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)
Jocelyn Davies	Plaid Cymru The Party of Wales
Keith Davies	Llafur Labour
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 Simon Fountain-Polley	Pediatregydd Ymgynghorol /Cyfarwyddwr y Rhaglen Glinigol—Iechyd Plant a Menywod, Bwrdd Iechyd Lleol Hywel Dda Consultant Paediatrician/Clinical Programme Director—Women's and Children's Health, Hywel Dda Local Health Board
Dr Brendan Harrington	Pennaeth Staff Grŵp Rhaglen Glinigol Blant a Phobl Ifanc, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr Chief of Staff for Children & Young People Clinical Programme Group, Betsi Cadwaladr University Local Health Board
Hamish Laing	Cyfarwyddwr y Strategaeth Glinigol, Bwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg Director of Clinical Strategy, Abertawe Bro Morgannwg University Local Health Board
Geoff Lang	Prif Weithredwr Dros Dro, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr Acting Chief Executive, Betsi Cadwaladr University Local Health Board
Trevor Purt	Prif Weithredwr, Bwrdd Iechyd Lleol Hywel Dda Chief Executive, Hywel Dda Local Health Board
Paul Roberts	Prif Weithredwr, Bwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg Chief Executive, Abertawe Bro Morgannwg University Local Health Board

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

Steven Davies	Cynghorydd Cyfreithiol Legal Adviser
Claire Griffiths	Dirprwy Glerc Deputy Clerk

Claire Morris Clerc
Clerk

Dechreuodd y cyfarfod am 12.44 p.m.
The meeting began at 12.44 p.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **Christine Chapman:** I welcome you to the committee for this afternoon's session.

Ymchwiliad i Ofal Newyddenedigol
Inquiry into Neonatal Care

[2] **Christine Chapman:** As you know, we are holding an inquiry into neonatal care and this afternoon we will take evidence from Betsi Cadwaladr University Local Health Board. This will be undertaken by video-conference. I welcome Geoff Lang, who is the acting chief executive of Betsi Cadwaladr University Local Health Board, and Dr Brendan Harrington, the chief of staff at Betsi Cadwaladr University Local Health Board. Can you hear me?

[3] **Mr Lang:** Yes, we can.

[4] **Christine Chapman:** It is good to see you. The Members will have read the written evidence that you have sent, so are you happy to go into questions?

[5] **Mr Lang:** Yes, Chair.

[6] **Christine Chapman:** I will start. There has been a great deal of discussion in this inquiry about the possibility of a shortage of nurses. Can you comment on that? The neonatal capacity review states that, for the north Wales community, there is a direct care nursing shortfall of 26.5 whole-time equivalents. What are you doing to combat this shortfall?

[7] **Mr Lang:** Dr Harrington will be able to update you on the progress that we have made and the plans that we have to move forward on that.

[8] **Dr Harrington:** A considerable shortfall has been identified by the capacity review. Even before it was delivered, we were aware of the situation and had our internal mechanisms looking at that and working on it. I am pleased to say that we have made significant progress in improving the situation. The figure you quoted was based on having 83 nurses in post, whereas the predicted number of nurses needed for full compliance with the standards would be 109.5. We have recruited a further nine whole-time equivalent nurses, which would improve our figure or decrease the deficit, whichever way around you want to express it, from 24% to 16%. Those nurses have been employed in all the different units for different purposes to alleviate the shortfalls in various areas. On that specific point, we feel that we have made significant progress, but we are aware that it does not finish there and, perhaps later, we might come on to our future plans.

[9] **Christine Chapman:** How are you working in collaboration with other health communities to address this issue?

[10] **Mr Lang:** I will start, and perhaps Dr Harrington will add more detail. Our situation in north Wales is somewhat different to that of other health boards, given our geographical position and our links into the English healthcare system. Within Wales, we have good links with the neonatal network. At a professional and peer level, that is helpful and supportive. We

have been having dialogue with colleagues in Powys about the relationship with their maternity service and how that might be commissioned for the future and its impact on neonatal care. That is one important aspect of our dialogue.

[11] The important aspect on a clinical day-to-day level is the strength of our links with the neonatal networks in England, particularly the network operating in Merseyside. You will be aware that we have significant flows of babies into England for neonatal intensive care, whether that arises from capacity issues in north Wales or planned care for issues such as surgery and so on. So, we have good links with England. Dr Harrington could add some detail to that about the benefits that can come from those links, if you wish him to do so.

[12] **Christine Chapman:** Yes, can you say something about that, Dr Harrington?

[13] **Dr Harrington:** Yes, I would like to add to that because, in a sense, we have our own health community, given that we have the entire population of the region under Betsi Cadwaladr University Local Health Board. That has been a significant step in developing health services in north Wales. I can speak only from the perspective of children's health services, but if I was to characterise how things were before the formation of the LHBs, we obviously had a relationship with each other, but, with the best will in the world, it was somewhat distant. The fact that we are all now within the same healthcare organisation has allowed us to have very different conversations—much more open conversations, and much less defensive ones. Essentially, we are working together much better, which, from my perspective as chief of staff for children's services, has been a great enabler to encourage people to work together. That has been one of the distinct benefits of the formation of the LHBs in Wales.

[14] **Jocelyn Davies:** You mentioned the links with England, and obviously there are some specialist services in terms of surgery and so on, but how much of the activity going into England is directly due to your shortfall in capacity?

[15] **Mr Lang:** There are two aspects to that. First, as you rightly say, there are some relationships with England that would not change, particularly those with Liverpool women's hospital and Alder Hey children's hospital. Where newborns access services in those areas, it is sometimes difficult to disentangle whether those are, by and large, clinically driven. The vast majority are, but some might relate to capacity transfers. The more important relationship in terms of capacity issues is that with Arrowe Park Hospital. In our response, which we sent in in March, we identified a significant number of cot days. This is on page 3 or 4 of our response. We had 164 cot days in intensive care in 2011, 64 in high-dependency care and 66 in special care. So, there is clearly an element of capacity and need where we have been relying on Arrowe Park, and it is important to note at this point that our relationship with Arrowe Park would not normally involve clinically planned transfers. That is right, is it not, Dr Harrington? So, there is a quite significant element where we have relied on the capacity of Arrowe Park for support, particularly at the intensive care level.

[16] **Jocelyn Davies:** What level of investment do you need so that you would be compliant with the all-Wales standards? When do you expect to achieve them?

[17] **Mr Lang:** I will start by talking about nursing. In terms of the movement from our current nursing establishment to the target level of about 26 full-time equivalents, we made a movement to nine, as Brendan has identified, at an order of cost of £250,000 to £300,000. I do not have the precise figures, but it is of that order of magnitude. Therefore, if we were to move on and make that step twice again, one could extrapolate those figures. The more significant cost—and I certainly do not have the details here, but Dr Harrington could perhaps comment—is in disentangling the medical rotas so that at consultant level, and indeed at the next tier, we could have dedicated neonatal medical cover for intensive care. Are you aware

of the cost of that, Dr Harrington, or of the numbers involved?

[18] **Dr Harrington:** Our internal neonatal working groups have been looking at the costing of a model that would achieve 100%, and that is something that we have ready and are in discussion with executives about. I talked about the progress that we have made, which has obviously been very welcome and much appreciated by staff and everyone involved.

[19] Moving into the next phase will critically involve a wider review of services, which is also currently under way, as I am sure many of you may know. As with many other health boards, Betsi Cadwaladr LHB is reviewing many of its clinical services, including maternity and child health services. So, there is a very strong linkage between making further progress towards 100% compliance and the progress of the maternity and child health review, in that one cannot proceed out of sync with the other. So, we are well aware, internally, that we are trying to move it forward as an integrated part of our maternity and child health review.

[20] **Jocelyn Davies:** I would like clarification of something. You mentioned Arrowe Park Hospital, which is referred to in your intensive care interim strategy:

[21] 'To successfully repatriate Welsh Neonatal Intensive Care activity provided by Arrowe Park hospital'.

[22] This is included in the column headed 'Target: Action' as something to be completed by October 2011, with the expected benefits to be realised by March 2012. Has that happened?

[23] **Dr Harrington:** That was some of the money that was given to us to employ these nurses, so I would say most definitely 'yes'. We do not have a monitoring period long enough to prove conclusively that we have driven down the number of babies being placed outside Wales without a prior expectation that that was what was needed for their care. Let us just say that, anecdotally, we feel that that is what is happening, and the early figures seem to support that. So, we feel that we have succeeded with that bit of the plan.

[24] **Aled Roberts:** May I just press you on this clinical programme group interim strategy? Jocelyn Davies has already made the point about Arrowe Park, with the expected benefits realisation in March 2012. Does your neonatal action plan provide for the total repatriation of cases from Arrowe Park and, if so, when will that be completed? Similarly, are you on track for the second bit of your interim strategy with regard to repatriation from the Liverpool women's hospital?

[25] As far as your long-term strategy is concerned, you state that business cases will be developed with regard to future provision by March 2012. Have those business cases been developed?

[26] **Mr Lang:** I will pick up the business case item first, and then Dr Harrington can respond on the detail.

[27] The business case is being developed as part of the service review. The timescale, when we submitted the documentation, was March; that has been delayed slightly. That business case will be produced and made available to inform the board in July, when it debates the potential issues for consultation on service reconfiguration arising from 'Together for Health' and our overall strategic change. So, there has been a slight delay with the business case, but that is in line with all the other review timescales, which were themselves slightly delayed to ensure that we did further clinical and broader stakeholder engagement. That business case will be ready to take to the board; it will be produced in June and it will go to the board in July as part of the option appraisal for the future of services.

[28] **Dr Harrington:** On your question about Alder Hey and the Liverpool women's hospital transfers, it is an important concept to put across that there is no neonatal network that provides 100% of its care in-house. The reason for that is that it is extremely hard to achieve without a huge resource input if you have a low-volume, high-intensity service, which would definitely be the case for neonatal intensive care. Neighbouring networks—by which I do not just mean what we call 'health communities' in Wales, but networks between England and Wales in this case—are well used to the concept that, during peaks in demand, they may need to rely on their neighbouring network for some care. We are also donators of care to other networks when they suffer crises of capacity.

1.00 p.m.

[29] Conventionally, when undertaking health service planning, the figure often quoted is that you should plan to deliver your services at around 80% capacity so that you have some slack to cope with peaks and troughs. For neonatal services, that figure is recommended to be 70% to try to cope with peaks. However, even with that relatively generous funding formula, you will still not eliminate or be able to cope with all of the peaks and surges in demand that come with the very unpredictable arrival of babies, because neonatal care is 100% emergency driven. There is no elective element to the care at all.

[30] That rather long preamble was basically to say that the figure will never go down to zero. Indeed, it would probably represent an over-resource for us if that ever became the case. However, to refer back to the earlier point, the placement of babies in Arrowe Park Hospital is now a rarity. We are doing that monitoring to satisfy ourselves as to whether those rare occasions are genuine and acceptable unusual peaks or whether they demonstrate that there is still insufficient capacity within our own system. Clearly, as Ms Chapman said at the start, we are not yet there with regard to our capacity, so the likelihood is that there are probably still some transfers out, which, in future, we hope would not occur.

