# Cynulliad Cenedlaethol Cymru
# The National Assembly for Wales

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

## Dydd Iau, 9 Chwefror 2012
## Thursday, 9 February 2012

**Cynnwys**
**Contents**

**Aelodau'r pwyllgor yn bresennol**
**Committee members in attendance**

| | |
|---|---|
| Christine Chapman | Llafur (Cadeirydd y Pwyllgor)<br>Labour (Committee Chair) |
| Jocelyn Davies | Plaid Cymru<br>The Party of Wales |
| Keith Davies | Llafur<br>Labour |
| Suzy Davies | Ceidwadwyr Cymreig<br>Welsh Conservatives |
| Julie Morgan | Llafur<br>Labour |
| Lynne Neagle | Llafur<br>Labour |
| Eluned Parrott | Democratiaid Rhyddfrydol Cymru (yn dirprwyo ar ran Aled Roberts)<br>Welsh Liberal Democrats (substitute for Aled Roberts) |

**Eraill yn bresennol**
**Others in attendance**

| | |
|---|---|
| Dr Sybil Barr | Cymdeithas Meddygaeth Amenedigol Prydain<br>British Association of Perinatal Medicine |
| Dr Iolo Doull | Coleg Brenhinol Pediatreg ac Iechyd Plant Cymru<br>Royal College of Paediatrics and Child Health Wales |
| Dr Mark Drayton | Coleg Brenhinol Pediatreg ac Iechyd Plant Cymru<br>Royal College of Paediatrics and Child Health Wales |

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

| | |
|---|---|
| Claire Griffiths | Dirprwy Glerc<br>Deputy Clerk |
| Sarah Hatherley | Gwasanaeth Ymchwil<br>Research Service |
| Claire Morris | Clerc<br>Clerk |

*Dechreuodd y cyfarfod am 12.46 p.m.*
*The meeting began at 12.46 p.m.*

## Cyflwyniad, Ymddiheuriadau a Dirprwyon
## Introduction, Apologies and Substitutions

[1] **Christine Chapman:** I welcome you back to the Children and Young People Committee. We will carry on with the evidence taking for our inquiry into neonatal care. As you know, we have had apologies from Aled Roberts and Jenny Rathbone. I understand that Eluned Parrott will be substituting for Aled.

12.47 p.m.

**Ymchwiliad i Ofal Newyddenedigol—Sesiwn Dystiolaeth 3**
**Inquiry into Neonatal Care—Evidence Session 3**

[2] **Christine Chapman:** I welcome Dr Sybil Barr, who is a consultant neonatologist and the Welsh representative of the British Association of Perinatal Medicine. I thank you, Dr Barr, for attending today. We have received your paper and Members will have read it. If you are happy to do so, we will move straight on to the questions.

[3] **Dr Barr:** Yes, that is fine.

[4] **Christine Chapman:** I will start. You state in your paper that progress in neonatal care has been made in some areas, including the establishment of the neonatal network, which has a role in providing advice to the Minister for Health and Social Services and health boards. How effective has the network been in helping to improve clinical practice in neonatal care?

[5] **Dr Barr:** It is still early days, but, so far, it has had a very good impact. We loosely worked as a network before its formal establishment, but now that we have established meetings and the other developments that have happened alongside the network, such as the cot locator and so on, that means that we now have a much greater handle on where the beds are and where the major stresses are on the system. So, communication is better, and the overall knowledge of what is happening is much better. Alongside the managed clinical network, there are other committees that help with nursing education, guideline formation and so on. So, in time, we will have a more streamlined approach to the way in which we provide care. We all see very similar babies in all of the different units, but sometimes what happens to the babies can be quite different. So, in time, the network will improve the overall care that we give to babies and families.

[6] **Christine Chapman:** I would like to ask you about the contribution of the health boards. Are you satisfied with the action that the health boards are taking to resource neonatal services? The Health, Wellbeing and Local Government Committee of the last Assembly made recommendations, which we have revisited. Do you have a sense of the contribution of the health boards in resourcing neonatal services?

[7] **Dr Barr:** The short answer is, ‘no’. We have been talking about this for around 10 years. They are the same old questions and answers. It is frustrating, particularly for those on the rock face, as it were. It is quite a stressful environment to be working in. There have been many inquiries and there is a lot of information available to inform health boards so that they can make decisions. Some of those decisions are politically quite difficult to make, and I can understand that there is some hesitancy in making them, but we are in a dangerous situation and, from a clinical safety standpoint, we are sailing close to the wind all of the time. We get away with it most of the time, but what is currently happening is not appropriate. It has been going on for a long time and the health boards need to act now. Any decisions that they make now will take a few years to bear fruit, so, in the interim, we need to think how best to manage what we have available now and where best to locate the cots that we currently have. In the future, we need to get more cots urgently.

[8] **Jocelyn Davies:** My question is about transport. As you know, the neonatal transport service is now operational and that is a 12-hour service. Is there a case for extending that to a 24-hour service?

[9] **Dr Barr:** The transport service has been going for around 13 months and overall we are very happy with it. It is a 12-hour service and all back-to-base retrievals happen during those times.

[10] **Jocelyn Davies:** What is a back-to-base retrieval?

[11] **Dr Barr:** For example, a baby may have come from west Wales to have surgery in Cardiff, but is now well enough to return to west Wales to recuperate—they are not particularly unwell, but are not well enough to go home because they need to feed and grow a bit more. Many of those transports are nurse-led. All of those transports are now happening through the 12-hour transport service, which is great because it means that nurses are on the unit as opposed to transferring babies.

[12] On the urgent retrievals, some of those are happening outside of the transport service. There will be babies who are too unwell and cannot wait until the transport service is up and running the following morning. There are some cases where treatment needs to be started immediately, for example, cooling after birth asphyxia, which needs to be started within six hours, and if a baby is born at midnight, it cannot wait until the next morning. So, those transfers are still happening. When they happen, they take away nursing and medical staff from the unit that is transferring the babies. That will be happening at night when there is already a skeletal system. That is not a great situation, but in Wales, because of our geography and because our birth rate is not particularly high—overall it is increasing, but we are not a very urbanised area—the cost and expense involved in having a 24-hour network is—

[13] **Jocelyn Davies:** It is desirable, but not realistic.

[14] **Dr Barr:** Yes, exactly. On balance, resources would be better placed elsewhere, so I do not think that that is the way forward.

[15] **Keith Davies:** Yn eich papur, rydych yn sôn am sefydlu system BadgerNet mewn 13 o leoliadau. A yw'r system newydd hwnnw'n golygu eich bod yn gwneud gwell defnydd o'r cotiau a'ch bod yn llai tebygol o symud plant o un uned i'r llall?

**Keith Davies:** In your paper, you talk about establishing a BadgerNet system in 13 locations. Does that new system mean that you make better use of the cots and that you are less likely to move children from one unit to the next?

[16] **Dr Barr:** BadgerNet is a system of gathering clinical information, so it has many uses. One is that we are able to move clinical information from one unit to another quite nicely. So, if a baby is coming to my unit from west Wales, the electronic information arrives in my unit and I have a very clear picture straight away of the baby's history. We are also able to produce streamlined discharge summaries, so all units are producing similar discharge summaries. I can read one from north Wales, Aberystwyth or Cardiff and the information that I need to find is all in the same place. That has made gathering information easier, particularly when babies come or go.

[17] BadgerNet is an audit tool as well. Through that, we are able to compare ourselves within Wales and with other units in England through the national neonatal audit project. However, we are also able to compare ourselves internationally because the way we collect information is very similar to the Vermont Oxford Network. Therefore, we are able to get a lot of information through that. That is what BadgerNet does. I do not think that BadgerNet per se helps us in being able to place babies in particular cots.

