Health and Social Care Committee

Meeting Venue:
Committee Room 1 - Senedd

Meeting date:
16 January 2014

Meeting time:
09:15

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

For further information please contact:

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Agenda

Private session

1 Introductions, apologies and substitutions

2 Follow-up to the general scrutiny session with the Chief Dental Officer (Dec 2013) (09:15 - 09:30) (Pages 1 - 8)

3 Inquiry into the work of Healthcare Inspectorate Wales - consideration of key issues (09:30 - 10:10) (Pages 9 - 21)

4 Initial discussion of the Committee's strategic plan for the remainder of the 4th Assembly (10:10 - 10:50) (Pages 22 - 44)

(Break 10:50 - 11:00)

5 Inquiry into access to medical technologies in Wales - introductory briefing from the expert adviser (11:00 - 12:00) (Pages 45 - 64)

Dr Alex Faulkner, expert adviser for the inquiry

(Lunch 12:00 - 13:00)

Public session

6 Legislative Consent Memorandum: Children and Families Bill - General scrutiny session with the Minister for Health and Social Services (13:00 - 13:30) (Pages 65 - 75)

Mark Drakeford AM, Minister for Health and Social Services

7 Papers to note (Pages 76 - 115)

Letter from the Chair of CELG Committee, directed to the Minister for Local Government and Government Business, relating to the Public Services Ombudsman for Wales (Pages 116 - 120)

Letter from the Chair of the Petitions Committee in relation to a petition regarding the cancellation of orthopaedic surgery during the winter months in Hywel Dda Local Health Board (Pages 121 - 122)

Letter from the Minister for Health and Social Services regarding the review of Continuing NHS Healthcare (CHC) Framework (Pages 123 - 151)

Letter from the Chair of the Public Accounts Committee regarding maternity services in Wales (Pages 152 - 202)

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To: Health and Social Care Committee

From: Policy and Legislation Committee Service

Meeting date: 16 January 2014

SUPPLEMENTARY LEGISLATIVE CONSENT MEMORANDUM FOR THE CHILDREN AND FAMILIES BILL: REGULATION OF TOBACCO PACKAGING AND PRODUCTS, AND THE CREATION OF ASSOCIATED OFFENCES

Purpose

1. To invite the Committee to consider the supplementary legislative consent memorandum (LCM) on the Children and Families Bill which relates to the regulation of retail packaging of tobacco products, the regulation of tobacco products themselves and the creation of associated offenses.

Background

2. This supplementary LCM for the Children and Families Bill was laid before the Assembly on 17 December 2013. Given that the Bill has reached its final stages in the UK Parliament, it is anticipated that the Welsh Government will table a motion seeking the Assembly's legislative consent shortly.

3. In light of the tight timescales associated with this supplementary LCM, prior to the Christmas recess, the Minister for Health and Social Services indicated his willingness to attend the Committee's first meeting in January to answer Members' questions. The Committee agreed that this session should take place in order to help inform Members about the supplementary LCM in advance of the relevant Plenary debate.

The supplementary LCM

4. The supplementary LCM is attached at Annex A to this paper. The amendment to which the supplementary LCM relates is attached at Annex B.

5. Legal Services have reviewed the supplementary LCM and have no points to raise in addition to those covered in the memorandum, save that the regulation-making power will be subject to the affirmative procedure at Westminster.

Action

6. The Committee is invited to question the Minister on the LCM and explore any issues Members wish to clarify in advance of the relevant Plenary debate.

SUPPLEMENTARY LEGISLATIVE CONSENT MEMORANDUM

CHILDREN AND FAMILIES BILL: AMENDMENT IN RELATION TO THE REGULATION OF RETAIL PACKAGING OF TOBACCO PRODUCTS, THE REGULATION OF TOBACCO PRODUCTS THEMSELVES AND THE CREATION OF ASSOCIATED OFFENCES

1. This supplementary Legislative Consent Memorandum is laid under Standing Order (SO) 29.2. SO29 prescribes that a Legislative Consent Memorandum must be laid, and a Legislative Consent Motion may be tabled, before the National Assembly for Wales if a UK Parliamentary Bill makes provision in relation to Wales for a purpose that falls within, or modifies the legislative competence of the National Assembly.

2. The Children and Families Bill (the "Bill") was introduced in the House of Commons on 4 February 2013. The Bill can be found at: http://services.parliament.uk/bills/2012-13/childrenandfamilies.html

Summary of the Bill and its Policy Objectives

3. The Bill is sponsored by the Department for Education (DfE) to make legislative changes to reform support to children and families. The first half of the Bill seeks to improve services for children and young people by reforming the systems for adoption, Looked after Children, family justice and Special Education Needs. The second half seeks to encourage growth in the childcare sector, shared parental leave and ensuring children in England have strong advocates for their rights.