[31] Making a distinction between Arrowe Park and the Liverpool women's hospital, it is probably fair to say that all the care delivered by Arrowe Park was not intended. In other words, it was a safety default when we did not have the capacity ourselves. The majority of the care delivered to neonates at the Liverpool women's hospital will be necessary transfers where the baby needs access to particular treatments or assessments that are available only in the women's hospital or from Alder Hey hospital, because Alder Hey hospital will often use the women's hospital. Alder Hey will ask us to transfer a baby to the women's hospital and then its consultants will go to see that baby there. So, there is likely to continue to be a significant level of use of the Liverpool women's hospital as a planned partner in care.

[32] **Aled Roberts:** Can you therefore confirm the increase in capacity outlined in your report, which was updated on 1 February 2012? It mentions increasing capacity for intensive care both at Ysbyty Glan Clwyd and Ysbyty Maelor Wrecsam by March 2011. What was the increase there? Similarly, on the following page, there is reference to increasing the number of high-dependency cots at Ysbyty Gwynedd from zero to two, which was due to be completed in February 2012.

[33] **Mr Lang:** I am pleased to confirm that the staffing of the high-dependency cots in Ysbyty Gwynedd is now in place. That was part of the recruitment of the nine nurses. Indeed, we have used the significant proportion of the remaining nurses to increase staffing in Ysbyty Glan Clwyd and in Wrexham, as was indicated in the plan. There is also a small component of that nursing increase that has been applied to establish an outreach service in north-west Wales, which previously did not exist. So, yes, we have opened the two cots in Bangor and they are now appropriately staffed, and we have supplemented staffing in Wrexham and in Glan Clwyd to give further resilience to the service there and to move us nearer to the

standards.

[34] **Aled Roberts:** The plan for Wrexham and Glan Clwyd hospitals was not to increase staffing to improve your resilience, but to increase capacity, according to your report. So, what is the increase in the capacity?

[35] **Dr Harrington:** To a certain extent, the two go together, because if we look back at times when we have had to close to admissions, it was usually because of insufficient nursing staff. So, to that extent, the increase in the nursing complement directly increases capacity.

[36] **Mr Lang:** It is really important that the nursing standards are defined against a number of cots, and we would have to be very careful not to open more cots in Glan Clwyd and in Wrexham with additional nurses when the existing cots are not staffed to the level recommended by the standards. By having more nurses available to be nearer to the standard, we have more resilience to peaks and troughs. So, capacity in terms of the number of babies that we can care for has risen. It is not actually capacity in terms of opening more cots.

[37] **Dr Harrington:** Sorry, but I think that I may have misunderstood your question slightly. The provision of physical equipment, such as cots and ventilators, is mainly a question of capital. In some ways, we are not behind with our capital requirements. We are behind with our revenue requirements for staffing, so by employing those nurses we can use the hypothetical capacity that we have, whereas it was difficult to do that before.

[38] **Keith Davies:** Gwnaf ofyn fy nghwestiwn yn Gymraeg.

Keith Davies: I will ask a question in Welsh.

[39] **Christine Chapman:** The witnesses will need to use the phone to get the translation.

[40] **Keith Davies:** Rwyf am sôn am hyfforddi. Mae fframwaith cenedlaethol ar gyfer nyrsys yng Nghymru, felly beth rydych wedi ei wneud i sicrhau bod y nyrsys sydd gennych yn barod wedi cael eu hyfforddi? Roeddech yn sôn bod angen, oherwydd eich bod wedi newid yr hyn sydd ei eisiau ym Mangor, hyfforddiant ychwanegol ar y nyrsys yno. A yw'r hyfforddiant ychwanegol hwnnw wedi effeithio ar hyfforddiant i'r nyrsys yn y ddau ysbyty arall?

Keith Davies: I want to talk about training. There is a national framework for nurses in Wales, so what have you done to ensure that your existing nurses have been trained? You mentioned the need, because you have changed what is required in Bangor, for additional training for the nurses there. Has that additional training affected training for the nurses in the two other hospitals?

[41] **Dr Harrington:** There has been training to support the increased intensive care provision and the increased high-dependency provision in Bangor. For example, we can deliver training in high-dependency provision in-house, and the consultant neonatologists who have been appointed have been crucial parts of that training programme. That has been pursued and completed, so we are now in a position to open and use those properly staffed two high-dependency slots in Bangor.

[42] We are also very proud of the fact that we can offer neonatal nurse diploma training in north Wales in association with Bangor University. That is a long-standing arrangement so that our nurses can have their training in north Wales, and that continues.

[43] **Christine Chapman:** Thank you. Just to clarify, you do not need to use the phones to respond, just to hear the translation.

[44] **Aled Roberts:** Bydd yn rhaid i chi

Aled Roberts: You will have to use the

ddefnyddio'r ffôn unwaith eto. [*Chwerthin.*] Rwyf am symud ymlaen at staffio meddygol. Rydym wedi derbyn tystiolaeth gan Bliss sy'n dweud bod ganddo gonsýrn ynglŷn â niferoedd staffio yn y gogledd o'i gymharu â'r niferoedd staffio yn y rhan fwyaf o Gymru. Mae'n dweud yn benodol nad oes digon o staff yn Ysbyty Glan Clwyd ac Ysbyty Maelor Wrecsam. Gwyddom fod adolygiad yn cael ei gynnal yn y gogledd ar hyn o bryd, ond beth rydych yn mynd ei wneud yn y tymor byr a'r tymor canolig ynglŷn â'r materion hyn os bydd yr adolygiad yn cymryd dwy neu dair blynedd i weithredu?

phone again. [*Laughter*.] I want to move on to medical staffing. We have received evidence from Bliss that it is concerned about staffing numbers in north Wales compared with those in the majority of Wales. It specifically says that there are not enough staff in Ysbyty Glan Clwyd and in Wrexham Maelor Hospital. We know that a review is being undertaken at the moment, but what are you going to do in the short term and the medium term about these issues if the review takes two or three years to implement?

[45] **Mr Lang:** I will make an initial comment, and then I am sure that Dr Harrington will fill in the detail. The reference that Bliss made in its evidence very much related to the standards, which is obviously what the committee is interested in. It essentially revolves around whether we have separate consultant and second-tier medical staffing complements dedicated to neonatal intensive care. At the moment, we do not have that. We have had an investment programme in terms of developing and trying to recruit neonatal consultants. We have had one consultant for some time and we have recently recruited a second consultant. At the moment, that person is working on a part-time basis, but we hope that that will move forward. That will give us two dedicated neonatologists in north Wales. In terms of the broader issue of medical cover, we need to think two things through. One is the current provision, how it copes with the demand that we have, and whether that is appropriate and delivering safe care at the moment, albeit that it is very different to what the standards specify for a dedicated unit. The key decision that we will have to make when we come to the review is around the clear clinical consensus now that we should have only one intensive care provision for the babies of north Wales. The issue that we are still debating is whether that can be safely and sustainably delivered in north Wales or whether we need to consider a more strategic alliance with another partner for that highest level of care. So, the medical issues are quite complex, but Brendan can perhaps comment on the detail of the safety and quality of the current medical provision and how we are working that forward.

[46] **Aled Roberts:** Mae gennyf un cwestiwn cyn i Dr Harrington ddod i mewn. Mae tystiolaeth y rhwydwaith yn dweud y dylai fod wyth ymgynghorydd yn y Gogledd o ran y boblogaeth sy'n cael ei gwasanaethu. Ar un adeg, roedd gennych un ymgynghorydd ac un locwm. Yn awr mae gennych un, ac rydych wedi recriwtio un arall sy'n gweithio rhan-amser. A fyddwch yn cyflogi wyth ymgynghorydd rhywbryd? A yw'r ffaith bod gennych cyn lleied o feddygon yn creu problemau ynglŷn â diogelwch, fel y dywedasoch? Mae eich ffigurau eich hun yn dweud y bu 44 o farwolaethau ymysg babanod o dan 1 oed yn 2009, sy'n rhoi cyfradd marwolaeth o 5.7 ar gyfer pob 1,000 o enedigaethau byw, sef y ffigurau gwaethaf, rwy'n credu, yng Nghymru. Rwyf am ddyfynnu erthygl yn y

Aled Roberts: I have one question before Dr Harrington comes in. The evidence from the network states that there should be eight consultants in north Wales for the population being served. At one time, you had one consultant and one locum. Now, you have one, and you have recruited one on a part-time basis. Will you be employing eight consultants at some point? Does the fact that you have so few doctors create problems around safety, as you said? Your own figures state that, in 2009, there were 44 deaths among infants under 1 year old, which gives a rate of 5.7 deaths for every 1,000 live births. Those are the worst figures, I believe, in Wales. I will quote from an article in the *Daily Post*, from around a year ago, in which Dr Simon Dobson says:

Daily Post, a gyhoeddwyd ryw flwyddyn yn ôl, lle dywed Dr Simon Dobson:

[47] 'I was at a stakeholder meeting this week where a consultant…tried to present some figures on perinatal and infant mortality rates. His figures suggested that North Wales has a higher mortality rate than the rest of the country. He'd also carried out some computer modelling which suggested that to go to a two-site model…would leave this region with mortality rates on a par with some countries from Eastern Europe and the former Soviet Bloc'.

[48] **Mr Lang:** I will give a general comment on the quotation, because we obviously do not have those data here to comment on. We need to put that in context. That discussion was around the whole proposal of changes to obstetric care and provision, as well as issues around neonatology. It is rather more broad than purely the debate on how we currently staff the neonatal units and the outcome from those units. So, I think that that is an important point of context. I am not sure whether Brendan has had those data—I certainly have not seen them—but you may want to comment on the fundamental issue about our current outcomes and the safety of our service, Brendan.

1.15 p.m.

[49] **Dr Harrington:** The best figures for the current and recent historical position are probably those from the all-Wales perinatal survey. Again, with all the caveats that come with trying to measure rare events that occur in small numbers, there is no evidence that the mortality rates for north Wales are materially different to those elsewhere in Wales or—to put Members' minds at rest—that rates within Wales are materially different to those in the wider UK.

[50] I was at the meeting that the *Daily Post* covered. I recall what was said, and it was obviously an impassioned view from one person, who took a speculative position on what might happen across a broad range of services. That view was heard and noted. As I say, it was a personal view, based on a highly speculative future position, which is difficult to substantiate.

[51] **Mr Lang:** The safety and quality of the service moving forward is precisely what the review will be looking at and identifying, namely how we should organise our services and how we can be assured that they will meet—or certainly rapidly move towards meeting—the standards that are expected. Those will be published as part of the review process of the options that we take to the board.

[52] **Aled Roberts:** Do you have more recent data? The data that I have go back to 2009. If there are more current all-Wales data available, I would like to see those. However, my data show that north Wales is, as far as I can see, the second-lowest-performing region. The figures that I have include a death rate of 5.7 per 1,000 live births, while the England and Wales average is 4.7 and the Welsh average is 4.8. The only region that performs worse in England and Wales is the west midlands, which has a rate of 6 per 1,000 live births. The figures for north Wales are worse than anywhere in Italy, France, the Republic of Ireland, Spain and Germany. So, if you have more up-to-date figures that give a different picture, I am sure that we as a committee would welcome those.

[53] I also wish to press you on the network figure. Do you not accept the recommendation from the network that there should be eight consultants serving a population like that of north Wales?

[54] **Mr Lang:** We have to be clear on this: we accept the standards and the numbers are

clear that, if you operate a stand-alone, intensive care neonatal unit at the appropriately staffed level according to the standard, with dedicated consultant staff, you should have eight consultant neonatologists. That is the standard and we accept that. That is the standard that we are applying as part of our review to consider the options of how we move to that. Our current situation is that we have few dedicated neonatologists, but we have a number of consultant paediatricians who are experienced and skilled in working in neonatology and who provide a strong medical input to the current service. However, we do not dispute that standard and that that is the end point towards which we should be working.