[18] The cot locator is different to BadgerNet. With the cot locator, every morning, the transport team phones all of the units to find out how many babies are in the cots and where the babies are from. That is put on the web and we are all sent that information. So, if you are on service, instead of having to ring around different hospitals to find out how many beds they have, the information has already been obtained and is there to see. So, it makes the theoretical movement of babies easier. For example, if a baby needs to go back to Carmarthen, you need to check whether there is a bed there. If it shows up red all the way

across, they do not have a bed and that will not happen that day. The problem is that it is red all over the place because we do not have enough cots. So, the cot locator helps with that, but BadgerNet is more for us and getting clinical information and ensuring that we are doing the right thing and comparing well with units like ours in England and internationally.

[19] **Keith Davies:** Rydych yn dweud yn y papur nad oes gennym ddigon o adnoddau.

**Keith Davies:** You say in the paper that we have insufficient resources.

[20] **Dr Barr:** Nid oes gennym ddigon o adnoddau. Nid oes gennym ddigon o gotiau. Mae angen mwy o gotiau.

**Dr Barr:** We do not have enough resources. We do not have enough cots. We need more cots.

[21] **Suzy Davies:** My question is on that point. We have already heard evidence that there are not enough cots to deal with level 2 and level 3 care. However, what about level 1? We do not have a lot of information about whether there is good capacity there or is that area under-resourced as well?

[22] **Dr Barr:** We do need more level 1 or special care cots. Recently, over the past five to 10 years, more babies have been delivered late pre-term. Full term is from 37 weeks to 42 weeks, and babies are now being delivered at 34, 35 and 36 weeks. They are not very unwell and they do not need intensive care, but they may have some clinical problems. They may have difficulty with feeding or they may be too small and so on. We do not have enough of those beds. Different hospitals within Wales deal differently with these babies. Some hospitals will have quite an aggressive attitude, meaning that they will try to keep the baby with mum as much as possible, with the midwife helping with nasogastric feeds on the postnatal ward, whereas other units will admit the baby to the unit. Some neonatal units will also admit babies who have gone home. For example, most units would admit a three-month-old baby who has been home for a little time and then becomes unwell to a paediatric ward. However, some hospitals bring those babies into their neonatal units. Of course, that occupies a special care cot, which would be better utilised for a baby born at 36 weeks.

[23] **Christine Chapman:** Dr Barr, are the inconsistencies between these hospitals desirable?

1.00 p.m.

[24] **Dr Barr:** No. You always find these inconsistencies. Within medicine, there are lots of different ways of doing things and there are some things that we all try to do in the same way because we make the clinical course safer if we are all doing the same thing. Some hospitals have different attitudes and that depends very much on whether you are a level 1, level 2 or tertiary unit. I work in a tertiary unit so I continually need high dependency level beds. It is not desirable. We have looked at that and there is an ongoing piece of work looking at how we use our special care cots. That is something that we plan to look at as a network.

[25] **Christine Chapman:** So you are looking at best practice.

[26] **Dr Barr:** Yes.

[27] **Lynne Neagle:** In your evidence you referred to the under-utilisation of some neonatal capacity due to inappropriate use of cots across the three levels of care. Can you say a bit more about that and perhaps explain what you feel the reasons for that are? You mentioned a few in your evidence, including clinical competence, and you have mentioned resourcing issues. Is it possible to identify the cause of this?

[28] **Dr Barr:** Intensive care should be done in tertiary units. A tertiary unit is different

from a level 2 unit or a level 1 unit in that it is run by neonatologists and there is a separate tier for the on-call staff. The middle grade staff, the registrars, are looking after only those babies and not paediatric patients as well. BAPM standards and all-Wales standards state that babies receiving intensive care should receive that only in a level 3 unit where there is the support for that. However, babies are receiving intensive care outside level 3 units. I do not think that that is appropriate. That is not the way to ensure good-quality care for those patients.

[29] **Lynne Neagle:** How widespread is that situation of babies receiving intensive care outside level 3 units?

[30] **Dr Barr:** It does happen. The level 3 units are in Swansea, Cardiff and Newport. There are intensive care cots in Nevill Hall Hospital, Merthyr hospital—I forget where else. Mark Drayton is giving evidence after me and he will be able to give you more information about that. The health boards need to think about whether those cots should be there or whether they could be reconfigured. I do not think that it is the best care for babies to be receiving intensive care there. You asked about high dependency units. HDU is the bottleneck at the moment and it is causing a major problem. A special care baby may be in a high dependency cot, which is an inappropriate use of that cot. I have just come from the ward—I was working this morning—and I am at 100% occupancy; 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. There are another four babies on the labour ward at 39 weeks who will be delivered in the next few days with complex surgical needs. If a bed is not made available on my unit they will be transferred to England and, in due course, we will get a bill for their neonatal care. This is happening day by day. That is just today. It is just today. Sorry, I was ranting a bit there. [*Laughter*.]

[31] So that is one reason. The HDU bed is sometimes blocked at that level. Then, because we do not have enough medical staff and nursing staff, a hospital may be looking at a cot but it may not be able to staff it, so it would have to say, ‘I’m sorry, we can’t take your patient because we don’t have the staff’, so that is a problem as well.

[32] **Jocelyn Davies:** You say that you are at 100% capacity. How many beds is that?

[33] **Dr Barr:** It is 28 plus two. It depends on whether we have someone in isolation. If we have someone in isolation, we have to look after fewer patients, because that takes more nurses. When you are doing critical care, you aim for between 70% and 80% occupancy, so that you always have a bed for when the emergency happens. I have 28 cots. Those 28 are full. There is this baby who is going to be having unusual care. That should happen on the neonatal unit, but it will not. It will happen on a paediatric ward. That is just today. Then, there are the other four who cannot go anywhere. One has a blood problem that needs the expertise of Cardiff and the other three are going to need operations immediately following delivery. So, if a bed is not found in Cardiff when the mothers go into labour they will be moved to England. I was on service last week and, again, I was in the same situation. This is the problem with surgical beds. We start with Bristol. If Bristol is full, we go to Birmingham. If Birmingham is full, we go to Southampton and then to London. There was a baby in Bridgend who would have had to go to Southampton. Again, we did a complicated move, moving a neonate at 10 p.m. down to the paediatric ward. Again, it is unusual and not what we normally do, but we did it in order to stop a baby going to Southampton. That was last week. It is happening all the time. We must get the health boards to realise that we need action now.

[34] **Jocelyn Davies:** I think that we might ask them to come to tell us about it. I know that this is supposed to be a one-day inquiry, Chair, but I think that we are going to have to

extend it and bring in the health boards, particularly the north Wales one, to explain why this is not a priority.

[35] **Dr Barr:** We try to get away with it; that is what we do, and most of the time we get away with it. However, it is not how I wish to work. It is not right for the patients, it is not right for the families, and it is a very high-risk situation. Last week, I had six babies in intensive care and the all-Wales standards and the BAPM standards say that these patients should have 1:1 nursing. There were six babies with four nurses for the whole shift. In the high dependency cots, there were eight babies with only three nurses. In adult intensive care, it is 1:1 nursing; in paediatric intensive care it is 1:1 nursing. Why is that not the case for neonates? It is not right. These babies are very sick. It is very stressful. The nurses do a fantastic job. There were six very sick babies ventilated on different drugs having different procedures done and there should be six nurses there, but they were not; there were only four.

[36] **Christine Chapman:** Lynne do you want to finish your questions? Julie and Eluned also have questions.

