Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Archwilio
The Audit Committee

Dydd Iau, 2 Gorffennaf 2009
Thursday, 2 July 2009

Cynnwys
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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 Cynulliad yn bresennol
Assembly Members in attendance

Lorraine Barrett	Llafur Labour
Irene James	Llafur Labour
Huw Lewis	Llafur Labour
Nick Ramsay	Ceidwadwyr Cymreig Welsh Conservatives
Jenny Randerson	Democratiaid Rhyddfrydol Cymru (yn dirprwyo ar gyfer Michael German) Welsh Liberal Democrats (substituting for Michael German)
Janet Ryder	Plaid Cymru The Party of Wales

Eraill yn bresennol
Others in attendance

Gillian Body	Swyddfa Archwilio Cymru Wales Audit Office
Jeremy Colman	Archwilydd Cyffredinol Cymru Auditor General for Wales
Tracey Davies	Swyddfa Archwilio Cymru Wales Audit Office

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

John Grimes	Clerc Clerk
Abigail Phillips	Dirprwy Glerc Deputy Clerk

Dechreuodd y cyfarfod am 9.17 a.m.
The meeting began at 9.17 a.m.

Ethol Cadeirydd Dros Dro
Election of Temporary Chair

[1] **Mr Grimes**: Good morning, ladies and gentlemen. Jonathan Morgan has sent his apologies today, so we need to elect a temporary chair. Are there any nominations?

[2] **Janet Ryder:** I nominate Nick Ramsay.

[3] **Mr Grimes:** Are there any other nominations? I see that there are not. I hereby declare Nick Ramsay temporary chair of this meeting.

Penodwyd Nick Ramsay yn gadeirydd dros dro.
Nick Ramsay was appointed temporary chair.

9.17 a.m.

Ymddiheuriadau a Dirprwyon
Apologies and Substitutions

[4] **Nick Ramsay:** Thank you, John. I welcome everyone to this meeting of the Audit Committee. I remind you all that participants are welcome to speak in English or Welsh. Headsets are available for translation and amplification. Please switch to channel 0 for amplification only and to channel 1 for a verbatim translation. I remind everyone to switch off mobile phones, BlackBerrys and any other electrical devices that might interfere with the headsets. If the fire alarms go off, the ushers will tell us what to do and, if necessary, direct us to the fire exits.

[5] We have received several apologies. Jonathan Morgan, as you have heard, has apologised, so I am standing in for him. We have also received apologies from Bethan Jenkins and Lesley Griffiths. Mike German has also sent apologies, and Jenny Randerson is substituting for him. Welcome, Jenny.

9.18 a.m.

Gwasanaethau Mamolaeth: Adroddiad Briffio gan Archwilydd Cyffredinol Cymru
Maternity Services: Briefing from the Auditor General for Wales

[6] **Nick Ramsay:** You should all have received this report. I welcome Tracey Davies to the committee. Would you give us a few words on the report and tell us what you think of it and how you feel the Audit Committee might consider it?

[7] **Ms Davies:** Gillian was going to give the introduction, and I will give the detail.

[8] **Nick Ramsay:** Sorry, Gillian.

[9] **Ms Body:** I am afraid that the auditor general has had a mishap on his way here: he has two punctures in his bicycle tyres, so he will join us as soon as he can. He has asked me to open the briefing in his absence. I will set out what we hoped he would say, but hopefully he will be here in time to provide any particular insights that he might have. Tracey, who was the project manager of this study, will provide the detail.

9.20 a.m.

[10] The report that you have before you is an all-Wales summary of an extensive amount of work that we carried out over 2007 and 2008 in each of the then 13 providers of maternity services in Wales—that is, 12 trusts and Powys LHB, which, in the report, we refer to collectively as trusts, and we shall continue to do so this morning. The upshot of our local work was a local report to the management of each of the 13 providers. They have subsequently been working on addressing our specific recommendations to them. This report provides a summary of that local work.

[11] We undertook the work in collaboration with the Healthcare Commission. Although the report focuses very much on the all-Wales picture, you will also see a number of comparisons with the position in England.

[12] The scope of our work focused on the whole of the patient pathway for maternity services, from the start of pregnancy and the care that women get while pregnant, through labour and birth, to postnatal care. We also looked at the leadership and management of

maternity services provided locally as well as from the Assembly Government. As well as an extensive amount of work at each of the 13 providers of maternity services, we undertook a survey of the staff who provide those services and also, importantly, a large-scale survey of new mothers, to get their perspectives on their experience of the maternity services that they had received. We also analysed national sources of information about the performance of maternity units.