[55] **Dr Harrington:** That was the point that I was going to interject with earlier. I want to reassure the committee that there is a lot of consultant input into neonatal care in north Wales, but the historical model that we are trying to move away from is one in which those consultants are simultaneously responsible for neonatal units, which, in the case of Wrexham and Glan Clwyd, are delivering neonatal intensive care—the highest level of care. As Geoff said, we fully accept that the model that we eventually want is one in which the majority of babies who receive intensive care are under the direct care of consultant neonatologists who have no responsibility for the general paediatric service. In my experience, as one of those consultants, when you are on call a not insignificant amount of your time and energy is devoted to ensuring that a safe service is delivered to the babies in your unit when you are at that highest level of care.

[56] **Lynne Neagle:** I hear what you are saying about the need to improve safety as things go forward, but the evidence that we had from Bliss was hard hitting and worrying. It expressed serious concerns about the safety of services as they exist now in Betsi Cadwaladr local health board. If you have you read Bliss's oral and written evidence, would you like to comment on it? Do you recognise its assessment of the situation in the health board?

[57] **Mr Lang:** In terms of its assessment, I have looked through the evidence. It compared the staffing and capacity review data of the standards that we should aspire to with where we are currently. Quite rightly, it focused on the fact that we are a significant distance away from those standards. That was reflected as a concern about the safety and quality of the care that we offer, given that we do not have the number of staff indicated. Brendan's previous comments on outcomes give assurances about the quality and safety of the service that we currently offer. It might be helpful if we provided a note to the committee, updating the data, as Mr Roberts referred to. On the ability of our unit to provide a quality service in its broadest sense—which includes support to parents and families as well as the clinical care of infants—it is difficult in relation to staffing, particularly with nursing staff recruitment. We have prioritised nursing staff recruitment as the first important step that will help us move along that path. Brendan, would you like to add to that?

[58] **Dr Harrington:** To answer your first point, I am familiar with Bliss's most recent information and publications, although I do not know if they differ in any way to the written papers submitted to you. With that caveat, on the position that Bliss takes, rather like the standards that Geoff referred to, we would not dispute the standard that it is lobbying for. Bliss, as a lobby group, would like to see those standards met as soon as possible; we feel that we are making honest progress towards them. As chief of staff for children and young people's services, I am also trying to balance the elimination of risk in many areas within our service, because that is what is important for the population. I feel that I make a contribution as a doctor by becoming involved in the leadership and management of these issues. I would like to see the problem solved overnight, but there is a timescale. We feel that we are making good efforts on that timescale. We plan to continue on that timescale. It might be interesting to ask Bliss's opinion on the position that we have reached by this point, to see if it would agree that it is reasonable progress towards the eventual objective. I am willing to hear Bliss's view on that.

[59] **Lynne Neagle:** I do not think that anybody expects it to be resolved overnight. We recognise that all health boards face challenges, but Betsi Cadwaladr health board was singled out by Bliss for specific criticism on safety grounds. That needs to be addressed.

[60] **Dr Harrington:** We have told you about some of the progress that we have made and the improvement to our compliance figures as a result of that. I do not know where that places us relative to the rest of Wales. I would be interested to know. I do not know whether we are still the furthest outlier.

[61] **Angela Burns:** Thank you for your evidence. I want to build on your answers to Aled and Lynne. As I understand the situation, you have very few neonatologists and are unable, at present, to meet the standards for the reasons that you have given. I note that there has been a sharp increase in the number of acute cases that you transfer to England. In that context, I wonder about your decision to repatriate services and investment from Arrowe Park Hospital.

[62] **Mr Lang:** I might have to ask for clarity on the sharp increase in numbers and the reference period for that. However, the strategy of repatriating from Arrowe Park is precisely for addressing that point. We need to invest locally, particularly in nursing staff for our units. That is important for high-dependency care in Bangor. We had a situation there where, because of a lack of well established high-dependency care, babies were being cared for in settings that were more complex than they needed to be. Adding to our nursing staff to deal with that will help Bangor to contain more of its demand, which will relieve pressure on Glan Clwyd. By increasing our nursing levels in Glan Clwyd and Wrexham, we will be able to avoid some of those unplanned transfers. Those two issues are connected. We are bringing that money back and investing in nurses in north Wales. As Brendan intimated earlier, we are still waiting for the data to come through, but the informal feedback on the ground is that our rate of transfer has dropped significantly as a result of investing in additional nursing capacity.

[63] **Angela Burns:** Just for clarity, the number of acute transfers in 2009-10 was four, in 2010-11 it was three, and in the 10 months up to January 2012 it was eight. So, it has more than doubled. That is my first point. Are you still waiting to realise the benefits from your investment of repatriating services from Arrowe Park? The other side of the coin, if you have concerns over your ability to provide those kinds of services, is that you should seek to maintain that relationship, so that you have a plan B.

[64] **Mr Lang:** On the number of transfers, the periods that you mentioned were before the impact of the additional nurses was felt. If we look at data in September or October this year, or compare the April to October period with previous reference periods, we should be able to see the impact. The data in our submission reflect the pattern prior to investing in nursing capacity.

[65] The point on whether we should maintain a strategic relationship in case we struggle to meet the standards goes to the very nub of our strategic review. If we wish to achieve the specified standard—and we do—then we have to be confident that we can recruit, retain and maintain the skills and competence of our staff at the level specified in the standards. That may prove to be a significant challenge for a small neonatal intensive care facility, compared with larger facilities elsewhere. We will be debating our strategic relationship with Alder Hey Children's NHS Foundation Trust and Liverpool Women's NHS Foundation Trust—as Brendan has explained, that is very important for other clinical considerations. We may need to review that position to determine whether, in moving to full compliance with the standards, the better option is to do it in north Wales or to have a strategic relationship with another provider that has a bigger footprint and resilience. We are still working through that information at the moment.

1.30 p.m.

[66] **Angela Burns:** Given that you are working through your strategic plans, what are you doing in your analysis to explore the reasons why the low-dependency activity in north Wales seems to be much higher than in other health communities?

[67] **Dr Harrington:** That is something that has usefully come out of the capacity review and given us a strong pointer, and we are currently looking into that. We have a task and finish group working specifically on that aspect of our neonatal care. If those babies being inappropriately cared for on a neonatal unit can be looked after adequately on a post-natal ward, closer to their mothers, then that is a win-win situation; it is good for the baby and for the family, and it is likely to be less resource-intensive. If that is the case, that resource can be redirected to those babies who definitely need high levels of care. So, put simply, the neonatal nurses who are looking after those babies would be able to devote their time to looking after the sicker babies and help us to achieve the standards. Returning to earlier questions, that is an important strand of how we see ourselves moving forward from where we are with the additional nine nurses: some of that gap will be covered, not necessarily by employing new nurses, but by freeing up nurses to care.

[68] **Lynne Neagle:** I want to stay on the issue of low-dependency activity. I am not sure that you answered the question as to why there is so much low-dependency activity in north Wales. However, how far are you from meeting the best practice guidelines and do you have a timescale in place?

[69] **Dr Harrington:** I am sorry if I did not answer the first question completely. Could you repeat it, because if I did not answer, it was probably because I did not catch it properly?

[70] **Lynne Neagle:** I do not think that you really answered why there is such a high volume of low-dependency work.

[71] **Dr Harrington:** In setting up a group, I have not prejudged, even based on my own involvement in that care, what might be the causes. We are still waiting for that group to get into the detail and to tell us, of the numbers that have come from the network, exactly what those babies are being admitted to the unit for and what categories of care they are receiving.

[72] Your next question was on the timescale. Our internal action plan for compliance with standards had a timescale attached to it with importance, and I think that that formed part of the papers for the committee. There has been slippage on that—not entirely as a result of our internal problems. For example, an important part of the slippage, particularly around the high dependency, was that we needed to be able to provide intravenous nutrition for premature babies in Bangor in order for it to be able to deliver high-dependency care. We had our own plan for that, but that was quite considerably delayed by the publication of a national recommendation around the delivery of intravenous nutrition for adults, children and neonates. It was felt by our Betsi Cadwaladr drug and therapeutics group that there should be no new development of intravenous nutrition that did not meet this new much higher standard, even though, paradoxically, essential services that were currently happening should not stop. So, we faced the somewhat ironic situation of having to pause to bring in a service that was going to be far in advance of what we previously offered in terms of the governance of that system. It is a better system, but it did delay us somewhat.

[73] As regards the timescale for the audit of the low-dependency work, that group is meeting. We have a regular monthly meeting of our neonatal working group. I cannot tell you exactly which of those meetings the group has been tasked to report back to at present, but I could supply you with that information.

[74] **Lynne Neagle:** How do you ensure that capacity is managed collaboratively between your facilities and those of the other health communities in periods of high demand?

[75] **Dr Harrington:** In north Wales, we talk to each other regularly. We have the cot locator system. I do not know whether the group has been briefed about that or whether it has come up in previous discussions. That system means that even without having to phone a unit, you can see where cots are available. Therefore, we do not even necessarily need to phone our colleagues in Wrexham or Glan Clwyd to be aware of their cot status. I hope that deals with the issue of whether, at an internal level, a unit that finds itself without the capacity to deal with a baby at a certain level of care can find out whether the neighbouring unit has that capacity. If we find that the whole of the north Wales community lacks the capacity for a particular baby, we contact our colleagues in the Merseyside and north-west network to enquire about capacity.

[76] **Mr Lang:** Our experience of that communication and the speed at which we can identify potential cots to transfer is very good, is it not, Brendan, as regards the response that we get?

[77] **Dr Harrington:** Yes, it is the length of time that it takes to make a phone call. It is a well established communication route, both within our own network, our own health community and outside of the network in Merseyside and the north-west of England.

[78] **Aled Roberts:** On the north-west issue, what would be the furthest facility that would be used in such a situation?

[79] **Dr Harrington:** I am sure that there are cases that hit the national press, whereby you contact your next-door neonatal network and find that they are full. There are babies that go as far afield as Leeds, which is right up the M62. I would say that that is not an event that is unique to any neonatal network in the UK. Sadly, there are often peaks of demand that lead to babies being looked after quite a distance from their homes.

[80] **Mr Lang:** We could accommodate the majority of our babies in Liverpool. It is important that the committee gets a reassurance that the majority of the time when we have a problem with capacity, those babies can be accommodated in Liverpool.

[81] **Dr Harrington:** Thankfully, those would be very rare events.

[82] **Suzy Davies:** I have a few questions about your relationship with Powys. Generally, where is the furthest south in Powys from which Betsi Cadwaladr health board would take neonates? I know that I have to ask you to answer generally.

[83] **Dr Harrington:** It is about halfway—the cut-off is around Newtown or Welshpool. Any further south than that, it is usually better for the baby to go into the Gwent service. To get the language right, that would be the south-east community.

[84] **Suzy Davies:** I have a question about Ysbyty Glan Clwyd, where there were four ambulance delays that counted as neonatal incidents. Could you explain what those are?

[85] **Mr Lang:** This is in the data that we provided in our response to the committee, is it not?

[86] **Suzy Davies:** Yes, it is on the second page. What does an ‘ambulance delay’ incident mean?

