, with the prospective cover for August and September, it looks as though the units will be okay for their particular needs at Nevill Hall and at the Royal Gwent Hospital.

[250] **Julie Morgan:** Have you been affected by the greater difficulty in having doctors from overseas coming here to work?

[251] **Dr Goodall:** We have been affected in the same way as all the general specialties; it is not necessarily peculiar to paediatrics or neonatology. So, in the extent to which there have been some gaps or vacancies, they have been for junior medical posts within the rotations. Obviously, we require that people apply for these positions, and that is where some of the medical recruitment approaches in Wales becomes important. This is probably one of the factors, but not necessarily the only one that has affected it. I think that it has been a general pressure throughout medical staff recruitment.

[252] **Lynne Neagle:** I would like to ask about the intensive care cot that was disestablished at Nevill Hall. What sort of impact has that had? Also, how have the resources attached to the cot been reinvested?

[253] **Ms Paget:** The network recommended disestablishing that cot because it was rarely used—the occupancy rate was very low indeed, and rarely did we have to staff it on a day-by-day basis with the level of resource that you would require for intensive care. So, we have disestablished it, but we have retained a stabilisation cot at Nevill Hall should the need arise to stabilise a baby prior to transfer to the Royal Gwent. In reality, intensive care was provided at the Royal Gwent anyway, and primarily, it was a cot in name only, as opposed to the reality of what was being delivered each day. So, the impact of that has been minimal.

[254] **Lynne Neagle:** What about the resources?

[255] **Ms Paget:** The resource is used flexibly anyway between the two units, so it now flexed for use at the Royal Gwent.

[256] **Lynne Neagle:** Okay. Thank you. I have just one other question. What are you doing to explore the reasoning behind critical care activity in the south-east Wales community being higher than in other health communities?

[257] **Ms Paget:** This is something that came out of the capacity review published in February. One of its recommendations was that we needed to work with the network to understand why our critical care requirements seemed to be higher than our population would demand. We are just in the process of doing our audit reports for last year. Once that is out of the way, we are going to work with the network, drawing down the information from the BadgerNet system that we have in place to look at whether it is something to do with the categorisation of cases, or something to do with the communities we care for with regard to the level of demand they place on our service. At the moment, we have not done that detailed piece of work; we have been concentrating our efforts on some of the other recommendations, but we will move on to that.

[258] **Lynne Neagle:** When would you expect that work to be completed?

[259] **Ms Paget:** I would have thought that it could be done during the calendar year. It will probably take about six months to do a thorough piece of work.

[260] **Dr Goodall:** Speaking generally about south-east Wales and, indeed, more broadly, I would just comment that—this is via the network—the health boards have had to work more closely. Also, there is an aspect of getting more personal experience of this. Every day in Wales, each of the health boards liaises on pressures. During the winter months in particular, it was important to discuss the pressure on the neonatal cot capacity. I know that there were very specific circumstances in areas such as Swansea that required the teams to work differently. Speaking as people who have been on call as part of that process when we are facilitating these discussions, it is very pleasing and it feels quite different from three or four years ago with regard to the way in which the teams have clearly liaised in advance. They are working very closely with each other, they are sharing the pressures and the cot locators are

working to allow some of the pressures to be moved around. So, there are some very specific issues for south-east Wales, but we have seen genuine co-working along the M4 corridor in terms of the pressures.

[261] **Aled Roberts:** Hoffwn symud ymlaen i drafod gweithgaredd dibyniaeth isel. Nodaf o'ch tystiolaeth fod llawer iawn o weithgaredd felly yn eich rhanbarth chi. Deallaf fod adroddiad wedi ei gyhoeddi ym mis Ionawr ar ffrwd waith dibyniaeth isel. A allwch chi ddweud sut rydych yn cydymffurfio â'r canllawiau arferion gorau ar hyn o bryd? Sut rydych yn monitro eich perfformiad yn eich rhanbarth?

Aled Roberts: I would like to move on to discuss low-dependency activity. I note from your evidence that there is a lot of such activity in your region. I understand that a report was published in January on the low-dependency work stream. Can you say how you are complying with the best practice guidelines at present? How are you monitoring your performance in your region?