[13] On the particular subject matter, more than 30,000 women give birth each year in Wales, and that number is increasing. The level of demand on maternity services varies hugely, however, with a third of all births occurring in just two trusts. You will not be surprised to learn that they are Cardiff and the Vale and Gwent.

[14] Essentially, we assessed whether NHS trusts in Wales are delivering efficient maternity services that result in positive experiences and outcomes for women and their babies. Although we concluded that maternity services are generally of an appropriate standard and that women's satisfaction levels are high, and relatively so when compared to the experiences in England, we also found inexplicable variations of practice across Wales. Tracey will give more detail about the conclusions, but we found that maternity services are generally given a very low strategic priority, at Assembly Government level and locally. We found significant deficiencies in the ways trusts collect and analyse maternity data and the information that they have to help to improve services. We found worryingly low levels of staffing in some trusts, as well as low levels of training for staff. We found that trusts are not providing the latest screening tests to detect Down's syndrome, and we found a worrying variation in the way labour is handled.

[15] I would also like to outline some of the findings from the survey of mothers before handing over to Tracey to cover the detail. As I said previously, in the main, most women were satisfied with the services that they received, although they were least satisfied with the postnatal phase of their care. It is fair to say, however, that satisfaction levels are higher and much more consistent than in England, where there is significantly greater variation in satisfaction levels. However, we found that nearly a third of the women felt that they were not treated with dignity, respect, kindness or understanding. We found that many women were not always provided with adequate information to help them to make informed choices about their care. During labour, a significant minority of women said that they were left alone and worried. This is a really rich source of information about women's experiences of the maternity services, and it helps us to compare this with the views that were given to us by trusts about their own performance and delivery.

[16] Although mothers' satisfaction levels are relatively high, it is not the sole test of how good maternity services are, because what satisfies a mother may not be the most clinically effective or cost-efficient course of action. So, it was a very useful source of information, but the other key findings have come from our audit work at the trusts. Maternity services should aim to achieve high levels of satisfaction from mothers, as well as providing high quality care.

[17] I will pass over to Tracey to fill in some of the detail.

[18] **Ms Davies:** The report is broken down into three key areas that cover planning, the delivery or the pathways for maternity care and the evaluation. I will cover each of those areas, and I will go into a bit of detail within each of the parts. Part one—the planning part—looks at the strategic context. We reported that maternity services lack a coherent strategic vision. We found that there was poor information about costs and quality and that some trusts are not meeting the recommended staffing levels. Going into more detail, at a national level there does not appear to be a strategic context within which maternity services are operating. There is a raft of guidance documents from the professional bodies such as the National Institute for Health and Clinical Excellence, and various organisations have a number of

policies, but they are not all brought together into a coherent articulated vision of maternity services. Having that type of vision in place may help to reduce the inconsistencies and the variation across the services.

[19] At a local level, we feel that services are hampered by a lack of robust information on costings and quality. When we looked at this, we found significant differences, and we were not assured by the robustness of those data, which we believed lacked sophistication. It makes it very difficult to make true comparisons. You will see across a number of other service areas that there are many targets—you could argue that there are too many targets. However, there are no targets in maternity services, which makes you question whether that has lowered the priority and taken the services off the agenda from the perspective of the trusts.

[20] The physical capacity—the delivery beds and theatre capacity—appears to be sufficient, but when you start to look at the equipment needs, much of the equipment is more than three years old. That may not be creating problems, but in nearly half of the trusts staff told us that they did not have equipment when they wanted it to be available.

[21] We looked at the impact of neonatal capacity on maternity services, and we found significant issues across Wales. We found that nearly all of the trusts, at the time of our review, experienced closures, so that premature babies, newborn babies, and, at times, pregnant women, were being transferred across Wales, at times to England. That does not help with the experience of the mother, and it is unsettling for the family as a whole. We found that it can also have an impact on the maternity capacity in that it can draw on the maternity resources to help to support the transfers.

[22] On midwifery staffing levels, we found that a number of trusts did not meet the recommended staffing levels. There are a number of areas of guidance that maternity services must examine in this regard. However, it is good to see that action has been taken in several trusts. We looked at this just before the report was published to see whether trusts had met those recommended levels, and many are going in the right direction.