[87] **Dr Harrington:** I am being a little speculative perhaps, but I would imagine, without

going back to check, that that is when a unit was aware that it would not be able to care for a baby itself and had perhaps clarified where that baby was going to go, whether it was from Glan Clwyd to Wrexham or to a provider in England—that might well include a baby in a condition in which that transfer was necessary; so, in other words, it was not necessarily a capacity issue—but, at that point, the unit was told by the ambulance service that, given that the baby was in a safe place for the short term, they were not going to dispatch an ambulance immediately. Again, from my experience, that can sometimes happen.

[88] **Mr Lang:** If it would help to provide some examples to support the headline data that we have put into our return, we can do that.

[89] **Suzy Davies:** I am trying to establish whether the ambulance delays result in potential detriment to a child who is in distress when we are talking about unplanned journeys.

[90] **Dr Harrington:** I would expect not, in that these babies are being adequately and safely cared for at that point in time. That can continue, but not indefinitely. To an extent, that is probably why the ambulance service makes the decision that it makes when it is trying to triage ambulances to different emergency calls. I would hope that if it genuinely was a time-critical case, that would be communicated to the Welsh ambulance service, and that case would be dealt with appropriately.

[91] **Suzy Davies:** Do you know roughly how long it takes an ambulance to get from Newtown to Wrexham Maelor?

[92] **Dr Harrington:** I do not, but a baby who has been delivered in that area would be an unexpected need for neonatal care, and you would have to ask the service about what provision it has for dealing with babies born unexpectedly.

[93] **Suzy Davies:** I am asking you, because they would be likely to come to Betsi Cadwaladr if they are from that part of Powys.

[94] **Mr Lang:** We probably do not have the answer to a specific question about the travel time for the ambulance, but that is information that we could ask our Welsh ambulance service colleagues to provide.

[95] **Christine Chapman:** If you could provide us with that, we would be grateful. Simon Thomas wants to come in with a follow-up question.

[96] **Simon Thomas:** We have asked some of the other boards about their discussions with the ambulance service regarding neonatal transfers, both planned and unplanned. You mentioned the ambulance service saying that the baby was in a safe place for the short term and, therefore, would be prioritised differently. Is it right that it is the ambulance service that is making that decision when you should be planning a set of services at different tiers across north Wales?

[97] **Mr Lang:** In terms of the general transportation of neonates, the investment made in the transport and transfer system has been helpful and that ensures that, at the time of transfer, an appropriately skilled team is available. There are very good working relationships with the Welsh ambulance trust around that. Brendan will comment in more detail on the clinical scenario, but it is important for us to recognise that, when we are looking at transferring, there will be a clear clinical judgment about whether an infant is stabilised, ready for transfer and there is not an immediate very high risk from any delay in the transfer—whether it is genuinely an emergency—or whether that infant is stabilised and needs a transfer within a timescale, but can be safely cared for during a window of time in the unit in which that baby

has been delivered. Brendan will go into detail, but they are not arbitrary ambulance decisions; they are very much decisions made in consultation within parameters that the clinicians feel are appropriate. Brendan will be able to expand on that.

[98] **Simon Thomas:** May I clarify my question so that we do not misunderstand each other? I was not suggesting that anyone was making arbitrary decisions; I was asking about who is making the key decision about when a neonate should be transferred. You will be aware that the capacity review makes it clear that stabilisation will be used, particularly in rural areas, as part of a way of delivering a coherent service. We have already had evidence from you that you are far off the standards of that coherent service, so I am asking specifically how you deal now, in current circumstances, with a period of time in which a baby may need an unplanned transfer. How do you ensure that the ambulance service is up to speed, quite literally sometimes, on doing and achieving that?

1.45 p.m.

[99] **Dr Harrington:** First, to make it clear, the decision on whether a baby needs transfer is obviously taken by the consultant caring for the baby at the time. In that situation, that baby is receiving safe care, and there are very few situations in which that safe care cannot be continued for a matter of hours or even, possibly, 24 hours. So, when the transfer occurs, in the time between the call being placed with the Welsh ambulance service and the ambulance arriving, there are very few situations in which it would be critical whether that transfer takes 30 minutes, an hour, or even two hours. The baby would be having adequate intensive care, or high-dependency care, whatever their need.

[100] I want to clarify something myself, if I may. In some of the questions that I have been asked, do I detect an overlap between a situation in which a baby is in a hospital setting and needs transfer—either for ongoing care because that unit cannot offer ongoing capacity or for some sort of care that is not available there—and other types of transfer where, going back to the Powys question, the baby has been delivered in a different unit that does not have neonatal care? If so, if I am reluctant to answer, it is because children's services are not involved at that point. In the case of Powys, although we have an important relationship as a partner, it would obviously have to be Powys that answered for the governance of that situation.

[101] **Simon Thomas:** Yr oeddwn eisiau gofyn cwestiwn am allgymorth, felly yr wyf yn newid y pwnc ychydig yn awr. Yr oeddech yn sôn yn gynharach yn eich tystiolaeth eich bod wedi arloesi neu wedi dechrau ar dimau allgymorth, neu timau sy'n estyn i'r gymuned, a soniasoch yn benodol am y gogledd orllewin. Tybed a allech ddweud ychydig mwy am unrhyw waith allgymorth yr ydych yn ei gynnal ar hyn o bryd, yn enwedig mewn ardaloedd cefn gwlad tua Phen Llŷn, neu ym Meirionnydd, neu lle bynnag. Pa gynlluniau sydd gennych? Pa rôl y mae'r timau hynny yn ei chwarae wrth ichi gyrraedd y safonau sydd wedi'u gosod?

Simon Thomas: I wanted to ask a question about outreach, so I am just changing the subject a little now. You mentioned earlier in your evidence that you have pioneered or have started using outreach teams, or teams that go out into the community, and you specifically mentioned the north west. I wonder whether you can tell us a little more about any outreach work that you are undertaking at present, particularly in rural areas towards the Llŷn peninsula or in Meirionnydd or wherever. What plans do you have? What role do these teams play as you try to reach the standards that have been set?

[102] **Dr Harrington:** We are very proud to say that, historically, we were one of the first areas in the UK to establish neonatal outreach nursing. It has been well over a decade ago now. More recently, we have been able to add to that capacity. There has been an outreach

service from the intensive care units at Wrexham and Glan Clwyd, but there has not been one from the unit in Bangor. Of course, some babies from Bangor do need intensive care, and they usually go to Glan Clwyd or Wrexham to receive that. Then, when the time is right, they move back to Bangor and then go home. We recognise that that left some of those babies being sent home without the support network of an outreach paediatric service, which we know from the feedback that we get from parents is very much appreciated. We could use those nurses to improve the staffing levels on our units, but that would mean a reduction in the quality in a different area, but that is not what we want to do, because we believe that this service is very important. As we build our service, we should do them in tandem, rather than saying that, once we get to 100% staffing on our units, we will then think about outreach nursing. Parents surveyed about the quality of the service have said that they find it extremely helpful.

[103] Taking babies who have been on the neonatal unit home, particularly those who have been the most ill, is an extremely anxious time for parents. Most parents would say that they spend all their time on the unit looking forward to the day they go home—and that is not a comment on our service—but when that day arrives, they are terrified. They did not think that they would be, but when that day arrives, they are, and our outreach service is a vital part of the emotional and psychological support that we can offer. That is why we are particularly pleased that—

[104] **Simon Thomas:** Sorry. I am pleased to hear that, but I just wanted to check something. Does that mean that you are able to offer that in all parts of the Betsi Cadwaladr area, now that you have introduced the Bangor end?

[105] **Dr Harrington:** We made a point of mentioning the north-west service because we already have that service in the other two, not because we have only just developed it across north Wales.

[106] **Mr Lang:** So, it is now available in north-west Wales.

[107] **Jenny Rathbone:** Given the excellence of your outreach service, which is excellent news, I am struggling to understand why you have developed these neonatal hospital services on three sites, given that the number of babies you have is very low. There were only 334 babies using this service in 2011, which is less than one a day—although some of them, I know, stay a long time in hospital. Nevertheless, I am struggling to understand how is it was ever possible to create this high-intensity service on three sites, because you need 24-hour care—babies do not arrive conveniently during the day—and you have one neonatologist and one part-timer. So, is reconfiguration going to deal with the problem of having this level of specialism 24 hours a day? Clearly, these people can be in only one place at a time, and they also need to sleep.

[108] **Mr Lang:** I will make some initial comments, and then perhaps Dr Harrington will want to add to them.

[109] To give you the background of the services that have developed, it is important to differentiate between special care, high-dependency and intensive care. The view that we have taken, which, to my knowledge, is supported by the neonatal network, is that where we have an obstetric service, it is appropriate to have special care and high-dependency care services on those sites. That is the right thing to do. So, if we have three obstetric units, we should be aiming to deliver up to high-dependency care and, indeed, the stabilisation and ready-to-transfer service on three sites.

[110] With neonatal intensive care, it is a bit of an exercise in looking back through history to see how things have developed. If we go back to the furthest part, we are back to the

Stroud report and the developments that took place in Wales many years ago, in which both Glan Clwyd and Wrexham were identified as centres that should develop such a service. That predates the establishment of the neonatal standards, and the world has moved on since then.

[111] Importantly, as context, Brendan referred to one benefit of having the new health board as being that there was not a uniform clinical consensus that moving to a single unit in north Wales was the right thing to do, certainly in the years predating the health board, it is fair to say, but we have now achieved that, and that very much aligns with the standards. Our strategic review is about setting out the options for how we deliver that standard at intensive care level. Clearly, that intensive care unit, wherever it may be, would be alongside high dependency and other levels of care. So, the history of how we got here is probably the result of a range of decisions made in different places. The important point is that we are recognising that this is not a sustainable position, and that we have to move to a service that recognises and delivers the standards. There is general agreement that that needs to be in one place for the infants in north Wales who require it. Where that one place will be and how it will be managed we have yet to work through in the final stages of the review. Brendan, do you want to add to that?

[112] **Dr Harrington:** To start with the original point about how it developed, it is a story that is mirrored in the development of medicine within society, in that the public quite rightly had an expectation of ever-rising standards, and that is what health professionals want to deliver. Another example outside children's services may be stroke care. There was an acceptable standard of stroke care that health professionals themselves would have accepted perhaps 10 or 15 years ago but that is not good enough now. We now expect acute stroke units and much better care, and the reason for that is to achieve better outcomes. That is mirrored in neonatal services.

[113] We had three units delivering the care that they did. At that point, there was no dissent that those units were delivering an acceptable level of care, but things move on. Professionals themselves are often behind the agitation for higher standards and, sure enough, the improved standards came out through consensus working between doctors and nurses involved in neonatal care through the British Association of Perinatal Medicine, saying that we should be aiming higher. That is what we are talking here about: that aiming higher. However, you could say that we are doing it off the footprint that we inherited of a previously accepted consensus position, which is no longer the consensus.

[114] **Jenny Rathbone:** That is very clear, thank you. How quickly do you think that you can go ahead with this reconfiguration, given that it is clinically necessary?