4. The Bill includes provisions relating to;

   (a) Adoption - to deliver on reforms to: reduce delays in the adoption system; widen the use of 'Fostering for Adoption'; improve the support available to adopters and the arrangements for the recruitment and assessment of prospective adopters and to make the Adoption and Children Act Register a statutory register in its application to England.

   (b) Reform of the family justice system in England and Wales[1] to tackle delays in public law cases;

   - by implementing a 26 week time-limit for care and supervision cases; reduce the excessive use of experts' reports; remove unnecessary duplication; and ensure the impact of the child is considered when timetabling decisions are made, and

[1] FJR review of the family justice system for England and Wales and written statement http://wales.gov.uk/topics/childrenyoungpeople/parenting/help/justice/;jsessionid=F5E2D1B1C006F79F4176E6D249D006D4?lang=en http://wales.gov.uk/about/cabinet/cabinetstatements/2012/familyjusticereviewupdate/?lang=en ,

- in private family law - by requiring parents to attend a family mediation and assessment meeting before applying to court; send a clear signal to separated parents that courts will take account of the principle that both should continue to be actively involved in their children's lives where that is safe and consistent with the child's welfare; and introduce a new "child arrangements order" so that the courts can make full use of powers to direct parents to undertake activities aimed at helping them to make child arrangements work; and streamline divorce processes for the courts.

(c) To reform the Special Educational Needs (SEN) system in England to; improve support for 16-25 year olds, offer a personal budget to children and families, require better collaboration between services; clearer information about the support available; streamline assessment processes and plans.

(d) Childcare including to increase flexibilities for childminders by the introduction of childminder agencies.

(e) Looked after children: to require every local authority in England to designate an officer to act as its 'Virtual School Head' (VSH) for the children it looks after; clarify the right to an assessment for support for young carers; and enable the Secretary of State to bring forward new regulations with the aim of raising standards in children's homes.

(f) Office of the Children's Commissioner for England – to enhance the commissioner powers in promoting and protecting children's rights and greater independence from UK Government. The changes will apply to the Commissioner's role in promoting and protecting the rights of children in the devolved administrations, but only in relation to non-devolved matters.

(g) Shared Parental Leave and Flexible Working; to introduce a system for shared parental leave and shared statutory parental pay as well as reform the system that gives individuals the right to request flexible working.

Provisions in the Bill for which consent is sought

5. The consent of the Assembly is sought to the amendment, tabled on 16 December 2013, which will give the Secretary of State enabling powers to make, regulations to (1) regulate the retail packaging of tobacco products; (2) regulate the markings on and appearance of tobacco products; and (3) create associated offences. Provided consent to the amendment is given by the relevant legislatures, these Regulations would apply to Wales, Scotland and Northern Ireland as well as England.

6. "Tobacco product" is defined as a product consisting wholly or partly of tobacco and intended to be smoked, sniffed, sucked or chewed. "Retail

packaging" in relation to a tobacco product means the packaging in which it is, or is intended to be, presented for retail sale. "Retail sale" means sale otherwise than to a person who is acting in the course of a business which is part of the tobacco trade.

7. The Secretary of State may make regulations if he considers that the regulations may contribute at any time to reducing the risk of harm to, or promoting, the health or welfare of people under the age of 18. The Secretary of State may also consider whether the regulations may contribute at any time to reducing the risk of harm to, or promoting, the health or welfare of people aged 18 or over.

8. The overall effect of the proposed provision is to give the Secretary of State the power to make regulations:

   (a) about the retail packaging of tobacco products. In particular regulations may impose prohibitions, requirements or limitations relating to: the markings on the retail packaging of tobacco products (including the use of branding, trademarks or logos); the appearance of and materials used for such packaging; the size, texture and shape of such packaging; the means by which such packaging is opened; the materials attached to or included with tobacco products; any other features which could be used to distinguish between tobacco products; the number of individual tobacco products contained in an individual packet and the quantity of a tobacco product contained in an individual packet;

   (b) that make provision imposing prohibitions, requirements or limitations relating to the markings on tobacco products (including the use of branding trademarks or logos); the size, appearance, flavour and shape of such products and any other feature of tobacco products which could be used to distinguish between different brands of tobacco product;

   (c) to create offences which may be committed by persons who produce or supply tobacco products or the retail packaging for tobacco products which breach the prohibitions, requirements or limitations set out in the regulations;

   (d) that amend, repeal or revoke or otherwise modify any provision made by or under any enactment in order to give effect to regulations containing provisions set out in (a), (b) or (c) above.