[262] **Ms Paget:** In response to a previous question, I commented that, in terms of some of the good practice, we are complying very well. So, we have six transitional cots on our postnatal wards—four at the Royal Gwent Hospital and two at Nevill Hall Hospital, where one of our neonatal nurses supports normal care for babies who just need a little bit of extra support before they go home. We have an outreach team of, I think, three whole-time equivalents, which supports babies to move on and to go home with support. We also have things like discharge criteria.

[263] There are areas within that checklist of good practice for low-dependency care that we need to follow up, such as making sure that admission and discharge criteria are complied with. So, it is more about auditing compliance rather than introducing new services. However, before we finally make the decision regarding how many additional cots we need, particularly for special care, we need to absolutely ensure that not only do we have the service in place, but that the standard of compliance is very good as well. That piece of work is under way at the moment.

[264] **Aled Roberts:** Pryd fydd y gwaith hwnnw yn cael ei gyflawni?

Aled Roberts: When will that work be completed?

[265] **Ms Paget:** It is under way at the moment. I did not check before coming here when it will be completed, but I would have thought that it would be completed within the next two months.

[266] **Suzy Davies:** I have some questions about Powys. Can you tell me how long it takes an ambulance to get from Brecon or Builth Wells to the Royal Gwent Hospital?

[267] **Ms Paget:** I probably can if I think about it. I think it takes about 30 or 35 minutes.

[268] **Suzy Davies:** Does it, really? I do not want to put you on the spot.

[269] **Ms Paget:** I should know, because I used to live in Brecon. I was just trying to work through the route.

[270] **Suzy Davies:** I asked the question because, obviously, we have been speaking to Powys Teaching Local Health Board, and ambulance travel times are quite long—they are bound to be, are they not? Would you say that there is a risk with long travel times from areas like Brecon or Builth to the Royal Gwent Hospital, where a baby who is being transferred on an emergency rather than a pre-planned journey might deteriorate sufficiently that, by the time they arrive, they need a higher grade bed or cot? That is, they may go from a high-dependency unit to the intensive therapy unit, for example.

[271] **Ms Paget:** I will have to think about that for a minute.

[272] **Suzy Davies:** I will ask my supplementary question and perhaps that will help you. We also heard that, in those circumstances, it will be a community midwife with a bagging oxygen system who keeps the baby going during that transfer. This is quite different to the dedicated transfer systems where specialist equipment and so on is tied in. So, the first question is: should there be a difference between the support available for planned transfer and emergency transfers, particularly when such long distances are involved. Does that lead to deterioration?

11.30 a.m.

[273] **Dr Goodall:** Clearly, we are able to respond to the planned transfers to move neonates across different sites as appropriate, and the transport system allows for that. With regard to the extent to which you are able to have a specialist response to a general emergency, we have to be very reliant on the 999 and emergency response services for that. There would ongoing care anyway for any mother in those sorts of difficulties at that time through the midwifery service. So, I find it difficult to believe that we would be able to respond to that specialist response.

[274] It is difficult to comment on the deterioration—I will be open and say that neither of us are clinicians, and it is very much a clinical question and would probably require a clinician to answer it. It also raises other issues about the care and where and when it can be received, irrespective of that situation. In terms of level 3 needs, for example, three units in south Wales would accommodate that particular situation: Royal Gwent Hospital, Swansea and Cardiff are the three centres. So, in terms of the high level of care that would be required, specialist requirements for service and training would mean that there would only be three centres that could respond in that situation.

[275] **Christine Chapman:** You talked about the response time. Would you be able to get a response from one of your clinicians on that specific issue? You cannot respond now, but perhaps you could send a response to us.

[276] **Dr Goodall:** Absolutely. I just thought that it was fair to comment that there is a bit of a clinical dimension to commenting on the extent to which there will be deterioration.

[277] **Suzy Davies:** Essentially, I want to know how you fit Powys into your planning. I appreciate that other boards can assist with emergencies, but how do you accommodate that?

[278] **Dr Goodall:** Our annual plan as an organisation is very much about Gwent as an area and south Powys as a catchment population, so we are clearly linked into it and it is a fundamental part of our planning. The one-to-one discussions that we have with Powys are an important part of the flow. In fact, our clinicians go out and work in Powys and we operate services on behalf of and with Powys in respect of mental health, for example. So, the flow of the south Powys catchment population is fundamental in all of our local strategic plans, and it is very important that we maintain those ongoing relations at this stage. We have discussions on the maternity requirements and how they flow into Nevill Hall Hospital and also into the step-up on neonatal services.