[23] When we looked at the medical staffing levels, it was interesting to see, particularly in light of the consultant contract, that a number of trusts could not distinguish between the time that obstetricians spend in gynaecology and the time that they spend in obstetrics, which is a concern to us. There is another area of standard where obstetricians should be spending a certain amount of time in the delivery suites. We found that a number of trusts could not meet this standard, and that that was to a significant level in three trusts which were well below the recommended standard.

[24] When we looked at training, we found that it varied considerably, not only between trusts but also between the professionals. We found that the level of training was very low in a number of trusts, and we found particularly low levels for obstetricians, which is quite worrying, especially when you compare the level of training for obstetricians against that in England.

9.30 a.m.

[25] Part two of the report looks at the maternity pathway from the antenatal elements through labour and birth and on to postnatal. In the main, as Gillian has referred to, we found that it was of an appropriate standard and that most patients are satisfied with their experience. However, we found unacceptable variation and postnatal care is the least satisfactory phase.

[26] I will go into each of those phases. In the main, antenatal care meets good practice guidelines, but we found that a number of women did not have sufficient check-ups. The

majority of women received the minimum number of scans, namely the dating scan and the foetal anomaly scans. However, in a number of trusts, excessive scans appeared to be undertaken. You could argue that that was on a clinical basis, but the variation between the trusts leads us to question whether that was down to individual practice rather than being based on the needs of the individual women. We also found that none of the trusts in Wales are offering the latest recommended Down's syndrome screening test and the funding required for that is still being debated between the Assembly Government and Health Commission Wales.

[27] With regard to mothers, over a third of the women thought that they were not given adequate explanations and were not fully involved in decisions about their care. So, you have to question whether they had informed choice. We found generally low attendance of antenatal classes, and that is among the women who wanted to attend. It is unclear what the reasons for that are, but they could be related to access, poor location and the times of those antenatal classes.

[28] The choices that mothers have over where they give birth are limited by local differences in the types of services provided. So, depending on where you live, different services may be available to you: there may just be an obstetric-led unit, whereas other areas may have a midwifery-led unit and a free-standing midwifery unit. We also found that the clinicians may differ in the way that they access the risks for mothers. They are reported as working to the same standard, but when you look at some of the examples, you see significant differences in the proportion of women offered the choice of a home birth, ranging from 71 per cent to as low as 36 per cent. You have to question the criteria that clinicians are basing those judgments upon. We found that the rate of home births ranged from 7 per cent to less than 1 per cent, and the average rate is higher than in England, but there is scope to increase the level of home births.

[29] The way that labour is managed gives us cause for concern. Normal births, which do not involve any interventions to assist labour, that is spontaneous births, should account for 60 per cent of births, and a target has been set that all trusts should achieve that percentage by 2010. We found that the typical rate in Wales was 40 per cent, and ranged from 18 per cent to 57 per cent according to area, so there is some way to go for some trusts. A significant contributory factor to that is the rate of caesarean sections. The World Health Organization states that there is no reason for the rate to be above 15 per cent, yet, in Wales, no trust is below 20 per cent.

[30] Turning to the women's experience, a number of women told us that they felt that they were left alone and worried during labour—between 10 and 24 per cent. A fifth of women felt that they did not get the pain relief that they wanted. Looking at postnatal care, more than a third of women were unhappy with the quality of support for infant feeding. We asked women to give us free text comments and we received significantly more negative comments about postnatal care, particularly in relation to the quality of support for infant feeding. In addition, the trusts gave us an indication of the lengths of stay, but the information that they gave us was not the best information. It was quite poor and weak. When you compare that with what the mothers said, a significant minority of mothers said that they were kept in for too long and, conversely, a significant minority so that they were kept in for too short a period. So, that makes you again question whether this is based on individual need, and it links to when mothers are reviewed by midwives after they have gone home. We found a significant variation in the number of visits. A number of women said that they would have liked more contact.

[31] I will now move on to the last section. We looked at the information available to maternity services, and we looked at users' views and whether they are informing the future planning of maternity services and obstetric litigation claims, which are costing significant

amounts of public money. In terms of the detail, there are no common data sets within maternity services. When we looked at the information—we collected more than 800 data sets—we saw that the trust had real difficulties in providing basic data in several areas. There were real inconsistencies in the way that the trusts monitor their data, and much of it was through a paper trawl. It was a hugely resource-intensive exercise for midwives. If they are going to move forward in future, they need some sort of a system; and a number of trusts told us that they did not have a system to support that. It is encouraging to see that the Assembly Government has commenced work on looking at common data sets to try to move that agenda forward.