[115] **Mr Lang:** It is quite difficult to give a timescale for it. The immediate timescale is for preparing our proposals and moving them to consultation, as we will have to consult with our community health council colleagues and have a very careful conversation with members of the public, parents and families about the benefits of having a single neonatal intensive care unit. That has been difficult in the past. The groundswell of opinion is now very much that that is the right thing to do, so we will have to move through that. That consultation will conclude in the autumn, with recommendations to come to the board in November. There are two potential scenarios that we have to work through, one being that we provide the unit in north Wales, and the other being that we do not. Therefore, the implementation timescales will vary depending on which option we move towards. So, it is quite difficult to give you a precise answer on the timescale, because it will crucially depend on the option that we choose and the route that we go down for the future care pattern for north Wales babies.

[116] **Christine Chapman:** On that note, I will draw this part of the session to a close. I thank Mr Geoff Lang and Dr Brendan Harrington for being part of this session today. We will send you a transcript of the proceedings for you to check for any factual inaccuracy. Thank

you once again for being part of this today.

[117] The committee will now take a short break and we will reconvene at 2.05 p.m.. There are refreshments in the room opposite for Members. We do not have an awful lot of time, so please grab your refreshments and come back in.

Gohiriwyd y cyfarfod rhwng 1.59 pm. a 2.06 p.m.
The meeting adjourned between 1.59 p.m. and 2.06 p.m.

Ymchwiliad i Ofal Newyddenedigol
Inquiry into Neonatal Care

[118] **Christine Chapman:** For this session of our inquiry into neonatal care, we are taking evidence from Abertawe Bro Morgannwg University Local Health Board and Hywel Dda Local Health Board. I welcome you all to this session. Will you introduce yourselves for the record, please?

[119] **Mr Laing:** I am Hamish Laing. I am the director of acute care at Abertawe Bro Morgannwg University Local Health Board.

[120] **Mr Roberts:** Hello. I am Paul Roberts, the chief executive at Abertawe Bro Morgannwg University Local Health Board.

[121] **Mr Purt:** Good afternoon. I am Trevor Purt, the chief executive at Hywel Dda Local Health Board.

[122] **Dr Fountain-Polley:** Dr Simon Fountain-Polley ydw i. Rwy'n gweithio yn Ysbyty Bronglais, sy'n rhan o Fwrdd Iechyd Lleol Hywel Dda.

Dr Fountain-Polley: I am Dr Simon Fountain-Polley. I work at Bronglais Hospital, which is part of Hywel Dda Local Health Board.

[123] **Christine Chapman:** I welcome everyone. Members have read the written evidence that you have sent. So, if you are happy for me to do so, I will move straight to the questions. I know that we will have a comprehensive discussion. I am sure that you have been following the inquiry. One of the issues raised is the concern regarding the shortage of nurses. We know that the neonatal capacity review states that, for the south-west community, there is a direct care nursing shortfall of 29.21 whole-time equivalents. Could you comment on that point?

[124] **Mr Purt:** I will take that question first, Chair, from Hywel Dda's point of view. After this, I would like to provide you with an updated red, amber, green report in terms of the actions that we were asked to submit to the committee in March. Since then, things have moved forward significantly. We have now moved to a situation where we will have 10 greens and one amber by September, the majority of which will be sorted by the summer. One of those relates to our shortage of neonatal nurses. I can confirm that we are currently in the process of recruiting seven nurses, which takes us to the number that the network has recommended. On top of that, we are also recruiting a discharge co-ordinator to ensure that we can use our special care baby units and high-dependency beds far more effectively and in tandem with our work across the border with ABMU. So, we are a long way down that route of resolving the issues regarding any shortfall that we had in permanent positions. Up to now, we have been filling those by using bank and agency staff.

[125] **Christine Chapman:** I am sure that we will come on to this point later, but using bank nurses does not provide the same sense of reliability as full-time staff, because you are dependent upon people wanting to take shifts if they are available. I do not know whether you

want to say anything about that.

[126] **Mr Purt:** I would not disagree. I heard some of the evidence given this morning. We have a very conscientious group of staff and we have a fairly stable bank, but obviously that is not the same as having employed individuals within our organisation specifically allocated to the hospitals and the shift patterns. That is why we are advertising, as we speak, for the seven additional neonate nurses who will take us up to our full complement.

[127] **Mr Roberts:** We have presented quite a comprehensive set of information, including things like the annual report and the updated RAG report. Our report on the standards, and our sense, is that our neonatal nursing staff is up to scratch. We have given a lot of information on that, including the training levels of neonatal staff. The difference in calculation comes from the percentage that is used to calculate absence and sickness rates and such things. There is a small percentage difference in the calculation that we use and what has been calculated in the capacity report. However, our view is that our neonatal staffing numbers are right. We do not use bank staff. We do—as has been a common theme today, from listening to the evidence—rely on the flexibility of staff. However, as you have probably heard before, the nature of some of these services is such that there are quite big swings in capacity and usage of beds and, therefore, flexibility of staff is part of what is required in a service like neonatal care. So, our services score reasonably well with our neonatal staffing.

[128] **Mr Laing:** It might just be worth adding that we have developed a tool to reflect the nursing requirements against the acuity by shift and by day, according to the babies who are in the unit. I understand that the network is planning to adopt that for use across the network; it has been helpful for us to ensure that we have a proper match between the nursing requirement and the sickness of the babies in the unit on any day or shift.

[129] **Suzy Davies:** How much will it cost to get all of the further investment that you need to bring you up to compliance with the all-Wales standard?

[130] **Mr Purt:** In terms of the neonate nurses, they have been paid for within our current staffing establishment by utilising the moneys that we would otherwise have used on bank and agency staff. Some of that money would also include overtime payments. However, moving to a much more solid cadre of staff is the highest priority for us.

[131] **Mr Roberts:** I have answered the question to some extent because the nursing staff is at the staffing level required for the neonatal unit. I should say that to get the most flexibility out of our services, which includes staffing, you will know from the plan that we submitted that our intention is to move the two intensive care beds that we currently have in Bridgend at the Princess of Wales Hospital to the Singleton Hospital unit. That gives us much more flexibility. So, it is not a net increase in staffing, but it gives us much more flexibility for the use of those intensive care beds. So, in order to achieve that—and for other reasons that we may well come to later—we are making quite a big capital investment in refurbishing the unit in Singleton Hospital that will allow us to have the capacity to do that. So, there is an overall investment of around £2.2 million in capital—not in staffing—because it helps us bring those two services together, which improves flexibility and does not mean a net increase in staffing.

[132] **Suzy Davies:** So, you are confident that you can make up the equivalent of 29.21 whole-time equivalents at no extra cost.

[133] **Mr Roberts:** I feel that I have already answered that question to some extent. There is a difference between how that figure is calculated and how we calculate staffing. Our calculation, which has not been challenged widely, is that our nurse staffing levels are appropriate for the service that we offer.

[134] **Mr Purt:** It is a similar situation as far as I am concerned. That calculation is in our revenue budgets and it is now allocated to those particular budget lines.

[135] **Angela Burns:** You talk about recruiting extra staff, but are you recruiting new staff into your units or are you taking people of a different grade and upskilling them?

2.15 p.m.

[136] **Mr Purt:** From our point of view, it would be a mixture of both. The advertisement is out for new staff at an acceptable level. We are looking for staff in the middle of band 5 who have experience and can come in. The recruitment process will tell us whether we need to look in a different way, in which case we can upskill after we have individuals in the posts. We have a good record on training on the job, as was said earlier. An average of 75% of staff go through additional training after they take up post.

[137] **Dr Fountain-Polley:** Now is the perfect time for us to advertise, because the end of the nursing college year is coming up. That will mean an opportunity for nurses coming straight from training who will be looking at whether they want to develop their careers in certain directions, be that children's nursing or neonatal nursing. Hopefully, there will be a whole load of new nurses available who want to be trained up. So, the auguries are good.

[138] **Mr Laing:** It might be worth noting our experience. Although we are not doing major recruitment because we meet the British Association of Perinatal Medicine and the Welsh standards, there is, of course, a turnover, so we do recruit. In our experience, it is hard to recruit experienced neonatal nurses. As you have heard, it is easy to get people coming out of college and starting their careers. However, when we have been seeking more experienced nurses in neonatal care, it has been difficult to recruit them. We have mostly been developing newly qualified staff.

[139] **Christine Chapman:** I have a broad question. We have talked about recruitment and the skills needed. Is there an element of nurses not coming forward? Have they gone somewhere else? What is happening?

[140] **Mr Laing:** As is often the case with nursing in many specialised health areas, when people get into a unit, they become experienced and often stay there. If you have specialised skills, there are often not very many places that you can work in the country. People tend to stay in their unit and develop within it. There is not much mobility of very experienced staff between units unless, for family reasons, they wish to move to a different part of the country.

[141] **Julie Morgan:** I want to pick up on training. If you have been listening to the evidence today, you will have heard that training has come up quite a few times. We have had evidence, from the Royal College of Nursing in particular, which says that it is difficult to get on-the-job training. Do you have any comments about that evidence? You have already said a bit about it, but could you say a bit more?

[142] **Mr Laing:** In our health board, we ensure that there is mandatory training and that staff are released for that training. There are specific requirements for neonatal nurses that would not be required for other nursing groups. When staff wish to do optional personal development, such as doing a Master's degree, they are released where possible. However, some of it may be done in their own time and some in paid time. We would meet some of the course's fee, although not necessarily all of it. We fund and provide mandatory training in paid time. However, optional development would be a negotiation between the individual and the health board. It would depend on whether it was appropriate and what the demands were at the time.

[143] **Mr Roberts:** We have provided information, albeit a snapshot in time, on the number of nurses who had mandatory training and those who did not. I think that that provided a good assurance about that issue.

[144] **Julie Morgan:** You said that you want to train an additional neonatal nurse at a cost of £60,000.

[145] **Mr Roberts:** That is the cost of backfilling. As you heard in evidence earlier, the practitioner training is not in Wales. Therefore, we have to backfill a nurse in order for the nurse to go off and do the advanced nurse practitioner training. We need to look at that area further over the next few years, given some of the challenges we are facing with medical staffing, which, once again, I am in no doubt we will talk about later. So, at the moment, that is our ambition, but I suspect—

[146] **Julie Morgan:** However, you have no money. You said earlier that you had not identified the money.

[147] **Mr Roberts:** I believe that we will have to identify the money to do that. It is a conversation that we have had with the directorate already. We have to think more strategically about that and think about doing that even more over the next few years given the challenges, particularly in junior staffing in medicine, because the nurse practitioners clearly help with that.

[148] **Julie Morgan:** What about Hywel Dda?

[149] **Dr Fountain-Polley:** At Hywel Dda, we are missing some nurses. We recruit to those spaces, which gives us the flexibility to be able to send our nurses away for training if necessary and gives them the time to undertake in-house training as well. At the moment, we are also looking towards our partner in ABMU, because it has a neonatal intensive care unit and can provide training for our nurses. The plan is to start to send our nurses across for shifts in order to upskill them. We have had discussions with the neonatal unit there and it might send some of its staff to us for some shifts. That way, there is a conversation in both areas and a transfer of skills. That is what the neonatal network is all about: using your resource wisely across a wider area. The network itself has a training sub-group, and part of its work and remit is to look at how we share our expertise across Wales so that everyone benefits.

[150] **Julie Morgan:** So, the collaboration is working well on training.

[151] **Dr Fountain-Polley:** Yes. We are in the early stages at the moment, but we have a clear idea of what we are aiming for. I think that that is probably the case across all of the health boards.

[152] **Julie Morgan:** Do you recognise the complaints of the Royal College of Nursing?