[279] **Ms Paget:** We have regular contact not only with Powys local health board, but also with the Brecknock and Radnor Community Health Council. As Aneurin Bevan Local Health Board, we recognise that we have a responsibility to the residents of south Powys to make sure that they can access our services in a timely and safe way. As Andrew says, in the planning for all of our services in terms of any operational or strategic changes that we may

wish to make—the development of our specialist critical care centre is fundamental to that—we engage Powys very strongly, and talk to the community health council and to local stakeholders, where they want us to, about the changes that we are making and how they might impact on their residents and the people who live in south Powys.

[280] **Simon Thomas:** I have a specific question on the ambulance service. Do you have discussions with the ambulance service regarding the type of equipment and training that it has? The evidence that we received earlier from Powys Teaching Local Health Board was very clear that they expect low-risk babies to be born in Powys, but they would plan for any other types of deliveries to take place outside the county. However, there are unplanned emergencies, so what is in place to deal with those?

[281] **Dr Goodall:** We talk regularly to the ambulance service. In fact, one of the concerns that we had as a health board was that it sometimes felt as if the organisational boundaries were getting in the way when we want the clinical teams to operate on the ground. We have had discussions about the transport service, which has raised the profile of neonatal expertise, and not only the profile of those specific staff, but also more broadly that of paramedics. So, there has been an issue about awareness and profile. We liaise with the ambulance service. If you are asking whether we would have a very specific discussion about the neonatal service on its own terms, we would if there had been an incident or if we had safety concerns. Do we talk to the ambulance service generally about the range of support required for neonates through to any emergency admissions? Yes, that is a very familiar and regular discussion. It may be a discussion with the clinical teams on a daily or weekly basis or, as happened just a few weeks ago, with the chair and chief executive of the Welsh Ambulance Services NHS Trust to work through the local issues for our population. We have a very regular dialogue with them.

[282] **Simon Thomas:** Are neonates a particular concern in that dialogue?

[283] **Ms Paget:** Not specifically from Aneurin Bevan Local Health Board's perspective, but I know that the neonatal network has had a lot of discussions with the ambulance service, particularly about the transport system, but also in general about how babies are moved around Wales safely and get to the right place at the right time.

[284] **Jenny Rathbone:** In relation to this, we must remember that there has not been an unplanned transfer in Powys since 2007, which rather indicates that Powys has got its planning of risk management right. I want to just follow up on whether you have the skill mix right in your ordinary postnatal ward to prevent babies being inappropriately transferred into your special care baby unit.

[285] **Ms Paget:** As I said, we have well-resourced practice educator-type roles. They clearly work within the neonatal unit, but they work on the ward as well. We have transition beds on the postnatal unit, to which a neonatal nurse is allocated. So, the relationship between the postnatal wards and the neonatal service is very strong indeed and, clearly, because they have transition beds, the neonatal staff are back and forth there every day.

[286] **Lynne Neagle:** My question was pretty much the same as Simon Thomas's, but I want to ask one more. Obviously it is great that most of the arrangements are pre-planned, but do you have any figures on the numbers of unplanned transfers that you have to make? It is not just about Powys; it is also about transfers within Gwent and outside the Gwent area.

[287] **Ms Paget:** Our audit reports set out the circumstances in which babies have been transferred out. Primarily, they would be going to Cardiff for specialist surgical or cardiac expertise, or to places like Birmingham for liver treatment. The audit reports for Nevill Hall and the Royal Gwent give an indication of the number of babies who are transferred out and

the reasons why they were transferred. I cannot remember the numbers off the top of my head.

[288] **Christine Chapman:** Could you write to us with those figures?

[289] **Lynne Neagle:** I hope that most of those are done on a planned basis, but I presume that, sometimes, you have to rely on emergency ambulances and I wondered—

[290] **Ms Paget:** I will write to you on that.