[32] In terms of the users' views, there are a number of fora and committees already in place, and there is widespread recognition that they are not used to their best effect. There is a real need to gather the views of users in a far better way and to use this in planning maternity services.

[33] Finally, turning to litigation claims, in 2007-08 they accounted for 66 per cent of the claims, or £28 million in expenditure. You need a little detail behind that because obstetric claims, by their very nature, can be extremely expensive and it can be just down to a small number. There has been acknowledgement by the National Patient Safety Agency and the Welsh Risk Pool that further work needs to be done. There could be efforts to reduce that, and work is under way looking at a project on how that can be reduced.

[34] In summary, the Wales Audit Office looks to the Assembly Government to articulate a comprehensive maternity strategy and to raise the profile of maternity services at both a national and local level. Effective planning, delivery and evaluation of maternity services must be supported by an agreed standard set of data that is routinely collected, monitored and used to support service improvement. Finally, safe and high-quality maternity services require an appropriate number of adequately trained staff, and new health boards must address this. Thank you very much.

[35] **Nick Ramsay:** Thank you, Gillian and Tracey. That was a very thorough appraisal of the report. There is a lot in the report. I think that I would be right in saying that you have identified a large number of inconsistencies. Right at the start, when you started speaking, you mentioned the need for overall strategic guidance and you mentioned that again at the end. Do you think that the bulk of the problems that have been highlighted in the report would be either solved or alleviated by that guidance, or would there still be a number of issues there even if you got the overall framework right?

[36] **Ms Body:** We think that it will help; we do not think that it will solve all of the issues. The fact that the Assembly Government has not articulated what a good maternity service looks like probably underpins some of the inconsistency in practice across Wales, and therefore setting out the framework will encourage greater consistency. Clearly there are many issues in the report that will not be solved by having a piece of paper that sets out the strategy.

[37] **Janet Ryder:** I was interested in that point, but I was very concerned by the report. In the report, you stress that there are no targets set and you also said in your report that we should be looking at providing a clinically effective and cost-effective service. Thankfully, maternity services are one of the few health services that I have accessed. Therefore, I can speak from experience and probably many women can. You are not ill; it is a natural process and therefore you do not want a lot of intervention. There should not be a lot of intervention on the health side. I would be concerned that if you are considering cost-effectiveness you move away from putting the mother and child and their wellbeing at the heart of the service. That must be the outcome. You said that perhaps one reason why trusts were not looking at maternity services to the extent that they should was because there were no targets for them to

meet.

9.40 a.m.

[38] If we were to look at targets in that area, and they were to be focused on achieving good outcomes for mothers and children, I would suggest that we should be looking at targeting things such as the number of parents you encourage to go on antenatal courses; the number of parents followed up with good postnatal support and the beginnings of parenting support, if that is needed; possibly an increase in home births and definitely an increase in breastfeeding, which is another point that you have noted. You have noted in your report that the issues to do with breastfeeding could be due to a lack of overall support that is needed to encourage first-time mothers in particular to breastfeed.

[39] None of those things would necessarily have an impact on cost-effectiveness, but may have an impact on the service later, because if you empower a woman and make her aware in an antenatal class of what is going to happen, she will become much more aware of not allowing people to intervene in the birth process when it happens. From my initial reading of the report, it would seem to me that mothers need to be much more aware that they should be in control in the birthing room to get the best outcome for them. To do that, they need to have been to antenatal classes.

[40] If we need to look at why targets have not been set, what are your thoughts on what sort of targets could be set and how those would be framed to encourage a much better experience for women and a good clinical outcome? More than anything, this is about achieving a better experience for women and their children.

[41] **Ms Body:** You are right that we have observed that there are no performance targets for maternity services. The point that we make in our report is that the consequence of that is that, locally, the services are given a lower strategic priority compared with other services for which there are performance targets. We did not take the next step of thinking about how targets should be framed if they were to be set. The sorts of targets that you have come up with seem to be very sensible, and we agree entirely that they should be about putting the mother and baby first.