[153] **Dr Fountain-Polley:** Yes, because, specifically in Hywel Dda, as I said, we are missing nurses. So, it makes it very difficult. If we send someone off at the moment, it means that we might have to close a couple of cots. So, yes, we do recognise the complaints. Once again, that is not true only of neonatal nursing, but nursing across the board. That is why recruitment, for us, is relatively key to our plans.

[154] **Christine Chapman:** I have a specific question for Paul. It was drawn to my attention that there has been some fundraising activity by parents whose babies were in a special care unit, but I was quite alarmed to hear that there was a request for it to be diverted for training purposes. Would you like to comment on that?

[155] **Mr Roberts:** I cannot comment on the specifics, because I am not sure exactly what fundraising you are talking about and—

[156] **Christine Chapman:** Fundraising by parents.

[157] **Mr Roberts:** Indeed, but I do not know the specifics, so I do not want to comment on that. However, from my experience, using charitable funds to subsidise some training, particularly the sort of training that Hamish talked about, which is not what you might call mandatory training, but training that is good for nurses or other healthcare professionals to support their development, is common—certainly within the UK and, I suspect, worldwide—and I do not believe that that is altogether a bad thing. One would worry more about it if fundraising funded mandated training that you absolutely need to do the job. However, with a professional workforce, one is trying to find all sorts of opportunities to allow people to develop their careers and their particular expertise. In my experience, it is not uncommon for trust funds or charitable funds to help with that. To a degree, it is the sign of a good unit that parents want to get involved in such fundraising.

[158] **Christine Chapman:** As I said, we were quite alarmed, in a way, because there would be an issue in view of the RCN's comments.

[159] **Mr Roberts:** I do not think that you should be alarmed. I think that, in healthcare, it is a common situation. I think that you should be alarmed if it was being used simply to substitute for core training and healthcare money.

[160] **Christine Chapman:** So, you are assuring me that that is not the case.

[161] **Mr Roberts:** I do not know the specifics of what you have been told, so it would be silly of me to assure you given that I do not know those specifics. However, I would very much doubt that that would be the case.

[162] **Mr Laing:** In general, one of the issues is what those who are giving the money felt they were giving it for. In other services, we have patients and families who give money, knowing that this may well help support some optional training opportunities—a variety of things—and they are very happy to do so. You might be concerned if the money was being given for one specific thing but being used for a different thing.

[163] **Christine Chapman:** It was—it was specifically intended for training, at the nurses' request.

[164] **Mr Laing:** In ABMU, it would be for the optional development opportunities that we were discussing a minute ago.

[165] **Simon Thomas:** Credaf fod hwn yn gwestiwn i Fwrdd Iechyd Lleol Hywel Dda, yn benodol; ni chredaf ei fod yn berthnasol i Abertawe Bro Morgannwg. Yn y llythyr a anfonwyd at y pwyllgor hwn, Mr Purt, rydych yn dweud yn benodol:

Simon Thomas: I believe that this is specifically a question for Hywel Dda Local Health Board; I do not believe that it is relevant to Abertawe Bro Morgannwg. In the letter that was sent to this committee, Mr Purt, you specifically say:

[166] 'Hywel Dda Health Board has never recognised itself as a "designated specialist centre" and has not produced an annual report on the quality of care in the way described.'

[167] Mae'r canllawiau a'r safonau'n cyfeirio'n benodol nid yn unig at ganolfannau arbenigol dynodedig ond hefyd

The guidelines and the standards specifically refer not only to designated specialist centres but also to the trusts, given that they date

at yr ymddiriedolaethau, gan eu bod yn dyddio yn ôl i 2008—fel bwrdd, rydych yn etifedd i un o'r ymddiriedolaethau hynny. A fyddai modd ichi egluro i'r pwyllgor beth rydych yn ei wneud o ran cyhoeddi a monitro ansawdd gofal, a sut rydych yn rhannu'r wybodaeth honno gyda'r bwrdd, gyda'r cyhoedd a chyda'r rhwydwaith genedlaethol sy'n gysylltiedig â gofal newyddenedigol?

back to 2008—as a board, you are a successor to one of those trusts. Could you explain to the committee what you do in terms of publishing and monitoring the quality of care, and how you share that information with the board, with the public and with the national network that is associated with neonatal care?

[168] **Mr Purt:** This happens at several levels. In terms of the organisational structure, we have a lead director for children, who sits on the board. We also have a very thorough reporting and audit system that is delivered through integrated governance and our quality and safety committee. We look, in particular, at transfers and at mortality data, and issues regarding near incidents. I am sure that Simon can provide greater detail if we need to go into that. Another thing is the recognition that we are working much more closely with our partner organisations within our county structures. So, a lot of our children's teams are integrated with those of our local authority colleagues. This is one of the areas that we focus on in particular, in terms of quality and safety for children, full stop. One reason why I wanted to bring back to the committee a reviewed RAG status is that the last one was conducted in December of last year, and the current one shows a completely different situation. We have gone through the reviews that we have had across a whole range of services, and our clinicians have been greatly involved in that. Simon, would you be able to provide any details?

[169] **Dr Fountain-Polley:** Yes. Operationally, within the health board, services for children are managed across the entire patch. We have a directorate management structure, and I am the lead for that. We have a separate quality and safety meeting, which encompasses all the work done around any problems that have come up in incident reports, any thoughts from families and any thoughts from my colleagues. We will feed into that various audits that we do on particular pathways of care. So, there is an ongoing process. However, as we look to having our own high-dependency care in the health board in the future, we will have to publish a report. In the past, the interpretation of my predecessors was that 'We are not providing high-dependency care, so we do not have to provide a report'. Whether that was right or wrong, I cannot say. However, the aim is for us to slot more into the area of governance around the network, and to make this much clearer through specific reports, as indicated in the standards.

[170] **Angela Burns:** I have a specific supplementary question relating to that point. I have a letter here from the trust, in April. It says that the facilities are six cots that provide high-dependency special care and short-term intensive care. That is why I am really confused as to why there is not a quality report and why you are not a designated specialist clinic. I would have thought that six cots and thirteen full-time nurses would be quite a lot of people.

2.30 p.m.

[171] **Dr Fountain-Polley:** We are aiming to meet the standards for a high-dependency-care unit, which is separate to providing high-dependency care. When we need to, we provide intensive care. Two weekends ago, I spent all night in Aberystwyth with a baby who was 12 weeks premature. The midwives and I looked after the baby until the neonatal service came to retrieve them. So, if needs be, we can provide intensive care, but we do not plan to do that, because we do not have the facilities or the ability to look after those babies in the long term. That is why our activity is slightly different to what our unit is officially branded as providing. That is why we are aiming to develop the service for our population in west Wales, so that we have a fully accredited level 2, or high-dependency care, unit. Our aim is to make

things better.

[172] **Simon Thomas:** Mr Purt mentioned a few things that you would be looking at—mortality is clearly one of them, as are transfers. Can you tell the committee anything about the current rate of transfers out of your region? I suppose that that includes out of Swansea as well.

[173] **Dr Fountain-Polley:** Out of Hywel Dda, you are looking at 35 babies. They went to various places, including to our immediate neighbours, our neighbours a bit further afield and our neighbours the other side of Offa's Dyke.

[174] **Simon Thomas:** Were they all planned? I would imagine that some of those would be unplanned.

[175] **Dr Fountain-Polley:** Some of those would be emergencies. In terms of that particular problem, using the terms 'planned' and 'unplanned' is slightly too black and white for a clinician. We have kids who are born when we were not expecting them to run into trouble, but they do, and we have to transfer them out for intensive care. We have kids who we know are probably going to run into trouble so, if you live in Ceredigion, we will deliver in Glangwili. If you do run into trouble, but more trouble than we expected, you have to be transferred across to intensive care—

[176] **Simon Thomas:** So, if it is not low-risk, Glangwili would be your first port of call.

[177] **Dr Fountain-Polley:** It depends where you live within the borders of the Hywel Dda health board area. That is purely an example.

[178] **Jocelyn Davies:** You know, as well, that some babies will need specialist surgery—

[179] **Dr Fountain-Polley:** Babies who are picked up antenatally as having congenital heart disease are usually delivered in Cardiff or Bristol, if they think that they are going to need immediate surgical input.

[180] **Simon Thomas:** I will finish the question on mortality. We had a little debate earlier with Betsi Cadwaladr health board on this. Are you able to tell us anything about your mortality levels as compared with the Wales average and the UK average?

[181] **Dr Fountain-Polley:** You will have to excuse me if I am a bit pedantic now. Mortality for babies is divided up in lots of ways—perinatal mortality, postneonatal mortality, neonatal mortality. There is a whole range. Mortality rates are affected by different things, depending on how old you are. So, if you are talking about perinatal mortality rates at Hywel Dda, because the number of babies involved would be a tiny number, it is hard to say how statistically significant that is. The UK average is about 4.2, but if you looked purely at the numbers of babies who, unfortunately, died last year who belonged to the Hywel Dda health board, it would very few. It would be much less than that.

[182] **Keith Davies:** I have a question for Simon. We had the neonatal capacity review in January, as you are aware, and it talks about having high-dependency capacity within the south-west Wales community. It says that there are substantial challenges to the implementation of compliant local high-dependency care in Hywel Dda health board and that the network welcomes the meeting that recently took place between Hywel Dda and ABMU health boards. You have heard the questions that we have asked today about proper staffing and so on.

[183] At the moment, there are two district general hospitals in Hywel Dda LHB that have

high-dependency beds. I assume that in the plans that are yet to materialise for Hywel Dda LHB, there will be a level 2 unit planned for Glangwili hospital, but what about staffing and training? Is there agreement between Hywel Dda LHB and Abertawe Bro Morgannwg university LHB on those proposals?

[184] **Mr Purt:** I will take the first bit, Keith. As people as aware, we are currently undertaking an engagement process, in which we have said that it is the intention of the health board to centralise level 2 and to have a proper level 2 neonates unit linked to complex obstetrics and high-dependency paediatrics, and to have a stabilisation and retrieval unit and a special care baby unit at the other two sites. That is the board's intention. At this stage, you will be aware that I cannot say whether it is going to be at Glangwili or Withybush. That will be subject to the consultation that will come out at the end of July. In getting to that point, we have had significant conversations with representatives from Betsi Cadwaladr UHB regarding the population that we serve in Tywyn and south Gwynedd. We have had the same conversations with Paul from ABMU, because we need to understand that clarity between intensive care and high-dependency care. We are very aware that what we need to do is to ensure that the levels are stepped in the right way. One of the reasons that we are moving towards having a discharge co-ordinator is so that we can ensure that we have the right babies in the right part of the system, whether that is with us or with Paul at ABMU.

[185] I will go back to training for a second, and part of the training that we did not touch upon earlier. There are two areas of training. It is not just a matter of training for neonatal nurses: one of the pressures that we have had historically on our special care cots is direct admission from communities. That needs to be dealt with in a way that means that they can be admitted into a hospital, but not necessarily into a special care cot. Therefore, that is a matter of training midwives and staff differently within the rest of the hospital and ensuring that we have the right protocols in place to ensure that they do not stay in a higher dependency cot than they need to be in for any longer than they need to be in it. That is particularly pertinent when babies are being treated in Swansea, as we want to keep the separation as short as possible. All of that is going on.

[186] There is one other thing that I would like to add as regards our commitment to training. It has got to the stage now, not only in relation to this topic, but also our community staff, that we are working with our universities—and we have two on our patch—on postgraduate education entry for additional courses that staff may get to via experience that they would not have been able to access without having a first degree, particularly around things like psychology, which is really helpful when the outreach teams are working with parents in the community. The debate around training is much wider than simply the issues that are related to neonates.