[291] **Keith Davies:** Soniodd Judith yn gynharach bod adnoddau hael gyda'r timau allgymorth. Clywais Powys yn sôn yn gynharach heddiw bod 40% o enedigaethau yn enedigaethau cartref, ond o edrych ar eich ffigurau chi, dim ond 5% o enedigaethau yng Ngwent sy'n enedigaethau cartref. Wedi cymharu'r ddau, a yw'r ffigur hwnnw'n afresymol? Nid wyf yn siŵr, ond y ffaith yw bod gennych dimau allgymorth sydd â'r adnoddau hael hyn, ond wedyn rwy'n gweld ffigurau isel o ran nifer y genedigaethau cartref.

Keith Davies: Judith mentioned earlier that the outreach teams have plentiful resources. I heard Powys mention earlier today that 40% of births were home births, but in looking at your figures, only 5% of births in Gwent are home births. Having compared the two, is that figure unreasonable? I am not sure, but the fact is that you have outreach teams with plentiful resources, but then I see low figures for the numbers of home births.

[292] **Ms Paget:** To clarify, the outreach team is a team that supports babies when they are discharged from the neonatal unit to go home with their parents, so it allows them to go home with babies a little earlier than they might have been able to do if that team was not there. Clearly, our community midwifery teams are the people who support mums to opt for having babies at home and in Powys there is a very good strong tradition of home births and that has been there for a long time. In different parts of Gwent, there is a slight variation, but it has tended to be around 10 to 12%. Although our midwives encourage mums by giving them the range of options that are available, they have not always opted for home births.

[293] One of the things that we have done strategically as part of our change programme is to extend our midwifery-led units, and we opened a very successful midwifery-led unit in Caerphilly some years ago. We have just opened a new hospital in Ebbw Vale, called Ysbyty Aneurin Bevan, and in the planning and commissioning for that, we have opened a midwifery-led unit as well. So, whilst the home-birth rate might still be 10 to 12%, we are now giving mums other options in terms of having a home-type delivery, but in a midwifery-led unit in their local hospital. That is part of our model going forward.

[294] **Simon Thomas:** Rydym wedi derbyn copi o'r adolygiad o gapisiti newyddenedigaethol. Mae'n adolygiad cenedlaethol ac mae'n cynnwys awgrymiadau am y fath o ad-drefnu a allai ddigwydd yn eich ardal. A ydych yn cytuno gyda chasgliad yr adolygiad hwnnw, ac os ydych yn cytuno ag ef ai peidio, pa gamau ydych yn eu cymryd mewn ymateb iddo?

Simon Thomas: We have received a copy of the neonatal capacity review. It is a national review and it contains suggestions about the type of reconfiguration that could happen in your area. Do you agree with the conclusions of that review, and whether you agree with it or not, what steps are you taking in response to that review?

[295] **Ms Paget:** On capacity itself, while the neonatal network was doing its capacity review, we were also doing our local planning, looking ahead to the specialist critical care unit, in terms of the number of cots and the configuration of cots that we would need when we opened that. As it was, the recommendations from the neonatal network and our local

calculations about the number of cots that we needed were almost the same. The network said that we needed eight ITU cots, 12 HDU cots and 17 special care cots and our calculations came out as eight ITU cots—the same—12 HDU cots—the same—and 18 special care cots—one more. So, we agree and we will be implementing it. That was the phased plan that Andrew referred to earlier, in that our specialist critical care centre is probably a few years away and will probably not open until in 2018, so we will reconfigure the services within our current capacity at the Royal Gwent and Nevill Hall to ensure that we are able to deliver that level of capacity in advance of opening the new unit. When it opens, they will all move in together.

[296] **Dr Goodall:** I would also say, Chair, that it will be about retaining the flexibility and having some additional beds on the general paediatric wards. So, again, we will make sure that the right neonates get to the right level of care and that we can provide ongoing support to the wards as well.

[297] **Christine Chapman:** If there are no other questions from Members, I thank our witnesses this morning for answering the questions. We will send you a transcript of the meeting so that you can check it for any factual inaccuracies. Before I close the meeting, I remind everyone that the inquiry will continue this afternoon at 12.45 p.m., but we will be holding that meeting in Tŷ Hywel in committee room 4. We will be video-conferencing, so it needs to be done there. I declare the meeting closed.

Daeth y cyfarfod i ben am 11.43 a.m.
The meeting ended at 11.43 a.m.