9. The amendment also provides that the Secretary of State must obtain the consent of the Welsh Ministers before making regulations which contain provisions which (if contained in an Act of the National Assembly for Wales) would be within the legislative competence of the Assembly. The amendment contains identical provisions in relation to Scotland and Northern Ireland.

10. The amendment to the Bill extends to the whole of the United Kingdom.

11. It is the view of the Welsh Government that these provisions fall within the legislative competence of the National Assembly for Wales in so far as they relate to the regulation of retail packaging of tobacco products; regulation of tobacco products and the creation of associated offences – subjects which fall under the health and health services and social welfare headings in Part 1 of Schedule 7 to the Government of Wales Act 2006.

Advantages of utilising this Bill rather than Assembly legislation

12. It is the view of the Welsh Government that it is appropriate to deal with these provisions in this UK Bill as it represents the most practicable and proportionate legislative vehicle to enable these provisions to apply in relation to Wales.

13. The proposed amendment would enable the Secretary of State to make regulations which apply to the whole of the UK. There are, in the view of the Welsh Government, clear advantages to such an approach:

(a) regulations regulating the retail packaging of tobacco products and the appearance of tobacco products themselves would come into force across the whole of the UK at the same time. This will minimise opportunities for consumers to seek to purchase tobacco products in conventionally branded packages;

(b) there would be no differentiation in the requirements for retail packaging of tobacco products nor the appearance of tobacco products themselves across the UK. This would minimise any burdens upon businesses and aid enforcement of the new requirements as there would be no cross-border issues. It would also be consistent for consumers of tobacco products;

(c) it is considered that the public health message will be more clearly communicated by a consistent strategy relating to the retail packaging of tobacco products across the whole of the UK as well as reflecting the importance that each of the administrations place in this area of public health.

Financial implications

14. There are no anticipated direct financial implications for the Welsh Government.

Mark Drakeford AM
Minister for Health and Social Services
December 2013

Annexe B – Amendment to the Children and Families Bill

Before Clause 80

LORD NASH

57B* Insert the following new Clause—

"Regulation of retail packaging etc of tobacco products

(1) The Secretary of State may make regulations under subsection (6) or (8) if the Secretary of State considers that the regulations may contribute at any time to reducing the risk of harm to, or promoting, the health or welfare of people under the age of 18.

(2) Subsection (1) does not prevent the Secretary of State, in making regulations under subsection (6) or (8), from considering whether the regulations may contribute at any time to reducing the risk of harm to, or promoting, the health or welfare of people aged 18 or over.

(3) The Secretary of State may treat regulations under subsection (6) or (8) as capable of contributing to reducing the risk of harm to, or promoting, the health or welfare of people under the age of 18 if the Secretary of State considers that—

(a) at least some of the provisions of the regulations are capable of having that effect, or

(b) the regulations are capable of having that effect when taken together with other regulations that were previously made under subsection (6) or (8) and are in force.

(4) Regulations under subsection (6) or (8) are to be treated for the purposes of subsection (1) or (2) as capable of contributing to reducing the risk of harm to, or promoting, people's health or welfare if (for example) they may contribute to any of the following—

(a) discouraging people from starting to use tobacco products;

(b) encouraging people to give up using tobacco products;

(c) helping people who have given up, or are trying to give up, using tobacco products not to start using them again;

(d) reducing the appeal or attractiveness of tobacco products;

(e) reducing the potential for elements of the packaging of tobacco products other than health warnings to detract from the effectiveness of those warnings;

(f) reducing opportunities for the packaging of tobacco products to mislead consumers about the effects of using them;

(g) reducing opportunities for the packaging of tobacco products to create false perceptions about the nature of such products;

(h) having an effect on attitudes, beliefs, intentions and behaviours relating to the reduction in use of tobacco products.

(5) Regulations under subsection (6) or (8) are to be treated for the purposes of subsection (1) as capable of contributing to reducing the risk of harm to, or promoting, the health or welfare of people under the age of 18 if—

(a) they may contribute to reducing activities by such people which risk harming their health or welfare after they reach the age of 18, or

(b) they may benefit such people by reducing the use of tobacco products among people aged 18 or over.

(6) The Secretary of State may by regulations make provision about the retail packaging of tobacco products.

(7) Regulations under subsection (6) may in particular impose prohibitions, requirements or limitations relating to—

(a) the markings on the retail packaging of tobacco products (including the use of branding, trademarks or logos);

(b) the appearance of such packaging;

(c) the materials used for such packaging;

(d) the texture of such packaging;

(e) the size of such packaging;

(f) the shape of such packaging;

(g) the means by which such packaging is opened;

(h) any other features of the retail packaging of tobacco products which could be used to distinguish between different brands of tobacco product;

(i) the number of individual tobacco products contained in an individual packet;

(j) the quantity of a tobacco product contained in an individual packet.