[187] **Keith Davies:** The reason that I am pursuing this is that I was very taken by the training element between Cwm Taf Local Health Board and Cardiff and Vale University Local Health Board this morning.

[188] **Mr Roberts:** It might be helpful for me to chip in and say that I can confirm what Trevor is saying: there is support between the two boards on this strategy. If you think about it, it is much easier for us to be working with high-dependency care that is stable, sustainable, aspiring and reaching the standards that we were talking about earlier, with regard to making sure that the babies are cared for in the right place and in the right environment. Our team will support that. They are already doing that. We already do that to the east of our patch, with Princess of Wales Hospital, so we welcome the development and have been part of the discussions that have led to it.

[189] **Mr Purt:** One final thing: as people will be aware, there are north, west and south plans that are being worked on. While we are not directly involved in the south, we are in the

sense that we have signed up to be a partner of that, so that we can ensure that the cross-boundary working—particularly between us and Paul's organisation—is as robust as it can be.

[190] **Lynne Neagle:** I want to ask a couple of follow-up questions to ABMU, following on from Simon Thomas's earlier question: how do you monitor progress against your action plan? At what level is that done in the health board?

[191] **Mr Roberts:** I may let Hamish may go into the details, but we have a performance management process in place for individual directorates. You have heard about other similar structures. We have a women and children's directorate, of which maternity and neonates are a part. We have regular meetings to look at all sorts of issues, including outstanding actions from any action plans and ensuring that they stick to the timescales, or, if they cannot, for a good reason, that we renegotiate those timescales and ensure that actions are being achieved. It is a fairly routine monitoring process. We take high-level reports on quality, mortality, infection, and so on, to board meetings. We also have specialist committees that look at particular issues. We have an infection prevention board that looks specifically at infection issues, but it looks at them across the board, not only at neonatal services. Things are sliced and diced in a number of ways in terms of reporting and monitoring.

[192] **Lynne Neagle:** Aneurin Bevan Local Health Board has said that it takes quarterly reports on progress at its board meetings. Would that be a better way of driving forward progress in an area that has taken a long time to make progress in Wales?

[193] **Mr Roberts:** I certainly think that they need to be regular—quarterly, at least.

[194] **Lynne Neagle:** But, you do not do that.

[195] **Mr Roberts:** We do not formally take a quarterly report on this individual action plan; that is correct. However, our performance meetings with the directorates are now monthly. There is a monthly follow-up, but not every item that comes up in the monthly meetings with directorates is taken up to board level. We do that by exception. If we have concerns about an area, we ensure that it is escalated to the board. I accept that a regular reporting mechanism is helpful so that more members can keep themselves apprised of progress.

[196] **Lynne Neagle:** The Minister made it clear in her letter to the committee that reporting to the network that is responsible for monitoring cannot be enforced. Should that be changed to give more clout to drive this forward?

[197] **Mr Roberts:** I am not quite sure what that phrase means. In a statutory sense, it is the responsibility of the boards, and they can choose to delegate some of that responsibility to a network. A board would look pretty weak if it was not regularly reporting the right information to networks. I also anticipate that, as progress is made, the networks might start asking for new information. This is a journey. Once you have achieved a certain set of standards then the network will, quite reasonably, press you for the next. Boards should be reporting information to networks on a routine and regular basis. I do not have a strong view on whether it needs to be enforced. However, it feels to me as if people will always ask you difficult questions if you are not doing things, which is reasonable.

[198] **Julie Morgan:** I want to ask Simon more about the 35 babies that he referred to. Would some of those babies always have to go to somewhere like the Heath or Bristol? What percentage would that be, and why would they have to go?

[199] **Dr Fountain-Polley:** Hywel Dda health board's plan would mean that if we had a

high-dependency care unit within our borders, some of those babies would not be heading out of our area. In our geographically diverse area, we can appreciate that there is a lot of travelling involved, so we want to try to keep as much care local as it is safe and possible to do so. For those 35 babies in particular, I cannot give you any percentages, because I would need to look through the individual sets of notes. The decision on when someone needs to be transferred is very individual. Knowing what I know, from working, some 10% of the babies who end up in special care need intensive care. Extrapolating from that, you are looking at three to five. So, you may be looking at stopping the transfer of 30 or so babies, which would be great. It is not just about preventing transfer out, however; it is also about repatriating babies more quickly.

2.45 p.m.

[200] At the moment, there are things that we cannot do that mean that a baby is classified as needing high dependency care. For example, if they are not feeding for long periods, we would need to give them their nutrition intravenously, but at the moment, we do not do that; if we did that, we would be able to have our babies back from intensive care a lot quicker. So, there are two sides to this issue: it is about doing more of our own work so that we are no longer a passenger in the network, but contributing to it, and it is also about making sure that we bring our families back together more quickly.

[201] **Julie Morgan:** Would some of those babies need surgery in Bristol or somewhere similar?

[202] **Dr Fountain-Polley:** Let us say that there is a baby who has a problem with its guts and needs an operation; at the moment, such babies will spend a lot of time in high-dependency care. We could maybe bring those kids back a little bit more quickly. Those with cardiac problems obviously go to Bristol, because that is where the surgery is done. They will probably not come back as quickly, because they have specialist post-operative requirements, but you are probably looking at quite a few babies who would end up spending less time away.

[203] **Christine Chapman:** Jocelyn; you are next.

[204] **Jocelyn Davies:** I can ask my question later on.

[205] **Christine Chapman:** Okay. Simon, do you want to come in at this point?

[206] **Simon Thomas:** I just want to confirm something that is puzzling me slightly at the moment. In your letter to us, you say very clearly that you have been able to discuss the plans—originally in outline and subsequently in detail—with the network and with your sub-regional partner, which I assume is Abertawe Bro Morgannwg. However, the neonatal capacity review states very clearly that the detail of these plans has not yet been shared with the network to allow a view to be taken on whether it will deliver appropriate capacity within the overall network context and whether they are professionally sustainable and compliant with standards—that review was done in January, of course. Are you therefore telling us that the work that had not been done in January has now been done?

[207] **Dr Fountain-Polley:** I have had a lot of discussions with the network, both formal and informal, and we have spent a lot of time thinking about how we might manage the variables from developing what is, in effect, a new service. We have set up a regular meeting with our colleagues in the neonatal unit at Singleton—we have met them twice now. So, we are starting to form those links, and the work is now picking up pace.

[208] **Simon Thomas:** Is that the work that you referred to that you able to furnish the

committee with more information on?

[209] **Mr Purt:** I can certainly furnish you with a significantly updated progress report on where we were in December. It is equally evidenced, I hope, by the amount of engagement we are now having over what the models will look like in a public issue. When we get to the consultation, all that will really be about is the site. The issue for us and the board is very focused on driving this forward as something for the population that we serve across our three counties.

[210] To pick up on one of the questions that Simon was asked earlier, we have an average of about 3,700 births a year in Hywel Dda health board area, about 3,500 of which are ours, as such, with some having come from across the boundaries. Of those, about 215 to 220 end up going into a level 1 to level 3 facility. So, the overall number is not huge. As Simon said, last year, it was 35, of which, two went outside, and they were Bristol based. So, for us, the numbers are more about how we can ensure that we keep our babies very much more local, and if they do have to go away, that they come back much more quickly, because we are really conscious about such things as multiple births, about which questions asked this morning. Obviously, a baby needs to go to the right place for the right treatment, but it also needs to come back as quickly as possible.

[211] **Jenny Rathbone:** I am puzzling over the changes to the medical staffing workforce following the European working time directive and how you are going to get the level cover on a 24-hour basis on a very small HDU? You were talking about having just over 200 babies a year, and I think that you said that 35 had high dependency requirements, which is numerically very small for quite an intensive service. How do the numbers add up in terms of the medical staff?

[212] **Dr Fountain-Polley:** In the middle grades—the tier between a junior doctor and a consultant—if you have babies who need high-dependency care, you can share them with the general paediatric cover. So, at one site, we propose to have juniors looking after the neonatal unit, along with deliveries and so on, and some juniors who see all the children. The middle tier would cover both sites, with a consultant layer above that. That is how we will be able to manage those babies who, as you say, are relatively few in number, and also the paediatric admissions. That is the sort of standard that the British Association of Perinatal Medicine accepts for high-dependency care.

[213] **Jenny Rathbone:** Would that involve one consultant or would it be more?

[214] **Dr Fountain-Polley:** It would be one consultant out of hours, but, in hours, you are probably looking at two consultants to cover both sites. However, in reality, because we are paediatricians, we are quite flexible about how we work, and, if necessary, we will stop what we were doing and help a colleague. That is often the case.

[215] **Jenny Rathbone:** You are talking about bringing this together on one site. So, does that mean having two consultants covering 24-hour care on one site?

[216] **Dr Fountain-Polley:** We would probably have one consultant out of hours covering that one site; that is standard practice.

[217] **Jenny Rathbone:** Okay. Would that meet the standards set by the royal college?

[218] **Dr Fountain-Polley:** That would meet the British Association of Perinatal Medicine standards. The royal college standards are slightly different. I assume that you are referring to the Royal College of Paediatrics and Child Health's 'Facing the Future: A Review of Paediatric Services' document, which has relatively clear criteria for what an inpatient unit

requires. However, reading between the lines, one consultant, for the numbers that we are talking about, would be adequate.

[219] **Jenny Rathbone:** Turning to Abertawe Bro Morgannwg, will transferring the ICU beds from the Princess of Wales Hospital to Singleton Hospital crack that problem, given that you will still have a lot of high-dependency beds at the Princess of Wales Hospital?

[220] **Mr Laing:** I think, as you rightly say, we will retain our high-dependency cots at the Princess of Wales Hospital. The current way that we look after the intensive care cots at the Princess of Wales Hospital is not compliant with the standards—we do not have a separate neonatal rota for junior doctors in Bridgend. Therefore, the transfer of the cots means that the care of those babies will become compliant—they will be looked after by full-time neonatologists. As you have seen from the data submitted, the occupancy of the cots in Bridgend is low. It has worked all right up until now, but it will be better under the new arrangements. The European working time directive does not really alter the position, because we are not providing a neonatal tier in Bridgend. The additional work will be absorbed by the staff who are already at Singleton.

[221] **Suzy Davies:** I have loads of questions on this, but I will write to you with some of them, because I am conscious of the time. You explained that both ICU beds at the Princess of Wales Hospital will transfer to Singleton, because the way that they are run at the moment is not compliant. Yet, in appendix 1 of the fantastic written evidence that you provided, I note that there were a huge number of referrals from Singleton to Bridgend ICU beds in 2010. There were 33 such referrals. If Bridgend is not compliant, why were you sending babies who were in trouble there?

[222] **Mr Laing:** I do not think that there were any babies in trouble, but we were sending babies there because Bridgend is able to provide intensive care. Those referrals would have been at times when Singleton was full, and so, with carefully selected babies, so not necessarily the next baby born, but a baby who was stable and might be close to stepping down to high-dependency care but could not quite yet, a clinical judgment would have been made that it was safer to transfer that child somewhere else, and it may well be that the only available 'somewhere else' was the cot in Bridgend. It is not optimal care, and it makes much more sense, therefore—and that is exactly why we want to do this—to move the Bridgend cots to Singleton so that they will be fully within the intensive care neonatal service in Singleton.