[37] **Lynne Neagle:** On capacity, I have one other question. We heard from Bliss that the network feels that there should be 82 extra neonatal nurses across Wales. You have basically said that we need more cots. Obviously, the cots depend on the nurses. Is it possible to quantify how many more cots with nurses we need? Is it as simple as saying that we need 82 more?

[38] **Dr Barr:** The short answer is ‘yes’. We need to have joined-up thinking. It is a cot, but, as I said, units will be looking at a cot but saying that they are sorry but they cannot accept the patient because they do not have a nurse. Both things need to happen at the same time. There is well recognised guidance on how intensive care units should be managed and what the nurse-to-patient ratio should be. As I just said, in adult intensive care and paediatric intensive care there is 1:1 nursing. That should be the case within neonatology as well. There is no difference. They need intensive care in the same way as if you went to hospital or a seven-year-old went to hospital. It is well established that that is what the ratio should be. We vaguely know how many extra cots we need, so it is a simple equation. The problem is that you do not get them just like that. It takes a while for the neonatal nurses to come through the system. So, even if we were to do that now, we need to be thinking about what we are doing in the meantime. It is going to take us four to five years. Generally, in neonatal nursing, the older people are retiring and there is a gradual downward trend in the experience and the grade of the nurses, which again is not appropriate, and is a worry. For the long term, we need to be thinking about what we will do.

[39] **Julie Morgan:** You have graphically described the situation that you are dealing with. Do you see the demand getting greater?

[40] **Dr Barr:** Yes, I do. I think that I have mentioned that the birth rate has increased—since 2002, so in the last 12 years, it has increased by about 20%. It is not clear why that is the case. Generally, in a recession, the birth rate goes down—that is normally what you see. Indeed, in 2009, the birth rate did dip a bit, but then in 2010 it went straight back up, although we were still in recession. So, it will be interesting to see what happens over the next few years. There are 35,000 deliveries a year in Wales, so the increase in the birth rate amounts to an extra 6,000 deliveries every year. Around 10% of those babies need to come to a neonatal unit, so that is 600 extra admissions a year that we have not taken into account at all. That is just the start, let alone the increase in capacity that we need. I work at the Heath hospital here in Cardiff, so it will be like having another hospital sitting alongside me doing the same thing. It is a massive extra workload. So, yes, I do see the demand getting greater.

[41] **Julie Morgan:** You go to Bristol first, you said, and then on to other places. Are the

hospitals in England experiencing the same problem?

[42] **Dr Barr:** Yes, they are, but England had clinical networks probably 10 years earlier than we did. What we are having to do now was done in England about five to 10 years ago. England still has similar pressures to us in terms of nursing and staffing shortages, and I do not think that the system is perfect in England, but reconfiguration and the assessment of where intensive care cots are needed has already happened there, so I think that it is working better there.

[43] **Julie Morgan:** That is how you are able to move babies to England, is it?

[44] **Dr Barr:** Yes.

[45] **Eluned Parrott:** I must confess that I was incredibly shocked to hear you describe the situation that you are facing. We probably all are. I want to ask you to lay it on the line for us and tell us whether this situation having an impact on the long-term clinical outcomes for these babies. Are we losing babies because the situation is as it is?

[46] **Dr Barr:** That is a hard question to answer. As a service, as nurses and doctors, we would always try to make sure that that does not happen, and not to allow standards to fall. It is very hard sometimes to make these decisions. You might have one cot, and there may be three or four babies who need it, so which baby's need is paramount? We liaise with the obstetricians and talk together as a group, sometimes, if we are not sure what is best to do. With regard to the baby that will be delivered this afternoon, it should be in a neonatal unit, but it will not be in a neonatal unit—it will be on a paediatric ward. Those paediatric nurses will do the best that they can, but it will not be ideal. Generally, we get away with it, but we will not always get away with it. I am sure that there have been instances, and will continue to be instances, when mistakes happen. Even when you have a neonatal unit that is functioning very well, it is a stressful, particular job—the nurses and doctors have a lot of responsibility. When you are working with that extra stress on top, mistakes happen. We are all human. None of us are robots. If it has not happened already, and if nothing changes, then it will.

1.15 p.m.

[47] **Christine Chapman:** Could we just put that into context? It is difficult, because there have been so many changes in medicine over many years. I am just thinking about the situation that we are in now with regard to this particular aspect of medicine—how do you feel that it compares with the situation five years ago? Are things better, or have we slipped back? What would you say the situation is?

[48] **Dr Barr:** I think that things are worse, because neonatology in particular is quite a young speciality that has developed over the last 10 to 20 years, and over the last few years we have been able to look after younger and younger patients, and now our threshold of viability is at 23 or 24 weeks. I do not see that changing. I do not see that threshold getting any lower. Certainly, at 24 weeks' gestation a quarter of the patients do very well, so as a society we all agree that we should be offering resuscitation for them. I do not see the threshold getting any lower for many reasons, one of which is practical and technical: we just do not have equipment small enough to be able to deal with babies below that age. So, I think that neonatology is as good as it is going to get, in that there will be further and finer advancements that we can make, but I do not see anything major changing otherwise. So, we now have to manage what we have, and I do not think that in five years' time that we will be looking after 22 weekers or 21 weekers.

[49] **Christine Chapman:** Sorry, what I meant was that, with regard to the situation that you described about the 24-week-old babies, there are obviously a lot of issues with the way

that we are caring for them. Have we slipped back? Were we doing it better five years ago, because of some of the things that you have raised, or are we actually making some improvement, albeit quite slowly? I am just trying to get a sense of where we are. Are we slipping back?

[50] **Dr Barr:** No, I do not think that we are slipping back. We are not slipping back in terms of long-term outcomes. That is not the case. The most recent figures would confirm that. What we are now having to do, compared with five years ago, is the same job with the same number of cots and nurses but with a higher birth rate, so we are doing the same job under more stressed conditions.

[51] **Christine Chapman:** Because of the birth rate.

[52] **Dr Barr:** Yes, plus the fact that there are not enough cots in the system.

[53] **Jocelyn Davies:** If a baby has to go onto a paediatric ward, what sort of ratio is there of patients to nurses?

[54] **Dr Barr:** It is 1:4. On the general paediatric ward there will be high dependency areas, and they have a ratio of 1:2. This baby would most likely initially go to a high dependency ward, where it would be 1:2.

[55] **Jocelyn Davies:** But that would not be a specialist ward.

[56] **Dr Barr:** No, and it would be a paediatric nurse. They are great and great for helping us out, and it is great for the family, because otherwise she would have to go to England. These are the decisions that you have to make: do I compromise and try to keep the baby here in Wales? It is a very stressful life event to have a baby on a neonatal unit, and so it is better if we can keep the baby here, but then the care will be less than ideal if it is not on a neonatal unit, so do you send the baby to Bristol? It is not a decision that—

[57] **Jocelyn Davies:** I would not want to have to make that decision.

[58] **Dr Barr:** If it was covered in medical school, then I must have been in bed at the time. [*Laughter.*] These are decisions that we have to make on a daily basis. I was on service last week, and I did a ward round this morning, and this happened this morning.

[59] **Lynne Neagle:** We know that we are seeing more multiple births, and I have had a case in my constituency of twins where one baby was sent to one hospital, and the other baby was in a different hospital, and the poor mother was absolutely tearing her hair out. How common is that kind of thing?

[60] **Dr Barr:** Unfortunately, it is common, and, in fact, I can tell you of a set of triplets who were in three different hospitals: Prince Charles Hospital, the Royal Glamorgan Hospital, and the Heath. It does happen, and, again, you try to avoid it as much as possible, because it is stressful having a baby on the unit. It is the third most stressful life event after divorce and moving house, and you need to be in your own environment with friends and relatives around, so we would always try to keep them together. However, that would have happened in order to avoid a baby going to England, so at that time you make that decision, but it is not ideal, and you are robbing Peter to pay Paul. That is not what we would wish to do, but it does happen.