(8) The Secretary of State may by regulations make provision imposing prohibitions, requirements or limitations relating to—

(a) the markings on tobacco products (including the use of branding, trademarks or logos);

(b) the appearance of such products;

(c) the size of such products;

(d) the shape of such products;

(e) the flavour of such products;

(f) any other features of tobacco products which could be used to distinguish between different brands of tobacco product.

(9) The Secretary of State may by regulations—

(a) create offences which may be committed by persons who produce or supply tobacco products the retail packaging of which breaches prohibitions, requirements or limitations imposed by regulations under subsection (6);

(b) create offences which may be committed by persons who produce or supply tobacco products which breach prohibitions, requirements or limitations imposed by regulations under subsection (8);

(c) provide for exceptions and defences to such offences;

(d) make provision about the liability of others to be convicted of such offences if committed by a body corporate or a Scottish partnership.

(10) The Secretary of State may by regulations provide that regulations under subsection (6) or (8) are to be treated for the purposes specified in regulations under this subsection as safety regulations within the meaning of the Consumer Protection Act 1987.

(11) The Secretary of State may by regulations make provision amending, repealing, revoking or otherwise modifying any provision made by or under an enactment (whenever passed or made) in connection with provision made by regulations under any of subsections (6), (8), (9) or (10).

(12) The Secretary of State must—

(a) obtain the consent of the Scottish Ministers before making regulations under any of subsections (6), (8), (9) or (10) containing provision which would (if contained in an Act of the Scottish Parliament) be within the legislative competence of that Parliament;

(b) obtain the consent of the Welsh Ministers before making regulations under any of those subsections containing provision which would (if contained in an Act of the National Assembly for Wales) be within the legislative competence of that Assembly;

(c) obtain the consent of the Department of Health, Social Services and Public Safety before making regulations under any of those subsections containing provision which would (if contained in an Act of the Northern Ireland Assembly) be within the legislative competence of that Assembly.

(13) For the purposes of this section a person produces a tobacco product if, in the course of a business and with a view to the product being supplied for consumption in the United Kingdom or through the travel retail sector, the person—

(a) manufactures the product,

(b) puts a name, trademark or other distinguishing mark on it by which the person is held out to be its manufacturer or originator, or

(c) imports it into the United Kingdom.

(14) For the purposes of this section a person supplies a tobacco product if in the course of a business the person—

(a) supplies the product,

(b) offers or agrees to supply it, or

(c) exposes or possesses it for supply.

(15) In this section—

"enactment" includes—

(a) an Act of the Scottish Parliament,

(b) a Measure or Act of the National Assembly for Wales, or

(c) Northern Ireland legislation;

"external packaging", "internal packaging" and "wrapper" have the meanings given by regulations under subsection (6);

"packaging", in relation to a tobacco product, means—

(a) the external packaging of that product,

(b) any internal packaging of that product,

(c) any wrapper of that product, or

(d) any other material attached to or included with that product or anything within paragraphs (a) to (c);

"retail packaging", in relation to a tobacco product, means the packaging in which it is, or is intended to be, presented for retail sale;

"retail sale" means sale otherwise than to a person who is acting in the course of a business which is part of the tobacco trade;

"tobacco product" means a product consisting wholly or partly of tobacco and intended to be smoked, sniffed, sucked or chewed;

“travel retail sector” means retail outlets in the United Kingdom at which tobacco products may be purchased only by people travelling on journeys to destinations outside the United Kingdom.”

Agenda Item 7

Health and Social Care Committee

Meeting Venue:	Committee Room 3 – Senedd
Meeting date:	Thursday, 5 December 2013
Meeting time:	09:16 – 15:25

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

This meeting can be viewed on Senedd TV at:
http://www.senedd.tv/archiveplayer.jsf?v=en_400000_05_12_2013&t=0&l=en
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Concise Minutes:

Assembly Members:	David Rees (Chair) Leighton Andrews Rebecca Evans William Graham Elin Jones Darren Millar Lynne Neagle Gwyn R Price Lindsay Whittle Kirsty Williams
Witnesses:	Gwenda Thomas, Deputy Minister for Social Services Julie Rogers, Welsh Government Mike Lubienski, Welsh Government
Committee Staff:	Llinos Madeley (Clerk) Helen Finlayson (Second Clerk) Joanest Jackson (Legal Advisor)

TRANSCRIPT
View the meeting transcript.