[223] **Suzy Davies:** Those beds are also much in demand from the eastern local health boards, are they not? The same statistics show that Princess of Wales Hospital had to turn down a lot of requests from Cardiff and Vale LHB and various other eastern LHBs, so they obviously thought that those beds were compliant. Even though they were turned away, because the beds were full—

[224] **Mr Laing:** It is compliance with the standard of having a separate neonatal tier, and the network knew that it was not compliant—

[225] **Mr Roberts:** You have to look at the big picture.

[226] **Suzy Davies:** I am not challenging the transfer of the two beds—

[227] **Mr Roberts:** I guess that the direction of travel that the network was set up to help us to achieve is to concentrate the intensive care beds in fewer places, where not only can the standards be maintained, but there is much more flexibility and capacity to deal with the work that you generate from your locality. So, the idea of transferring those two intensive care beds to Swansea and concentrating intensive care in fewer places mean that the need for transfer

should be less.

[228] **Mr Laing:** It shows that, although the overall use of those cots is low, there are moments of pressure within the network when they play an important part in the capacity in the network.

[229] **Suzy Davies:** Quite often, by the looks of it.

[230] **Mr Roberts:** We would do better if they were in Swansea. If you look at the differences between utilisation in Princess of Wales Hospital and in Swansea, you will see that they will make a more effective contribution—that is part of what you are saying, I think, Hamish—to the overall intensive care provision across south Wales if they are located in Swansea.

[231] **Suzy Davies:** I am happy to leave it there, because I am conscious of time, but I will write to you separately.

[232] **Simon Thomas:** Mae rhai o'm cwestiynau wedi eu hateb ond hoffwn droi yn benodol at y ffrwd waith dibyniaeth isel. Rydym wedi bod yn sôn am ddibyniaeth uchel, ond mae hefyd, yn ôl yr hyn rwyf wedi ei ddarllen, amrywiaeth sylweddol yn y ffordd mae'r ffrwd waith dibyniaeth isel yn cael ei chynnal yn ôl y safonau ar hyn o bryd. Pa fath o gamau a ydych yn eu cymryd i wella hynny? Efallai bod hwn yn gwestiwn i Hywel Dda LHB hefyd, achos rydych yn delio gyda dibyniaeth isel, rywfodd neu'i gilydd, onid ydych?

Simon Thomas: Some of my questions have been answered, but I wish to turn specifically to the low dependency work stream. We have talked about high dependency, but, according to what I have read, there is also substantial variation in the way that the low dependency work stream is carried out according to the standards at present. What kind of steps are you taking to improve that? Perhaps this is also a question for Hywel Dda LHB, because you deal with low dependency, in some way or another, do you not?

[233] **Dr Fountain-Polley:** There are two main problems with low dependency care. One is that our admission criteria are slightly different in the two units that have a neonatal unit. So, in one of them, if babies had gone home, were eight months old and were unwell with bronchiolitis, which is a problem with their chest, instead of being admitted to the ward, which is what happens in most places, they would be admitted to the neonatal unit. We are changing that. So, the admission criterion has dropped from a year to 28 days, and that will drop further to 14 days, with the plan for that to be that if you have gone home, you will not come back to the neonatal unit. That will take out quite a chunk of the numbers for one of our hospitals.

[234] **Simon Thomas:** So that we are clear, we are talking about Glangwili and Withybush as the two locations.

[235] **Dr Fountain-Polley:** Yes. We are looking at our admission policy to ensure that we are admitting only babies who need what we term neonatal care.

[236] The other side is looking at how we get babies home appropriately. So, you have a baby who was born very early, who has come back for what we would call feeding and growing to make sure that they are big enough and that you can keep their temperature up to get home. To make that happen in a more co-ordinated, orderly fashion, we will have a neonatal outreach nurse, so we will be able to take the cork out of one end of the bottle, as it were, and then, hopefully, we will get some flow out of the unit, so the babies get home more quickly and appropriately. We are also looking, for our colleagues across the way, who often have our babies, as it were, blocking up their low-dependency capacity, at moving those

babies across, because we will have created capacity. That goes hand-in-hand with more neonatal nurses, because we will be able to staff our cots more appropriately.

3.00 p.m.

[237] **Simon Thomas:** That blocking was recognised in the capacity review report, was it not? How would that affect your plans for low-dependency care?

[238] **Mr Roberts:** The plan that Simon has described is very helpful, as you can see, because it will give us a much better use of our capacity within Swansea and within Singleton Hospital. I suppose that, in some respects, there is a parallel process with the Princess of Wales Hospital; although it already has a fully resourced high-dependency unit, it is still running the intensive care. When we relocate the intensive care to Swansea it will also be able to look after its lower-dependency babies much better. You will also see from the evidence that we have submitted that we have a plan, once we have our refurbishment completed, to do a business case on having a transitional care unit as well, which, particularly for a population like Swansea, would be a very helpful addition. However, that is a next step.

[239] **Angela Burns:** I will be honest—I am quietly getting lost between high, low and middle dependencies. To put it bluntly, the concern that I have is that everybody is coming to you—Hywel Dda Local Health Board is sending more and more of its babies to you, people in the east are sending them to Bridgend, as stated in your evidence, and yet your reports here show that, in January and February 2012, the unit in Singleton was fully open for just four days in total. For 20 out of the 60 days it was restricted, and for a further 25 out of the 60 days it was restricted to what I guess is the sub 36-week model because of a lack of available cots. For 11 out of 60 days it was closed completely. You had the same sort of statistics in 2010 and 2011. It says here that high-dependency cots were running at 145% capacity in 2010, so my worry is that everybody will use you—which is fine, because you can develop and get these two extra cots, but is that really enough? You are turning away lots of people and sending them further downstream, so they are further away from their families at times of great stress. I know about reconfiguration plans at Hywel Dda LHB, and I know that all the other health boards are looking at their provision, so I have concerns that more and more pressure will be put on you. Can you meet that pressure going forward?

[240] **Mr Roberts:** We have given a very frank account of some of the issues that we have faced. I would say a couple of things about that. In the last few months, partly because we had our well-reported infection control issue in Singleton—

[241] **Angela Burns:** I should just say that those were not including the infection control bit.

[242] **Mr Roberts:** I agree with that, but there is an element of having gone through that, and therefore admissions were restricted at that point because of a much stronger desire to restrict the workload of the unit and make sure that it was properly staffed, rather than taking on work, as happened historically, that it was felt the unit might flexibly be able to do, in admitting patients from neighbouring units or locally. There has been a much clearer sense from that unit that it wants to stick to the capacity that it has and that it is staffed for.

[243] In terms of the future, I have a couple of points. The work that we have been talking about, both in Hywel Dda LHB and in the Princess of Wales Hospital, will help. Let us be clear about it: we are not expecting more babies; we are expecting a properly—sorry, that sounds almost pejorative—we are expecting high-dependency care that satisfies standards, that can be relied on sustainably, and that therefore can take babies back earlier, or mean that babies do not have to transfer to Swansea at all. It is similar, in a way, in the Princess of Wales Hospital, although that already has a well-established high-dependency unit without

trying to do critical care as well, because critical care will be in Swansea. It will also be able to cope with the dependencies of babies lower down the scale, so that will take some pressure off the Singleton unit, in addition to having those two critical care cots. Whether that is enough in terms of capacity is a big question, and experience will tell us that. What the network has done, which has been really useful, is to establish the cot locator service, and we have much better data now to plan our beds. We have had a review of capacity, but I believe that we will have to keep looking at capacity, because it might be that the mix between critical care, high dependency and special care in Swansea is not right, and we will decide that we need to take another look at that in future. However, everything that we have talked about so far in the Hywel Dda Local Health Board, in the Princess of Wales Hospital and what we are doing in Swansea will help to deal with some of the problems described in our quite frank report.

[244] **Angela Burns:** I do appreciate that frank report, but my worry is that you will deal with the babies who are in real trouble, but then you will move them on to other hospitals relatively speedily where they will fail and, subsequently, die—and I have a case history to support that assertion, which I would be delighted to share with you and Trevor. I just worry that if you are under as much pressure as we can see you are from this report, and if it is not resolved in the long term, it will exacerbate the situation.

[245] **Mr Roberts:** I think that there is a high level of attachment among the staff of the unit and, quite rightly, the clinicians running it to make sure that the standards are right, and that is why I think we are able to give such frank information. It is very much in their interests to work closely with our colleagues to the west, to make sure that there is mutual confidence in the arrangements that are in place. If there is mutual confidence and mutual support, people will be much happier transferring babies back to the unit or supporting the unit to care for babies who might in the past have been transferred to Swansea. It is not one of those black-and-white issues, when it suddenly all becomes right. The people have to work together to establish that confidence and make sure that they share a common understanding about the care of those babies. Simon, you are a clinician but I would say that that is what we have to do—and that does not happen overnight; it takes a bit of time.

[246] **Dr Fountain-Polley:** Traditionally, in south Wales, we have worked by supporting each other, enhanced by the network. So, when the unit is at capacity, that might be because Cardiff had too many babies and, naturally, Swansea had to take up the slack. There are times when the UHW has closed for refurbishment or whatever and has had to drop its cot levels down, and so Swansea has taken up the slack. It is a bit like the mortality statistics in that you cannot look at them in isolation. You have to look at the entire M4 corridor, in effect, because every unit is putting different pressure on and taking different pressure off. It extends beyond Newport, because quite a lot of our work for cardiac disease is done in Bristol, so what is happening in Bristol has a bearing, too. The interdependencies are so great that it is hard to unpick why, say, Singleton was at full capacity on certain days without knowing what was happening in the Cardiff and Vale area or somewhere else on the same day.

[247] **Mr Laing:** One problem is that we have had separate areas in the Singleton unit designated specifically for intensive care, high dependency and special care. As part of this £2.3 million investment and refurbishment, we are creating a lot more flexibility to move between high dependency and intensive care, for example, just because they will all be in a single space. In the special care baby unit that we will end up with in Singleton by next January or February, we will have the opportunity for half those cots to become high dependency cots in the event of a particular peak. We could not do that now because they are remote and it would not be safe. So, we will have more flexibility.

[248] We are clear that we would like to be able to care for all the babies we need to care for all the time. It is inevitable that there will be times when, within one individual centre, it

will not be possible, and that is why we have a network so that there is crossover. However, we need to minimise the amount of movement, for babies' and their families' sake.

[249] **Christine Chapman:** On that note, I will have to close this session. I know that Members had further questions, and so I suggest that the committee's clerk write to you with them and you can respond to us in writing, if you would be happy to do that. It was a comprehensive session, and we will be sending you a transcript of the meeting to check for factual accuracy. Thank you for attending today and answering our questions.

3.10 p.m.

Cynnig o dan Reol Sefydlog Rhif 17.42 i Benderfynu Gwahardd y Cyhoedd ar gyfer yr Eitem Nesaf ac Eitem 1 yn y Cyfarfod ar 23 Mai 2012
Motion under Standing Order No. 17.42 to Resolve to Exclude the Public for the Following Item and Item 1 of the Meeting on 23 May 2012

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

the committee resolves, under Standing Order No. 17.42, to exclude the public from the remainder of the meeting and from its discussion of item 1 at the meeting on 23 May 2012.

[251] Are Members all agreed? I see that you are content with that.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 3.10 p.m.
The public part of the meeting ended at 3.10 p.m.