[42] We drew out the point about cost-efficiency because we found examples of variations in practice. This was particularly the case with pregnant women; there was a huge variation in the number of scans they received. We were concerned that women should receive the minimum number of scans. However, there was evidence that, in some areas, women were getting well in excess of the recommended number of scans, which does not seem to be a very efficient way of delivering services if the mother does not need the scans for her care. That is where the issue of cost-efficiency came from, but that is not to say that it should not be about putting the mother and baby and their experience and achieving a positive outcome first.

[43] **Janet Ryder:** In the trusts where women received a higher number of scans, were you able to trace it to a particular consultant or doctor, or was it the practice within the trust generally?

[44] **Ms Davies:** We could trace it to individuals in discussion. There appeared to be a number of reasons, and individual clinical practice is an issue. The other issue identified was the training of middle-grade doctors. So, the profession needs to look at this. There is guidance on the minimum requirements for scanning. It needs to revisit that because it is achieving the minimum requirements, but it needs to consider how efficient it is being and ensure that it is not subjecting women to more scans than they need. The answer that we get from many clinicians is that women are pressurising them. However, we have not found evidence that women are pressurising clinicians to undertake more scans. So, more work

needs to be done within the service and the professions to really understand the reasons for this.

[45] **Ms Body:** One of the things about the level of information women get when they are pregnant is that it is not only about making informed choices about their labour, but about having realistic expectations of the maternity services. That is a relevant point here, because it is not realistic to expect to have a scan every time you have a check-up. You will have a scan when it is appropriate for your care.

[46] **Jenny Randerson:** To follow on immediately from that, I am thinking about targets. Targets on the numbers of mothers breastfeeding, the amount of information given out and so on would perhaps be appropriate, but targets on the number of home births and the number of caesareans are really a matter for National Institute for Health and Clinical Excellence guidelines and for a strategy that encourages good practice. Perhaps they should not be specific, Government-administered NHS targets. Would you agree with that?

[47] **Ms Davies:** Absolutely. All the elements that we have discussed have to be taken into consideration, including the development of the common data set. Linked to that, there needs to be consideration of intelligent targets and it needs to be decided what the professions will portray as key areas of performance. There should be some caution in identifying targets where clinicians are practising in a way that is perhaps not appropriate for every individual, as it should be based on individual needs. So, there has to be really careful consideration of the development of those targets.

[48] **Jenny Randerson:** I have another question, which is totally different from the last. You said at the beginning that a third of all births in Wales take place in the area of two trusts. I tracked through those two, namely Cardiff and Gwent, and found that, although there is variation from one to the other, there is a pattern of relatively low performance across them. Probably the most significant diagram in your report is the one that shows the shortage of midwives. Cardiff and Gwent top the league for the shortage of midwives, if I may put it that way. First, overall, your report is much more worrying that it possibly first appears, because, when you compare the different trusts in Wales, you see that a third of all children born in Wales, namely those born in those two trust areas, are getting a far from perfect service in many respects. Secondly, do you think that the poor performance of those two trusts stems largely from the shortage of midwives? I must add a caveat though, as I noticed that, although Gwent had nowhere near enough midwives, it had very good training in place for them. Do you think that the shortage of staff is a key issue in those trusts for a third of the children born in Wales?

[49] **Ms Davies:** I think that the shortage of staff must feature as a key factor, but, in the responses from the women, there were also positive comments about the Cardiff and Vale NHS Trust and Gwent Healthcare NHS Trust, so I would not like it to be perceived that the experience is always negative in those trusts. Many of the mothers who responded to the survey wrote in the free text section that the midwives did their best under difficult circumstances. So, staffing levels are a key factor, but if you look across all the indicators, many of which are not even included in the report, you will find that there are areas of good performance in both those trusts. So, we have not found any failing trusts. We would not say that the Cardiff and Vale or Gwent trusts are failing. We found deficiencies in all trusts across Wales, but it is good to see that both those trusts are addressing the staffing shortfalls. They have already contacted me to say that they are interested in undertaking a further survey of women, because they really want to address any deficiencies in their services.

[50] **Huw Lewis:** Like Jenny, I am very concerned about your report and, in many ways, I think that, through no fault of the Wales Audit Office, the way in which the information is presented to some extent masks a problem that is worse than the headline figures suggest.

9.50 a.m.