1 Introductions, apologies and substitutions

1.1 No apologies were received.

1.2 The Chair welcomed the Deputy Minister for Social Services and her officials to the meeting.

2 Social Services and Well-being (Wales) Bill: Stage 2 - Consideration of amendments

2.1 In accordance with Standing Order 26.21, the Committee disposed of the following amendments to the Bill:

Section 43:

Amendment 293 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 414 (Lindsay Whittle)

For	Against	Abstain
William Graham Elin Jones Darren Millar Lindsay Whittle Kirsty Williams	Leighton Andrews Rebecca Evans Lynne Neagle Gwyn Price David Rees	
5	5	0
As there was a tied vote, the Chair's casting vote was applied in the negative, in accordance with Standing Order 6.20(ii). Therefore, Amendment 414 was not agreed.		

Section 44:

Amendment 431 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 98 (William Graham)

For	Against	Abstain
William Graham Elin Jones Darren Millar Lindsay Whittle Kirsty Williams	Leighton Andrews Rebecca Evans Lynne Neagle Gwyn Price David Rees	
5	5	0
As there was a tied vote, the Chair's casting vote was applied in the negative, in accordance with Standing Order 6.20(ii). Therefore, Amendment 98 was not agreed.		

Amendment 102 (Kirsty Williams) was not moved.

Amendment 103 (Kirsty Williams) was not moved.

New Section:

Amendment 254 (William Graham)

For	Against	Abstain
William Graham Elin Jones Darren Millar Lindsay Whittle Kirsty Williams	Leighton Andrews Rebecca Evans Lynne Neagle Gwyn Price David Rees	
5	5	0
As there was a tied vote, the Chair's casting vote was applied in the negative, in accordance with Standing Order 6.20(ii). Therefore, Amendment 254 was not agreed.		

Section 45:
No amendments were tabled to this section, therefore Section 45 was deemed agreed.

Section 46:
No amendments were tabled to this section, therefore Section 46 was deemed agreed.

Section 47:
No amendments were tabled to this section, therefore Section 47 was deemed agreed.

Section 48:
No amendments were tabled to this section, therefore Section 48 was deemed agreed.

Section 49:
No amendments were tabled to this section, therefore Section 49 was deemed agreed.

Section 50:
No amendments were tabled to this section, therefore Section 50 was deemed agreed.

Section 51:
No amendments were tabled to this section, therefore Section 51 was deemed agreed.

Section 52:
No amendments were tabled to this section, therefore Section 52 was deemed agreed.

Section 53:

Amendment 432 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 104 (Kirsty Williams) was not moved.

Amendment 105 (Kirsty Williams) As Amendment 104 was not moved, Amendment 105 fell.

Amendment 433 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 54:

Amendment 69 (William Graham)

For	Against	Abstain
William Graham Elin Jones Darren Millar Lindsay Whittle Kirsty Williams	Leighton Andrews Rebecca Evans Lynne Neagle Gwyn Price David Rees	
5	5	0
As there was a tied vote, the Chair's casting vote was applied in the negative, in accordance with Standing Order 6.20(ii). Therefore, Amendment 69 was not agreed.		

Amendment 78 (William Graham)

For	Against	Abstain
William Graham Elin Jones Darren Millar Lindsay Whittle Kirsty Williams	Leighton Andrews Rebecca Evans Lynne Neagle Gwyn Price David Rees	
5	5	0
As there was a tied vote, the Chair's casting vote was applied in the negative, in accordance with Standing Order 6.20(ii). Therefore, Amendment 78 was not agreed.		

Amendment 434 (Gwenda Thomas)

For	Against	Abstain
Leighton Andrews Rebecca Evans Lynne Neagle Gwyn Price David Rees Kirsty Williams	Elin Jones Lindsay Whittle	William Graham Darren Millar
6	2	2
Amendment 434 was agreed.		

Amendment 79A (Gwenda Thomas)

For	Against	Abstain
Leighton Andrews Rebecca Evans William Graham Darren Millar Lynne Neagle Gwyn Price David Rees Kirsty Williams	Elin Jones Lindsay Whittle	
8	2	0
Amendment 79A was agreed.		

Amendment 79 (William Graham) was agreed in accordance with Standing Order 17.34(i).

Amendment 80A (Gwenda Thomas)

For	Against	Abstain
Leighton Andrews Rebecca Evans William Graham Darren Millar Lynne Neagle Gwyn Price David Rees Kirsty Williams	Elin Jones Lindsay Whittle	
8	2	0
Amendment 80A was agreed.		

Amendment 80 (William Graham) was agreed in accordance with Standing Order 17.34(i).