[61] **Christine Chapman:** We have fewer than 10 minutes remaining, because we have other witnesses as well; I ask Members to keep their questions as brief as possible. I know that it is difficult—I include myself in that. Julie Morgan is next.

[62] **Julie Morgan:** I think that a lot of the questions about the standards and staff availability have been covered. What would be the benefits of Wales moving towards a consultant-driven model?

[63] **Dr Barr:** That is a large question. Medical staffing is a problem for us for various reasons. In the last few years, the European working time directive has had a major impact on medical staffing, and junior doctors can be on the ward for less time. In order to provide cover, we therefore need more bodies. There was a change in the immigration rules a few years ago that has made it much harder for doctors from overseas, that is, doctors who are not UK or EU nationals, to work in the UK. Traditionally, Wales has been quite dependent on overseas doctors, so their experience has been missed. We need to look innovatively at how we can manage. At the moment it is a consultant-led service, but I know that BAPM has been looking into this, and there is a committee looking at the major crunch that will happen in March, when fewer junior doctors will be available, which will affect the smaller hospitals. Doctors will go to the larger hospitals because of their training needs, but, for the smaller hospitals, the middle tier is just not going to be there, so how those hospitals will manage is going to be very difficult. One of the options that is being looked at and considered is moving towards a more consultant-delivered service. England has done that already, in that there are two neonatal units that I know of that have a kind of hybrid system—a senior registrar who sometimes works as a consultant and sometimes as a junior—and I think that we will find that rota systems similar to that will be used more and more frequently in order to cope with a lack of junior doctors.

[64] **Julie Morgan:** I was very interested to hear what you said about overseas doctors. Is that a significant loss?

[65] **Dr Barr:** That is a major, significant loss. I trained in Cardiff, which means going around lots of different hospitals within Wales, and I learned so much from these people. They were an invaluable asset, and it is very difficult now. In March, we had eight registrars, and one of those slots is uncovered. We have tried to get a locum and, because of the financial pressures within the trust, that decision has had to go up to chief executive officer level—just to get one locum. Particularly in Wales, traditionally and historically, they were a big asset, and it has been a big loss.

[66] **Suzy Davies:** In your evidence, you stated that you think that there is a risk of precipitous rather than planned change in relation to neonatal care. Yet earlier you said that we have been talking about the same old issues for the last 10 years, and, in fact, the Welsh Government has given until 2018 to get a framework in place, so we are looking at the best part of 20 years here. Do you think that the local health boards will bring this up their list of priorities? It is a difficult question, I know, but we need a plain answer to this one.

[67] **Dr Barr:** This should be No. 1 on their agenda. This is a very important topic, and we have been talking about it for 10 years. In March, there will be, quite suddenly, a lack of junior doctors, which will lead to changes, quite quickly, in how rotas run. Hospitals will have to make decisions overnight, essentially, on how they will manage their service. We have known about this for a long time; we just need to see urgent action in terms of what their plan is.

[68] **Christine Chapman:** Do you think that the BAPM standards are being used to plan ahead?

[69] **Dr Barr:** I would hope so, because all of the information is out there—you have heard from Bliss as well—and it therefore needs to inform us. That has not happened, it is disappointing that we are in this situation and I would wish for us not to be in this situation.

[70] **Christine Chapman:** That could not be plainer.

[71] **Eluned Parrott:** You state in your evidence that any change to neonatal services will need investment and reconfiguration of what is available. If you were making that decision, what actions would you take in both of those areas? What new investment would you make and what can be done through reconfiguration?

[72] **Dr Barr:** Plainly, we need more cots. We do not need many more, but we need more particularly in the high dependency area, which is a major bottleneck, as I have already described today. The cots are of no use unless there are nurses who are able to look after the babies in them. So, we urgently need new nurses also, but they will not magically appear overnight. Again, while we are waiting for or, hopefully, getting new cots, we need to look aggressively at where those cots are now. The cots that we already have could be managed differently. Intensive care needs to happen in the intensive care unit—it should only be happening in the tertiary units. High dependency beds should be used for high dependency and not as special care cots.

[73] **Christine Chapman:** Thank you very much, Dr Barr. The message has been quite consistent today that there is a definite need for more cots and nurses. Clearly, it is also important where those are located. That message has come across strongly. Thank you for attending today. I appreciate how busy you are and I am sure that you are very much missed on the wards. We appreciate your evidence, which is extremely useful to us.

[74] **Dr Barr:** If anyone would like to visit the hospital to get more of a first-hand feel for it, then you are very welcome.

[75] **Christine Chapman:** I am sure that Members will take you up on that. Thank you very much. We will send the transcript of the meeting to you to be checked for accuracy.

1.28 p.m.

## Ymchwiliad i Ofal Newyddenedigol—Sesiwn Dystiolaeth 4
## Inquiry into Neonatal Care—Evidence Session 4

[76] **Christine Chapman:** I would now like to invite our next witnesses to come in. Welcome to you both. Please introduce yourselves for the record.

[77] **Dr Doull:** My name is Iolo Doull; I am the Royal College of Paediatrics and Child Health officer for Wales and I am here representing the RCPCH today. I am also chair of the national specialist advisory group on paediatric and child health.

[78] **Dr Drayton:** I am Mark Drayton, consultant neonatologist. I am here at the invitation of the RCPCH because I chair the all-Wales neonatal committee, which is a professional body. I would also like to say at the beginning that I am the clinical lead for the neonatal network, about which you have already heard a lot today. I will remind you that in my role as clinical lead for the neonatal network, I am responsible to the health boards through the Welsh Health Specialised Services Committee and, therefore, ultimately to the Minister. I therefore ask you to understand my position, but I will answer your questions as fully as I feel able.

[79] **Christine Chapman:** Thank you for that. Members will have read the paper that you have sent, so if you are happy, we will go straight to questions. I wanted to start with a broad question. The evidence that we have received suggests that neonatal services in Wales have faced many key challenges for many years. We have had several reviews into neonatal

services, but these problems persist. Why is that the case?

1.30 p.m.

[80] **Dr Drayton:** What you say is accurate. However, we should recognise that there have been some positive changes. We have a functional, high-quality transport service, which has made a big difference to getting babies into the right place at the right time and in a safe fashion. The cot location system allows us to identify capacity and make best use of the limited capacity available to us. We have done a lot of work with the nursing sub-group in terms of nurse training and establishing a structure for nurse training in neonatology, including transfers of nurses between units to share skills. We have worked hard to nurture a better culture of co-operation between units, so that we all recognise that we work together as part of a large system and that we need to collaborate to make the system work properly. So, a lot of positive things have happened during the past 12 to 18 months since we had a clinical network.

[81] However, returning to your original point, we have significant issues, particularly on access to the critical care end of neonatal care. We do not have adequate access. I was listening to some of Dr Barr's evidence, and, as I shall be on call tonight, I shall be inheriting the problems that she experienced this morning—that is the regular day-to-day experience. Through the network's work and collaboration between units during the past year we have been able to get a much better handle on what is happening in the system and what could or should happen to produce a system that works more coherently, effectively and efficiently.

[82] At the top of my list—and it is not only my list—is the need to make our nurse staffing compliant. We are at about 20% below the standard at the moment, and compliance overall varies from unit to unit. We need more capacity at the high-dependency and critical-care end of the spectrum. We also need to be more efficient in how we use the low-dependency resource, and find better ways of managing some of that low-dependency, low-acuity activity. There are better ways, and the network has done a substantive piece of work to look at best practice in that area to help health boards.