[51] I want to concentrate first on the headline perception of what women feel about the totality of their care. We have a comparison here between the average of Welsh trusts and the average of English trusts. I am always suspicious of comparisons with England, given that the asymmetry of the numbers is so enormous. I am much more interested in the breakdown of women's perceptions within Wales trust by trust. As far as I can see, we have not been presented with that information on their perception of care. I would very much like to see that, because you are talking of one in three women coming out of that experience, particularly in postnatal terms, dissatisfied. One in three Welsh women comes out at the end unhappy with the birth experience. That in itself is completely unacceptable. One in three women is unhappy with the feeding advice that she receives. After all the efforts of the Assembly Government to promote breastfeeding in particular, we still have a third of women, and therefore a third of babies, not benefiting.

[52] One nugget of information in the report that particularly worried me, because it is broken down partly by trust in Wales, relates to the readmission rates for babies with dehydration and jaundice. To my mind, with my limited experience, in a sense, those are key indicators of something going wrong in postnatal care. There must have been premature discharges from hospital in those cases, and so an insufficient degree of care taken over whether a mother and child should be discharged at that point. One trust, which is unnamed in the report, is one of the worst three trusts in the whole of England and Wales for such readmissions. One in three kids is being readmitted to hospital after going through the maternity service in that trust. I want to know which trust that is, although it is not named in the report. It is really worrying that something has gone wrong to such an extent that these babies have potentially life-threatening problems, because that is what dehydration and jaundice are, even though people do not regard them as such. It is really worrying that a third of kids are immediately hoicked back into hospital because the postnatal care that they received in hospital was nowhere near up to scratch.

[53] In a second Welsh trust, a quarter of babies are taken back in and readmitted because of dehydration and jaundice. I am sure that that is not unconnected to the quality of advice on feeding, particularly the dehydration figures. So, if the committee agrees, I would like to see a trust-by-trust breakdown of women's perceptions. That would give us a much clearer idea. At the end of the day, no-one understands the quality of care better than the women who received it. We need more detail on the postnatal aspect of this. It is an all-Wales issue. A third of women are unhappy with feeding advice, and there are quite extraordinary levels of readmissions in two trusts. We need to get to the bottom of that in particular.

[54] **Ms Davies:** I am very familiar with the trust that comes out as the second highest in England and Wales in respect of levels of readmission, and I work very closely with it. That is a difficult indicator, because, with regard to the robustness of the data, there are issues and problems with the coding of readmissions and the patient episode database for Wales data. We found that many trusts are coding readmissions incorrectly, so we have to question how accurate these data are. However, for that trust, the data are accurate. One reason why—

[55] **Huw Lewis:** Which trust was that?

[56] **Ms Davies:** It was Swansea NHS Trust.

[57] **Huw Lewis:** That was the second worst.

[58] **Ms Davies:** No, Swansea NHS Trust is the worst in Wales, and North East Wales NHS Trust is the second worst. There were a number of factors relating to Swansea. There

was a policy directive from the paediatricians, which identified a very low threshold for readmission. There had been a lot of debate between the obstetricians and the paediatricians about the threshold, so many babies were coming back in. The obstetricians felt that they did not need to be readmitted, but the paediatricians felt that they did. I understand that that policy has since been changed. However, it has recognised that that area of work needed to be identified in the action plan. Interestingly, Swansea was one of the better trusts on the initiation of breastfeeding and there were quite good comments from mothers about breastfeeding. So, it is a difficult area to pick out and it is difficult to tease out the problems.

[59] Each of the local reports lists the detail on performance, and individual auditors have worked with them to identify areas that they need to improve and to identify action plans. However, we have the detail behind each of the phases and the satisfaction levels. I am sure that we could provide that information.

[60] **Huw Lewis:** I would like to see that and I am sure that other members of the committee would, too.

[61] **Lorraine Barrett:** I do not want to take up any more time, but I would like to make a tiny point that follows on from Huw's point. The report says that you can question problems with the health assessments received before discharge, which can relate to the high incidence of readmissions. When you say 'health assessments', should that also include health and social care or social services assessments? What percentage of those readmissions comes from families that need some extra support on the social care or social services side, such as with parenting skills? It may be a case of poor parenting or a poor awareness of how to look after a baby when you get home as opposed to just poor health. That support is not there. Could the audit office follow that up a bit? It is not just health; it is the social side as well.

[62] **Ms Davies:** We looked specifically at the health service, but I take your point on board.

[63] **Nick Ramsay:** I want to return to something that was raised by Huw Lewis in his question on a more detailed breakdown of information. You came back to the problem of the information that is collated, and we come back to this point frequently on this committee. Are there barriers to providing a detailed breakdown across each area of the sort that Huw wanted? Would you be unable to provide that regardless of the amount of work that went in?