Amendment 99 (William Graham) was not moved.

New Section:

Amendment 255 (William Graham)

For	Against	Abstain
William Graham Elin Jones Darren Millar Lindsay Whittle Kirsty Williams	Leighton Andrews Rebecca Evans Lynne Neagle Gwyn Price David Rees	
5	5	0
As there was a tied vote, the Chair's casting vote was applied in the negative, in accordance with Standing Order 6.20(ii). Therefore, Amendment 255 was not agreed.		

Section 55:

Amendment 106 (Kirsty Williams) was not moved.

Amendment 107 (Kirsty Williams) was not moved.

Section 56:
No amendments were tabled to this section, therefore Section 56 was deemed agreed.

Section 57:

Amendment 481 (Elin Jones) was withdrawn in accordance with Standing Order 26.66.

Section 58:

Amendment 294 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 295 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 296 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 59:

Amendment 517 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 60:

Amendment 246 (William Graham) was withdrawn in accordance with Standing Order 26.66.

Section 61:

Amendment 188 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 189 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 62:

Amendment 127 (William Graham)

For	Against	Abstain
William Graham Elin Jones Darren Millar Lindsay Whittle Kirsty Williams	Leighton Andrews Rebecca Evans Lynne Neagle Gwyn Price David Rees	
5	5	0
As there was a tied vote, the Chair's casting vote was applied in the negative, in accordance with Standing Order 6.20(ii). Therefore, Amendment 127 was not agreed.		

Amendment 518 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 435 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 519 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 482 (Elin Jones)

For	Against	Abstain
Elin Jones Lindsay Whittle Kirsty Williams	Leighton Andrews Rebecca Evans William Graham Darren Millar	

	Lynne Neagle Gwyn Price David Rees	
3	7	0
Amendment 482 was not agreed.		

Section 63:
No amendments were tabled to this section, therefore Section 63 was deemed agreed.

Section 64:
No amendments were tabled to this section, therefore Section 64 was deemed agreed.

Section 65:

Amendment 436 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 190 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 191 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 192 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 193 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 194 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 195 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 196 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 197 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 198 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 199 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 200 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 66:

Amendment 520 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 67:

Amendment 437 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 438 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 201 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 68:

Amendment 439 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 440 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 441 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 297 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 69:
No amendments were tabled to this section, therefore Section 69 was deemed agreed.

Schedule 1:

Amendment 532 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

For the purposes of voting, **Amendments 533, 551, 534, 535 and 552 (Gwenda Thomas)** were grouped and subject to a single vote, in accordance with Standing Order 17.36. The amendments were agreed in accordance with Standing Order 17.34(i).

Amendment 536 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 231 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 70:

Amendment 521 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 71:

No amendments were tabled to this section, therefore Section 71 was deemed agreed.

Section 72:
No amendments were tabled to this section, therefore Section 72 was deemed agreed.

Section 73:
No amendments were tabled to this section, therefore Section 73 was deemed agreed.

Section 74:
No amendments were tabled to this section, therefore Section 74 was deemed agreed.

Section 75:
No amendments were tabled to this section, therefore Section 75 was deemed agreed.

Section 76:

Amendment 202 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 203 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 538 (Elin Jones)

For	Against	Abstain
Elin Jones Lindsay Whittle Kirsty Williams	Leighton Andrews Rebecca Evans William Graham Darren Millar Lynne Neagle Gwyn Price David Rees	
3	7	0
Amendment 538 was not agreed.		

Amendment 204 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 205 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 77:

Amendment 143 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 442 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 144 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 145 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 146 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 78:
No amendments were tabled to this section, therefore Section 78 was deemed agreed.

Section 79:

Amendment 206 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 80:
No amendments were tabled to this section, therefore Section 80 was deemed agreed.

Section 81:

Amendment 207 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 82:

Amendment 443 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 83:
No amendments were tabled to this section, therefore Section 83 was deemed agreed.

Section 84:
No amendments were tabled to this section, therefore Section 84 was deemed agreed.

Section 85:
No amendments were tabled to this section, therefore Section 85 was deemed agreed.

Section 86:

Amendment 208 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 87:
No amendments were tabled to this section, therefore Section 87 was deemed agreed.