[83] I think that your question was why that has not happened. One of our roles has been to ensure that health boards understand the problems and solutions. We are starting to get that engagement at health board level. I would have preferred for that engagement to have been a little stronger, perhaps six, nine or 12 months ago. That engagement is now coming. Why is it not happening from a health board point view? There are some resource issues associated with it, and we are all aware of the enormous pressures that every health board is under in terms of resources. That must be part of the problem.

[84] **Christine Chapman:** I put the question to Dr Barr about whether there is a sense that things have slipped back or whether we are making some progress. There are a lot of concerns, but are we heading in the right direction, and not going backwards?

[85] **Dr Drayton:** The problem is getting bigger because, as Dr Barr explained to you, the birth rate has gone up significantly, and that has not been matched with extra resource. We are more successful—little babies are surviving when they did not survive before, but they require a lot of care before they are ready to go home. So, that is an extra demand upon the service, which has not been met by additional resource. We are no further forward in terms of the number of nurses we have overall in Wales than we were in 2005 when the original review was done or, indeed, than we were 18 months ago when I took on the role of clinical lead, and we do not have any more cots than we did then.

[86] **Christine Chapman:** We will tease out some of these other aspects. I will ask Jocelyn Davies to come in now.

[87] **Jocelyn Davies:** You know that the network looked at the capacity required in October 2010 and that the local health boards were asked to develop action plans in response by last summer, I think. Are those in the public domain?

[88] **Dr Drayton:** I am not sure whether they are in the public domain. They were developed. I suppose that I would describe them as indicative action plans. They were rather general. Obviously, we have gone through another round in terms of the capacity review, and the most recent capacity review has a great deal more evidence to support its conclusions. That was presented to the network steering board last week. That has now gone out to the health boards, but, of course, they have not had very long to consider it.

[89] **Jocelyn Davies:** I do not suppose it contained any surprises.

[90] **Dr Drayton:** There certainly should not have been any because the messages did not change in any major way. There was a much larger evidence base for the conclusions we had reached a year ago.

[91] **Jocelyn Davies:** What information needs to be included in the action plan and what sort of timescale would you ideally like to see attached to the action plan?

[92] **Dr Drayton:** As a professional and as a representative here of the college and my professional colleagues, I think that our first priority is that the nurse staffing standards are met. We fully recognise that that is not something that can happen overnight. It takes time to recruit nurses. It then takes time to train them in our specific specialty. If the health boards were to become compliant, the salary bill for nursing staff would increase by about 20% overall. That may be something it would be difficult to do in one go. Therefore, I would look to see a plan with milestones that took every health board forward to achieving full compliance within what might be a reasonably accepted timescale in terms of achievability. It might be 18 months, it might be two years. We could negotiate over what was achievable for each individual health board. I would like to see some plans and to start to get some numbers on it that we can monitor.

[93] With regard to the number of cots we need on top of additional nursing staff for the cots we already have, actually, if we can deal with what we might call efficiency issues, the number is quite modest. It is probably an increase of only about 8% or 9% on what we have at the moment. It is not uniform across the piece. The issues are focused in certain areas. The proviso there is that we need to be more efficient or effective in the use of the cots we have. We have quite a lot of high-dependency cots in the network, particularly in the smaller units—what we now call the local neonatal units—that are less than 50% occupied despite the pressures on some of the larger units where the occupancy is approaching and sometimes over 100%.

[94] We have got to do something to even it out. We cannot afford to have cots that are only 50% utilised. There are quite complex issues related to why they are under-utilised. Part of it is the management of the low-dependency stream and low-dependency babies taking up the nurses who should be doing the high-dependency care. Some of it has to do with the way units are structured in Wales. We have too many small units in Wales. We have a considerably larger number of small units compared to most network areas in England. That means that those very small units cannot effectively deliver high-dependency care. Take the example of one of the hospitals in west Wales where I know that, on many nights of the year, there are only two nursing staff on duty on that unit. You cannot deliver high-dependency care if you have only two nursing staff on duty overnight. If, instead, in west Wales we had a single unit, we would probably be able to have five nursing staff overnight, which creates the opportunity to deliver proper high-dependency care and therefore getting the occupancy of

the cots up to a reasonable level and allowing babies to get back closer to home sooner than they currently can. There are complex issues about building the competency of medical and nursing staff, but that is what we need to work with, and that is where we need the help of the health boards.

[95] **Lynne Neagle:** I have been asking for the Aneurin Bevan Local Health Board plan since November, and I still have not had it. I have been told that it is going to the board in the next few weeks. Is that where you think that the Aneurin Bevan Local Health Board—I am just using that as an example—should be at this point after all these years of work on this issue? It is all very well to have a plan, but someone then has to drive it forward locally. Will the health boards be expected to put something specific in place—a member of staff or whoever—to drive this forward locally?

[96] **Dr Drayton:** I would hope so, but it is not in my gift, as you realise. In many ways, Aneurin Bevan Local Health Board is well up with the game compared with some other health boards, but we should not go into individual comparisons of health boards. The most recent version of the capacity review was only completed in January. It has been shared with the health boards through their directors of planning. I had a meeting with all the directors of planning for the health boards last Friday. We spent about an hour discussing this and the implications, so the message is getting there at a senior executive level. I understand that all the chief executives plan to have this as a major agenda item in their meeting in March. The message is getting there, and we are starting to get some kind of engagement. However, in terms of what happens next, that is very much an issue for the health boards.

[97] **Keith Davies:** I have seen guidelines that say that to have a neonatal unit, you need 2,500 births a year in a hospital.

[98] **Dr Drayton:** I do not think that that is quite accurate. I will try to explain the system. There is more than one kind of neonatal unit. Ongoing neonatal intensive care—that is beyond stabilisation and just short-term intensive care—beyond, say, 48 hours or 72 hours at the outside, should only be delivered in neonatal intensive care units. We define neonatal intensive care units, essentially, as being run by consultant neonatologists, having a separate tier-2 middle-grade medical rota, which is completely separate from general paediatrics, and, obviously, having the appropriate cots, nursing staff and other support facilities in place. With regard to the number of deliveries to support a neonatal intensive care unit, the sort of number that you should have in your heads is around 7,000 to 7,500.

[99] Those units are supported by, and provide support to, local neonatal units, which I was talking about in my last answer. Those units are capable of doing stabilisation and short-term intensive care, and high-dependency care and low-dependency care, which are the critical components of the overall system. Beyond that, we have special care units, which really are units that are generally in very small hospitals and that provide relatively low level care for babies who cannot be cared for at the bedside before they can go home. We have a complex structure; it is not just one neonatal unit. Going back to the original question, we have three neonatal intensive care units in south Wales. In north Wales, we do not have a compliant neonatal intensive care unit, and that is a cause for concern for me. I have spent a lot of time in north Wales over the last year. There is a bit of a mixture between ongoing intensive care being provided in the two local neonatal units—one in Wrexham and one in Rhyl—and some babies going to England for their care, which is not really a satisfactory solution.

[100] **Christine Chapman:** We want to touch on that point later, so we will leave that for the moment. We have quite a lot of areas to cover, so I ask Members to be as concise as possible, because we have to finish by 2.30 p.m. at the latest.

1.45 p.m.

[101] **Lynne Neagle:** Turning to occupancy levels, you state in your paper that the standard is 70% for critical care and 80% for low dependency, but we heard earlier that UHW is currently at 100%, and that that is not uncommon. Do you have any figures as to how well this standard is being met, or is it more often the case that it is not being met?