[64] **Ms Davies:** We can provide the information that we have gathered on women's perception. That is clear cut, and we have data on that. On the data sets, until the Assembly Government completes its exercise in making the common data sets available and the collection of them far more robust, we have to question the validity of some of the data within maternity services. So, there is some urgency in taking that forward to have the right information available to inform maternity services, to help them when they are planning improvements.

[65] **Janet Ryder:** Can you track information about women who have to be moved to another hospital by trust? If so, is there a correlation? Can you identify areas where women are transferred more often? Are they being transferred to England?

[66] **Ms Davies:** Are you just talking about neonatal services?

[67] **Janet Ryder:** Yes. It would probably correlate to the number of specialist baby units. It may well touch on the number of cases in which women may also be facing a difficult birth and may have to be moved.

[68] **Ms Davies:** The neonatal element was a very small part of this review. We just

wanted to look at the impact. Far more detailed reviews in Wales have looked at the services, which, I believe, can track the patterns of transfers for those babies. We asked whether there was any point at which maternity services were closed to external admissions and whether there was any point at which they were closed to their own admissions. We did not go into much more detail than that.

[69] **Janet Ryder:** Were the same trusts repeatedly closed?

[70] **Ms Davies:** A number of trusts had higher levels of closures. However, we found that mothers were being moved right across Wales, so it was just not possible to understand the pattern of transfers across Wales in light of the capacity that was available.

[71] **Janet Ryder:** Were the closures all due to capacity? Were they full to capacity?

[72] **Ms Davies:** It was due to staffing and cots.

10.00 a.m.

[73] **Janet Ryder:** Okay; thank you.

[74] **Nick Ramsay:** I welcome the Auditor General for Wales, who has just arrived. I am sorry to hear about your earlier cycling problems, but I am glad that you could make it. Gillian Body and Tracey Davies have given us a thorough briefing. Would you like to add anything, auditor general?

[75] **Mr Colman:** No; I will leave it to my colleagues.

[76] **Nick Ramsay:** Thank you for what has been said about the report; there is much in it for us to consider. I throw this open to committee members now to comment on where we go from here. There are many options open to us. I assume that, given some concerns that have been raised in the report, Members would like to look into those further. We can write to the relevant accounting officer, Paul Williams, and ask him if he would like to come before the committee. Another option open to the committee would be to refer this report to the Health, Wellbeing and Local Government Committee. I have a letter from its Chair, Darren Millar, in which he says that that committee would be happy to include this in its forward work programme. So, how would you all like to proceed?

[77] **Lorraine Barrett:** As a member of the Health, Wellbeing and Local Government Committee, I am aware that there is much in this report that is relevant to that committee. However, it depends on the timescale. Some things are pertinent to the Audit Committee and we have discussed the fact that we must be careful not to step on the toes of subject committees. Some brief work should, perhaps, be done on this to work out what is relevant to this committee, without delving into the whole issue, which should rightly sit with the Health, Wellbeing and Local Government Committee. Do you see what I am getting at? I think that a few issues in this report are specific to the Audit Committee, on which we could do some work relatively soon. I do not know what our workload is, but perhaps we should look to see what bits we could consider fairly quickly here and leave the rest, and then bring it all back for discussion. This is a huge issue that, as far as I am aware, has never been considered; I cannot remember it being considered by the Assembly.

[78] **Nick Ramsay:** The Health, Wellbeing and Local Government Committee is happy to take this on, but there are specific issues that the Audit Committee has teased out, which I understand that Members would like to consider further. Are there any other comments?

[79] **Jenny Randerson:** I think that the Audit Committee should consider the data and

general approach; there are some major clinical issues in this report for the Health, Wellbeing and Local Government Committee to consider.

[80] **Nick Ramsay:** I suggest that we write to the accounting officer as an initial way forward, so that we can get a bit more detail from him. Based on what we get from that, we can then consider whether we wish to undertake a more detailed piece of work on this at a future meeting. Would that be okay with Members? I see that it would.

[81] I thank Gillian and Tracey for their contributions. You can see, from the interest of Members, how concerned we are about this.

10.04 a.m.

Cynyddu Gweithgarwch Corfforol: Y Wybodaeth Ddiweddaraf gan Lywodraeth Cynulliad Cymru
Increasing Physical Activity: Welsh Assembly Government Update

[82] **Nick Ramsay:** The committee published a report on increasing physical activity on 31 July 2008, which was critical of the lack of progress on this policy. We called for an update after a year and here it is. Auditor general, would you like to comment on this?