Section 88:

Amendment 298 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 299 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 300 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 301 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 302 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 303 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 304 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 306 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 305 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 307 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 308 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 309 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 310 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 209 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 311 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 312 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 313 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 314 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 315 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 316 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 317 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 318 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 89:

Amendment 319 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 320 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 321 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 90:

Amendment 322 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 323 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 324 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 91:

Amendment 325 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 326 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 327 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 328 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 329 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 330 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 331 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 332 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 333 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 334 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 92:

Amendment 335 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 336 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 93:

Amendment 337 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 338 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 339 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 340 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

New Section:

Amendment 341 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

New Section:

Amendment 342 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

New Section:

Amendment 343 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 94:

Amendment 344 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 345 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 346 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 347 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 348 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 349 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 350 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 351 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 352 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 353 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 354 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 355 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 356 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 357 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 358 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 359 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 360 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

New Section:

Amendment 361 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

New Section:

Amendment 362 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 95:

Amendment 363 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 364 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 365 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 366 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 210 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 96:

Amendment 367 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 368 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 369 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 370 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 371 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 372 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 373 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 374 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 375 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 97:

Amendment 376 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 377 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 378 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 98:

Amendment 211 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 379 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 99:

Amendment 212 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 380 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 100:
No amendments were tabled to this section, therefore Section 100 was deemed agreed.

Section 101:

Amendment 444 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 102:
No amendments were tabled to this section, therefore Section 102 was deemed agreed.

Section 103:
No amendments were tabled to this section, therefore Section 103 was deemed agreed.

Section 104:

Amendment 256 (William Graham)

For	Against	Abstain
William Graham Elin Jones Darren Millar Lindsay Whittle	Leighton Andrews Rebecca Evans Lynne Neagle Gwyn Price David Rees Kirsty Williams	
4	6	0
Amendment 256 was not agreed.		

Amendment 495 (Kirsty Williams)

For	Against	Abstain
William Graham Elin Jones Darren Millar	Leighton Andrews Rebecca Evans Lynne Neagle	

Lindsay Whittle Kirsty Williams	Gwyn Price David Rees	
5	5	0
As there was a tied vote, the Chair's casting vote was applied in the negative, in accordance with Standing Order 6.20(ii). Therefore, Amendment 495 was not agreed.		

Amendment 496 (Lindsay Whittle)

For	Against	Abstain
William Graham Elin Jones Darren Millar Lindsay Whittle Kirsty Williams	Leighton Andrews Rebecca Evans Lynne Neagle Gwyn Price David Rees	
5	5	0
As there was a tied vote, the Chair's casting vote was applied in the negative, in accordance with Standing Order 6.20(ii). Therefore, Amendment 496 was not agreed.		

Section 105:
No amendments were tabled to this section, therefore Section 105 was deemed agreed.

Section 106:

Amendment 39 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 40 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 41 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

New Section:

Amendment 257 (William Graham)

For	Against	Abstain
William Graham Darren Millar	Leighton Andrews Rebecca Evans Elin Jones Lynne Neagle Gwyn Price David Rees Lindsay Whittle Kirsty Williams	
2	8	0
Amendment 257 was not agreed.		

New Section:

Amendment 258 (William Graham) As Amendment 257 was not agreed, Amendment 258 fell.

New Section:

Amendment 259 (William Graham) As Amendment 257 was not agreed, Amendment 259 fell.

New Section:

Amendment 260 (William Graham) As Amendment 257 was not agreed, Amendment 260 fell.

New Section:

Amendment 261 (William Graham) As Amendment 257 was not agreed, Amendment 261 fell.

Section 107:
No amendments were tabled to this section, therefore Section 107 was deemed agreed.

Section 108:

Amendment 42 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 43 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 44 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 497 (Lindsay Whittle)

For	Against	Abstain
William Graham Elin Jones Darren Millar Lindsay Whittle Kirsty Williams	Leighton Andrews Rebecca Evans Lynne Neagle Gwyn Price David Rees	
5	5	0
As there was a tied vote, the Chair's casting vote was applied in the negative, in accordance with Standing Order 6.20(ii). Therefore, Amendment 497 was not agreed.		

New Section:

Amendment 45 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 109:

Amendment 445 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 110:
No amendments were tabled to this section, therefore Section 110 was deemed agreed.

Section 111:

Amendment 46 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 114 (William Graham)

For	Against	Abstain
William Graham Elin Jones Darren Millar Lindsay Whittle Kirsty Williams	Leighton Andrews Rebecca Evans Lynne Neagle Gwyn Price David Rees	
5	5	0
As there was a tied vote, the Chair's casting vote was applied in the negative, in accordance with Standing Order 6.20(ii). Therefore, Amendment 114 was not agreed.		

Section 112:

Amendment 262 (William Graham) was agreed in accordance with Standing Order 17.34(i).

Amendment 247 (William Graham)

For	Against	Abstain
William Graham Elin Jones Darren Millar Lindsay Whittle Kirsty Williams	Leighton Andrews Rebecca Evans Lynne Neagle Gwyn Price David Rees	
5	5	0
As there was a tied vote, the Chair's casting vote was applied in the negative, in accordance with Standing Order 6.20(ii). Therefore, Amendment 247 was not agreed.		