[102] **Dr Drayton:** Overall, it is not being met in any of the large neonatal units. It is being met in some of the smaller units, but that in itself is a problem, because they are not always able to use their capacity, particularly their high-dependency capacity, as effectively as we would like. Some units are well below 50% occupancy. So, if we are going to run the service like that, we need even more cots. I suggest that we need to look at improving efficiency, getting the right babies in the right place and getting the right skills in the right place, which will mean a degree of reconfiguration.

[103] There are all sorts of drivers for reconfiguration, but, rather paradoxically, having a smaller number of more effective local neonatal units will allow a lot more baby care to be delivered within reasonable striking distance of the families' homes than at present.

[104] **Lynne Neagle:** You go on in your paper to say that we are not that far from having adequate provision with regard to the number of cots, but that there are the problems that you alluded to with distribution, utilisation and staffing of existing capacity. How confident are you that these plans by the health boards will genuinely address this issue, because it seems like a bit of a no-brainer that they have not dealt with it? If there is a deficiency of five cots in Wales, how much does it cost to run one of these critical care cots effectively, with appropriate staffing?

[105] **Dr Drayton:** I will try to answer the first question now and if I forget the second, please remind me of it when I get to it. I have now forgotten the first question. [*Laughter*.]

[106] **Lynne Neagle:** How confident are you, given these fairly entrenched problems?

[107] **Dr Drayton:** Where we need to start addressing the problem in an immediate fashion is at the low-dependency end. We have got the messages out about the variable practice between units with regard to how relatively low-acuity babies are being managed. On top of that, we commissioned a piece of work through the low-dependency work stream, again reporting in January, and an excellent piece of work was produced. The work contains, among other things, a best-practice list for the management of those kinds of babies. It contained 15 points or so. What we are now asking of the health boards, not only at the management level, but also at the clinical level, is to look at that best-practice guidance and to ask themselves 'How are we doing against that?' I am fairly confident that that will happen, but how quickly and effectively is something that we as a network will have a duty to monitor and to feed back on to health boards as to how well they are doing. However, that piece of work will happen and will take us some way forward to unclogging the system.

[108] I suspect that some units will find that there is a limit to how much increased efficiency they can achieve by managing that work stream better through outreach nursing, better discharge planning, better obstetric practice and so on. I am afraid that those units will need to invest in some more low-dependency capacity, and the decisions on which route to take or to what extent they are going to improve their efficiency or invest more will have to be made locally by the health boards. However, if we start there, we can start unclogging the high-dependency capacity. Most of the high-dependency capacity is there, but it is just not being used right. There are some exceptions to that, but, mostly, it is there.

[109] Getting that capacity to be used right also means thinking about reconfiguration. We

are all aware that reconfiguration is not one of those things that can either be considered or implemented really quickly. So, I have some concerns as to how rapidly that process can move forward. Although Betsi Cadwaladr has the largest problem, it is also probably the furthest on in the game in terms of trying to get to a strategic solution.

[110] **Christine Chapman:** I do not particularly want to stray onto reconfiguration, because I am not aware of the different areas, but there have been cases of difficulties with reconfiguration because of local demand and what different communities want. However, it is not just the communities, but also the clinicians. Do you have any thoughts on that? They are coming from a perspective of clinical need as opposed to just 'We want something locally in our area'. Do you have any comments on that?

[111] **Dr Drayton:** As far as— [*Interruption.*]

[112] **Christine Chapman:** Could you answer the question on the cost of cots as well?

[113] **Dr Drayton:** I cannot do the calculations off the top of my head. A cot means equipment and, most importantly, the nurses that go along with it. For a high-dependency cot, you are talking about six nurses—I think that I have got that right.

[114] Reconfiguration raises the temperature a lot in the clinical, professional environment and in the public environment, and also in this environment, I suspect. I can speak only on behalf of my neonatal and, to some extent, my paediatric colleagues. There is substantial understanding in north and west Wales, and possibly also in Cwm Taf, which are the primary areas where there is a need for reconfiguration in relation to neonatal services. Dr Doull was also part of that process. We are moving that culture forward, from a neonatal professional point of view and from a broader paediatric point of view. Maybe you would like to chip in about some of the stuff that we have been doing to move that culture along, Iolo.

[115] **Dr Doull:** The difficulty is that we have two different strands in the paediatric context, namely general paediatrics and then neonatal paediatrics. In many hospitals, such as the Princess of Wales Hospital in Bridgend, the same doctors will do both, while in the specialist level 3 units, such as those in Cardiff, Newport and Swansea, there will be different doctors in the two strands. You cannot see the two in isolation. Medical staffing for paediatrics is probably now the worst of any speciality, and it is probably worse in Wales than anywhere else. So, reconfiguration will need to happen, but we would rather that that happens in a structured and controlled manner than in a reactive, crisis manner.

[116] **Julie Morgan:** You have a substantial body of activity data. Can you tell us how many times neonatal units in Wales had to close during 2011 due to insufficient capacity?

[117] **Dr Drayton:** I cannot. We have not collected that piece of information prospectively, and it is not that easy to collect it prospectively because closure is generally a somewhat flexible situation—if you think about it hard enough, you can find innovative solutions to the immediate crisis in terms of moving babies around. Again, Dr Barr alluded to some of the difficult decisions that have to be made. So, you can be closed, but then a mother comes in in advanced labour and it does not make any difference that you are closed, because if she delivers a baby at 27, 26 or 25 weeks gestation, that baby is there and you have to do something about it—and we do.

[118] Over the last year, we have been able to collect the occupancy data, where those babies come from and the cross-border flows, and a lot of the capacity review conclusions are based on that information. That is the first time that we have had information with that level of detail. What we will have ongoing for this year is the BadgerNet information that was, again, referred to earlier today. The cot locator or capacity information is cot based, but the

BadgerNet system is patient based and, therefore, gives us a much more valuable dataset to interrogate, to know what is going on and to track babies from unit A to unit B and so on. Although we have been collecting those data since January 2011 as a network, we have not had permissions to use the data on an all-Wales basis. We are just waiting for the last health board to give us permission before we can start that analysis.

[119] **Julie Morgan:** That would give you some idea about the question that I asked.

[120] **Dr Drayton:** Yes, it would, but it is always difficult to define a unit as closed, because it is a slightly flexible term. It means that you should not be admitting any more babies, but it does not mean that you do not admit any more babies.

[121] **Julie Morgan:** No, but if you had data on when it was supposed to be closed, that would give some idea of the extent of the moving around and of the problem.

[122] **Dr Drayton:** The problem is very significant. I have little doubt that the introduction of the transport service and the cot locator in January last year made a big difference to how we can better manage these acute situations. We got through most of 2011 without the situation getting that bad, although we had our moments. Since December of last year, it has been awful, and it is still awful today. This demonstrates that we are an emergency-led service with high acuity and quite low volume. What that means, in terms of this capacity modelling, is that we have enormous peaks and troughs of demand that are pretty random, and we have to have sufficient capacity to manage the peaks, often with stress, but reasonably effectively. We do not have that capacity at the moment. When those kinds of situations arise—and this has been pretty constant since late December—we end up sending mothers quite unreasonable distances. There are clinical risks associated with that, and there is certainly an enormous amount of stress for the parents, the family, and, I have to say, the staff. There are also considerable resource implications in doing that, because these transfers have to be escorted. Most of it is accommodated within Wales, but not all. In these last few weeks, we have seen quite substantial numbers of mothers having to be transferred to England, and then we have great difficulty trying to get the babies back into our system as soon as possible. As you have heard, yes, families are split up—twins and triplets do get split up in that process, and we would wish to avoid that.