[83] **Mr Colman:** I will first apologise for my late arrival. I achieved no fewer than three punctures on one journey, which is quite remarkable given that there are only two wheels on the bike.

[84] This is an update after a year. Some committee members, who were present for the original hearing, may recall that, because of the intervening election, that hearing took place a full year after we had published our report. Our report, therefore, was published two years ago and reported disappointing progress on a policy that was announced as long ago as 2004. The Assembly Government's response appears to be very positive. I ask the committee to bear that timetable in mind. An action plan exists, but it has not been finalised. It is out for consultation, in relation to a policy that was announced four and a half years ago. Progress has certainly been slow. Nevertheless, I think that the Assembly Government's response shows that it is now taking this policy much more seriously and it has put it under the charge of the Chief Medical Officer for Wales, as the senior official to drive it forward. That is clearly an improvement and is in line with the recommendations in my report.

[85] The update on recommendation 2 shows that the main focus of activity is on the sedentary population. That is a policy choice and I cannot comment on the wisdom, or otherwise, of it. I do wish to point out two factors in focusing on the sedentary population. The first is that that is the group in which the health gains could be greatest but, on the other hand, it is the group that presents the greatest challenge. The Assembly Government is seeking a high gain by taking on a difficult task. My report, the evidence session and the committee's report reflected the fact that driving up levels of physical activity requires a co-ordinated effort across the public sector. The current economic circumstances and the prospective position for public finances over the coming years must leave questions in one's mind as to how much effort will go into this in the future.

[86] **Nick Ramsay:** Thank you, auditor general. It sounded as though you have some positive things to say about the progress that has been made. I suppose that the question is whether this is adequate. Are we happy with this update? Do we think that sufficient progress is being made? Do Members have any views on the report? I see that they do not. I therefore think that, at this stage, we would be happy with what we have seen so far.

[87] **Mr Colman:** We will, of course, keep our eye on what follows and report back to the

committee as necessary.

[88] **Nick Ramsay:** Thank you. We will therefore have a watching brief on that.

10.08 a.m.

Y Gyfarwyddeb Oriau Gwaith Ewropeaidd: Ymateb y Swyddog Cyfrifyddu i Lythyr gan y Cadeirydd
European Working Time Directive: Accounting Officer Response to Letter from Chair

[89] **Nick Ramsay:** We have the accounting officer's response to the letter from the previous Chair, David Melding. This is another report arising from our new way of working. After a briefing from the auditor general, we wrote to the accounting officer. You have seen his response. Do Members have any comments on that response? Auditor general, would you like to make some comments?

[90] **Mr Colman:** I think that the response is reasonably positive, but, at this point, the interesting question is what the position will be in August. I have one suggestion, which is that, possibly, the committee might ask the accounting officer for a report in September on what was actually achieved and whether or not the target was met.

[91] **Nick Ramsay:** In September?

[92] **Mr Colman:** Yes, in September.

[93] **Nick Ramsay:** I am happy to follow that up, if Members are in agreement. I see that they are.

10.09 a.m.

Cydweithio rhwng Sefydliadau Addysg Uwch: Ymateb Llywodraeth Cynulliad Cymru
Collaboration between Higher Education Institutions: Welsh Assembly Government response

[94] **Nick Ramsay:** Auditor general, do you have anything to say on the Welsh Assembly Government's response on the collaboration between higher education institutions?

[95] **Mr Colman:** This is a positive response. I certainly would not recommend the committee taking any action. There has been a recent announcement of a merger in the Heads of the Valleys area. My suggestion is that my staff should keep a watching brief on this and report back as necessary.

[96] **Nick Ramsay:** The Government has accepted all the recommendations that were made.

[97] **Mr Colman:** Indeed.

[98] **Nick Ramsay:** Would Members like to ask any questions on that? Everyone looks happy. Thank you.

10.10 a.m.

Cynnig Trefniadol
Procedural Motion

[99] **Nick Ramsay:** At this point, we will bring the public part of the meeting to an end.

[100] I move that

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order No. 10.37(vi).

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

Derbyniwyd y cynnig.
Motion agreed.

Daeth y cyfarfod i ben am 10.10 a.m.
The meeting ended at 10.10 a.m.