[123] **Julie Morgan:** Have you got any particular comments about the south-central community?

[124] **Dr Drayton:** The south-central community is pivotal, because the capacity in relation to demand—both in terms of population base and the demand for surgical services based in Cardiff—is particularly inadequate. There is a historical background to that; partly, it relates to the amalgamation of Llandough and UHW services back in 2006. That amalgamation resulted in a loss of capacity. It is also partly because, until about three years ago, the Royal Glamorgan Hospital provided ongoing neonatal intensive care; it ceased doing that because it became unsustainable, due to staffing problems. There was no commissioning of any new capacity to take on what it had formerly been doing, so a lot of that pressure applies to the south-central community—in other words, the Cardiff and Vale and Cwm Taf local health board areas. In terms of capacity, getting that right has to be a major priority, because as soon as that part of the axis gets clogged up, babies and mothers are exported and the whole network becomes like concrete.

[125] **Jocelyn Davies:** You mentioned the cost of increasing capacity, but if a mother goes to England, we heard earlier that we get the bill anyway.

[126] **Dr Drayton:** I believe so. I do not deal with the finances. I am not the best person to talk to about the money flows in the system, but I think that I can answer the question

indirectly and say that one of the ways in which we might get progress in sorting this mess out would be to look at the commissioning processes and try to make them more effective. Currently, we have what I would describe as a fractured commissioning process, whereby the Welsh Health Specialised Services Committee is responsible for neonatal intensive care in the three big units in south Wales, but is not responsible for the inappropriate intensive care that is going on in other units just because those units cannot get their babies into the big three. It is responsible for high dependency care in those three units, but not the large amount of high dependency care that occurs in the other units. So, we have no joining up between the commissioning processes, and that does not produce the incentives for change.

2.00 p.m.

[127] **Jocelyn Davies:** In putting the individual action plans together, are they joined up?

[128] **Dr Drayton:** We have been trying to get them joined up on a health community basis. We have described the health communities on the basis of the level 3 units, or the intensive care units: south-west, south central, south-east and north. It is easier for the south-east and the north, because that is one health board each, so they are already planning at a community level. It is quite a challenge for west Wales, in Hywel Dda Local Health Board and Abertawe Bro Morgannwg University Local Health Board, and it is quite a challenge for Cardiff and Vale University Local Health Board and Cwm Taf Local Health Board. However, we are now getting meetings—they are now happening—and we are starting to see some synergy between the health boards in terms of their thinking about their responsibility for sorting the community out, as opposed to just sorting out their health board patch.

[129] **Suzy Davies:** I think that it is really fair to say that we would really like to hear from both of you about what has been going wrong in Betsi Cadwaladr in terms of compliance and what is happening to overcome that. Chair, do we have time to take the level of evidence that I would love to hear?

[130] **Christine Chapman:** Possibly not today, but some brief comments would be useful. We need to cover some other areas.

[131] **Suzy Davies:** That is what I was thinking. Would it be possible to request a follow-up note, if appropriate?

[132] Are you able to give us some details?

[133] **Dr Drayton:** Yes. I will start from the neonatal point of view, and Iolo may want to add to that from a broader perspective. From a neonatal point of view, the problem, as I alluded to earlier, is that we have three centres in north Wales, two of which provide ongoing intensive care. However, they do not have the appropriate infrastructure to do that. As of today, I believe that they have just one consultant neonatologist—I believe that another, a locum, is about to start, which will bring us up to two, but it should be eight.

[134] **Jocelyn Davies:** Is that an announcement that you are making today?

[135] **Dr Drayton:** No; I am telling you what I hear. There has been money for two of them for a year and a half, but there have been major recruitment problems because the structures are not satisfactory or attractive to professionals to work there.

[136] **Suzy Davies:** Where is that money at the moment? Is it being held to finance the second consultant—

[137] **Dr Drayton:** It is being used flexibly on training for advanced neonatal nurse

practitioners and various other training issues in Betsi Cadwaladr. So, the money is being used constructively in the short term, but not for what it was originally intended.

[138] **Suzy Davies:** Do we have time to hear more, Chair?

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

[140] **Dr Drayton:** The second problem is that the junior and middle-grade paediatricians, who are responsible for much of the 24-hour hands-on care, also have responsibilities to children walking in off the street who will need to go onto the general wards. That goes way beyond the standards and way beyond what has been happening in the rest of Wales for at least eight years, and it goes way beyond what is happening almost everywhere else in the United Kingdom. That needs to be resolved.

[141] **Suzy Davies:** You mentioned that they came from a worse starting point—

[142] **Dr Drayton:** I think that they understand what they have to do. There are two solutions, and they have to decide which to go for. One solution is that they provide a compliant level 3 neonatal intensive care service. That will be really difficult to achieve, in terms of recruitment and so on, from their current point, as well as from the point of view of additional resources. Alternatively, they need to formally commission that intensive care service over the border in England and concentrate on developing their services at a local neonatal unit level—in other words, a high-dependency level.

[143] **Christine Chapman:** We need to move on, because there is a possibility that we will ask the local health boards to give evidence, depending on what Members want. For the moment, however, we will leave it at that and move on to other questions.

[144] **Keith Davies:** Mae sawl adolygiad wedi bod; a yw'r byrddau iechyd yn gwrando? Maent yn gwneud argymhellion yn yr adroddiadau, ond nid yw pethau'n symud. Yn eich papur, rydych yn dweud:

**Keith Davies:** There have been several reviews; are the health boards listening? They make recommendations in the reports, but things do not move. In your paper, you say:

[145] 'Occupancies of around 20% for some IC cots are evident in Abergavenny and Bridgend and the Network cannot afford to have such poorly utilised capacity.'

[146] In paragraph 3.7, you say:

[147] 'Poor cot utilisation is evident at High Dependency (HD) level. This adversely affects the repatriation of infants from the Intensive Care Units back to their local units'.

[148] You list five hospitals in a table underneath paragraph 3.7, and you note the percentage occupancy for each. If the occupancy rates are so low—these five are under 45%—why can you not move children back there from intensive care? It would seem to me that there is room in those five hospitals.

[149] **Dr Drayton:** There are two main reasons. The first is that most of those units are stuffed full of low-acuity, low-dependency babies, who are either sitting in the high-dependency cots, so they are not available or, if they are not, they are occupying the nursing time as the nurses are providing that low-dependency care. So, although the cots are there, they are not available and they are not well occupied by high-dependency babies. They are not available.

[150] I alluded to the second reason earlier, namely that the capability of some of those

units is limited because of their size. They need to be reconfigured into bigger units to be able to use those high-dependency cots effectively. If that does not happen, then either that high-dependency capacity has to be transferred and recommissioned in the big units, which is problematic and is not what I would wish to see, because I am signed up to getting a locality-based service as far as possible, or we leave them there and we commission some extra resource in the level 3 units where it can be used properly. I think that it is fairly clear in which direction I would wish to see things moving.

[151] **Christine Chapman:** Eluned, I know that we have covered some of the areas that you wanted to cover, but would you like to ask anything else on this issue?

[152] **Eluned Parrott:** Would you, very briefly, talk about compliance with nurse staffing standards, which we have heard is very poor? It takes a long time to train nurses to the right standard, but what can we do in the very short term to address what is clearly an emergency situation?

[153] **Dr Drayton:** The first thing is that we need to create the vacancies. At present, we know that we can fill vacancies at band 5. There are nursing staff out there who are keen to do neonatal nursing. That has not always been the case; there has been a big, positive change in the last six years or so. We then need to start on the process of enhancing their skills so that they can move along their career pathway within neonatology. At the moment, the staffing levels are so poor that it is making it very difficult at a unit level to release nursing staff to do the training to move on through the system so that the nurses can operate at that high level—to be clear, the high dependency and intensive care level. We have to start somewhere and the only starting point is that we need to have a programme of introducing more vacancies. It will cost money.

[154] **Christine Chapman:** Jocelyn, do you want to come in on this point?

[155] **Jocelyn Davies:** No. I think that most of the points have been covered. However, the nurses will have to fund the training themselves.

[156] **Dr Drayton:** Not out of their individual pockets, but they need to be released from their jobs. There are two levels of training. One is undertaking the modules, which are delivered by the universities on behalf of the service in order to train nurses. There are many nurses undertaking those modules and, at the moment, health boards are funding only a small number of those and they need to fund more. There is then the unit-based training, or cross-unit training, which is done by the service as opposed to the universities. That is what units find difficult to do: they organise training and then, on the day, it is so busy that the nurses cannot be released to attend, so they are not getting there and the whole thing is a waste of time.

[157] **Christine Chapman:** We heard evidence this morning that some nurses were funding their own training.

[158] **Dr Drayton:** Some may be funding from their own pockets. I do not think that that is appropriate.

[159] **Christine Chapman:** Why would they do that? Why would that happen?

[160] **Dr Drayton:** If it is happening, I am sure that it is because the health boards are saying that they can only afford so much. Some dedicated nurses may be willing to put their hands in their own pockets to further their careers or to get better job satisfaction.

[161] **Keith Davies:** When you introduced yourself earlier, you talked about being the

community lead. The Royal College of Nursing suggests that there should be a neonatal outreach service. How would that work and would you support that?

[162] **Dr Drayton:** Very much so. It is all a part of better managing the low-acuity babies—it is about getting babies out of hospital sooner and to their families, which is where they belong, as soon as they possibly can from a health point of view. Many units have a neonatal outreach service—it is not something that does not exist. However, its provision is patchy; there are places where it does not exist and where I would like it to be developed. There are various models in terms of how it can develop, and smaller units may need to think a little bit more laterally about developing a service that is cost-effective. Nonetheless, every unit in Wales that looks after babies should provide an outreach, community-type service to support getting babies out of hospital as quickly as possible.

[163] **Lynne Neagle:** Could you let us have a note on which hospitals offer that community outreach service and which do not?

[164] **Dr Drayton:** Yes, I can do that.

[165] **Eluned Parrott:** I wanted to know if you could tell us that now. Is it patchy on a hospital-to-hospital basis or on a health-board-to-health-board basis?

[166] **Dr Drayton:** I would need notice of that question. I will need to go back and extract that information and provide a note on it.

[167] **Suzy Davies:** Bearing in mind that there is a level of scepticism in the evidence that we have heard today about the seriousness with which the LHBs, generically, are treating this, are the lines of accountability for resourcing and improving neonatal care services in Wales sufficiently evident and robust?

[168] **Dr Drayton:** I am in a difficult position to answer that, because of my role in life. I would refer you to my answer to the commissioning question. There is widespread acceptance that the commissioning process is not fit for purpose and that that, if it were appropriate, would bring with it a degree of accountability and redirection of resource. Iolo is not under the same restrictions as me.

[169] **Suzy Davies:** I apologise if I have put you in a difficult position.

[170] **Christine Chapman:** Dr Doull, would you like to say anything?

[171] **Dr Doull:** I possibly am under similar restrictions, in that I am the speciality paediatric advisor to WHSSC. My role has not been taken up far enough yet to address those questions.

[172] **Christine Chapman:** I can understand if you are not comfortable with answering that question.

[173] **Jocelyn Davies:** Earlier, we heard about babies being placed on general paediatric wards when they should be in the neonatal unit, and about the nurse to baby ratio and so on. How do you feel about the care that is given to those babies?

[174] **Dr Doull:** I listened to Sybil Barr, who spoke eloquently about the increase in birth rate, but one thing that needs to be re-emphasised is that society's expectations of what we can achieve have changed. Sybil alluded to the patients who came at short notice and I suspect that that child would come under my care. That child will need one-to-one nursing for six months before it goes home. That is a huge burden on a general paediatric ward,

particularly in the middle of winter. By and large, children will get the best care that they can, but paediatric nurses and paediatricians have different skills to neonatologists. They will have a basic understanding, but they are not as skilled as neonatal nurses.

2.15 p.m.

[175] One of the other concerns is that neonatal units are generally good places not to catch things. Generally, you go to a paediatric ward if you have an infectious disease. Therefore, you are at much higher risk of being exposed to infectious diseases on a paediatric ward, despite everyone doing the hand washing and with the best will in the world. You cannot say that it is bad care, but it is not as good as a neonatal unit.

[176] **Dr Drayton:** May I come in to give you a mirror image of that? This relates to some evidence that you received and some questions that you asked witnesses earlier. The neonatal population is, by definition, immunocompromised. In other words, pre-term babies are highly susceptible to picking up community-type infections. The mirror image dimension of the question that you asked is about the babies who are currently—perhaps only in one unit in Wales regularly—coming in from the community and going on to neonatal units. That is highly inappropriate in terms of risk, not only to babies on the unit that is operating this policy, which we recommend against, but, because we work as an overall system and because babies are regularly transferred between units for reasons that we have explained, there is a high risk that that problem might expand and become more generalised. So, the very strong professional advice is that babies who have the potential for coming into hospital with community-acquired infection, and particularly community-acquired respiratory infection, should not go to neonatal units.

[177] **Lynne Neagle:** I realise that the accountability issues are difficult for you to comment on, but I am not sure that I understand factually how they work. The Minister's evidence emphasises the importance of the neonatal network and its role in monitoring compliance. However, this morning, we were told that the network is advisory. Therefore, I am not clear about what happens when the network finds there is a problem. How is that reported, either to health board level or to the Minister? Who is accountable for sorting that out?

[178] **Dr Drayton:** It is perhaps easiest for me to answer the last question. I have regular meetings with my network manager, Karen Stapleton, and the medical director of NHS Wales, who obviously communicates with the Minister. We report the progress at Welsh Government level through him. He also receives all our paperwork from the network steering group. So, there is that line of communication.

[179] With regard to compliance with standards, health boards are self-reporting. In other words, we ask for reports to us at six-monthly intervals. They know whether they are compliant, because they report it back to us, and we pass that to Welsh Government level. The issues that we are highlighting with regard to the major evidence base that you have heard about today relating to capacity and nursing staffing are issues that we keep taking back to health boards. As I said, we now have better evidence than we have ever had before. I am getting the impression that we are getting those messages home. However, it is not my role to reassure you on whether the next steps will happen or what those will be. I guess that you understand that.

[180] **Christine Chapman:** I have one final question. We have covered quite a lot of ground here, but this is always about priorities. This is a question to both of you. If you could make one recommendation to the committee in relation to its neonatal care inquiry, what would it be? What is your biggest priority?

[181] **Dr Drayton:** You are very mean in giving us only one. [*Laughter*.] The most critical element in terms of capacity is nurse staffing, and getting a plan from every health board with a timeline against which it can be measured for improving the nurse staffing levels. If you are going to give me only one, that is the one.

[182] **Christine Chapman:** That has been a very consistent message today. Thank you both very much for attending and for your evidence. Members will now consider how we report this. There will be a transcript of the meeting, which we will send to you to check for factual accuracy.

2.20 p.m.

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

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

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

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

*Derbyniwyd y cynnig.*
*Motion agreed.*

*Daeth rhan gyhoeddus y cyfarfod i ben am 2.20 p.m.*
*The public part of the meeting ended at 2.20 p.m.*