Section 113:
No amendments were tabled to this section, therefore Section 113 was deemed agreed.

Section 114:

Amendment 446 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 447 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 115:
No amendments were tabled to this section, therefore Section 115 was deemed agreed.

Section 116:
No amendments were tabled to this section, therefore Section 116 was deemed agreed.

Section 117:

Amendment 70 (William Graham)

For	Against	Abstain
William Graham Elin Jones Darren Millar Lindsay Whittle Kirsty Williams	Leighton Andrews Rebecca Evans Lynne Neagle Gwyn Price David Rees	
5	5	0
As there was a tied vote, the Chair's casting vote was applied in the negative, in accordance with Standing Order 6.20(ii). Therefore, Amendment 70 was not agreed.		

New Section:

Amendment 147 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 118:
No amendments were tabled to this section, therefore Section 118 was deemed agreed.

Section 119:
No amendments were tabled to this section, therefore Section 119 was deemed agreed.

Schedule 2:
No amendments were tabled to this Schedule, therefore Schedule 2 was deemed agreed.

Section 120:

Amendment 448 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 121:
No amendments were tabled to this section, therefore Section 121 was deemed agreed.

Section 122:
No amendments were tabled to this section, therefore Section 122 was deemed agreed.

Section 123:

Amendment 449 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 124:
No amendments were tabled to this section, therefore Section 124 was deemed agreed.

Section 125:

Amendment 450 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 451 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 126:
No amendments were tabled to this section, therefore Section 126 was deemed agreed.

Section 127:

Amendment 483A (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 483 as amended (Elin Jones) was agreed in accordance with Standing Order 17.34(i).

Section 128:

Amendment 484A (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 484 as amended (Elin Jones) was agreed in accordance with Standing Order 17.34(i).

Amendment 452 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 485A (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 485 as amended (Elin Jones) was agreed in accordance with Standing Order 17.34(i).

Section 129:

Amendment 453 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 130:

Amendment 454 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 381 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 131:

Amendment 382 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 132:

Amendment 455 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 133:

Amendment 456 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

New Section:

Amendment 486A (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 486B (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 486C (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 486 as amended (Elin Jones) was agreed in accordance with Standing Order 17.34(i).

Section 134:

Amendment 522 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 135:

Amendment 457 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 136:

Amendment 458 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 137:

Amendment 487 (Elin Jones) was withdrawn in accordance with Standing Order 26.66.

Amendment 539 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 540 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 541 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 542 (Gwenda Thomas)

For	Against	Abstain
Leighton Andrews Rebecca Evans Elin Jones Lynne Neagle Gwyn Price David Rees Lindsay Whittle Kirsty Williams	William Graham Darren Millar	
8	2	0
Amendment 542 was agreed.		

Amendment 250 (William Graham) As Amendment 542 was agreed, Amendment 250 fell.

Amendment 543 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 488 (Elin Jones) As Amendment 542 was agreed, Amendment 488 fell.

Amendment 524 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 138:

Amendment 460 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

For the purposes of voting, **Amendments 525, 526, 527, 528 and 529 (Gwenda Thomas)** were grouped and subject to a single vote, in accordance with Standing Order 17.36. The amendments were agreed in accordance with Standing Order 17.34(i).

Section 143:

Amendment 263 (William Graham)

For	Against	Abstain
William Graham Elin Jones Darren Millar Lindsay Whittle	Leighton Andrews Rebecca Evans Lynne Neagle Gwyn Price David Rees	

	Kirsty Williams	
4	6	0
Amendment 263 was not agreed.		

Amendment 461 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 264 (William Graham)

For	Against	Abstain
William Graham Elin Jones Darren Millar Lindsay Whittle	Leighton Andrews Rebecca Evans Lynne Neagle Gwyn Price David Rees Kirsty Williams	
4	6	0
Amendment 264 was not agreed.		

Amendment 265 (William Graham)

For	Against	Abstain
William Graham Elin Jones Darren Millar Lindsay Whittle	Leighton Andrews Rebecca Evans Lynne Neagle Gwyn Price David Rees Kirsty Williams	
4	6	0
Amendment 265 was not agreed.		

Amendment 266 (William Graham)

For	Against	Abstain
William Graham Elin Jones Darren Millar Lindsay Whittle	Leighton Andrews Rebecca Evans Lynne Neagle Gwyn Price David Rees Kirsty Williams	
4	6	0
Amendment 266 was not agreed.		

Amendment 544 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 462 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 463 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 545 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 546 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 547 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 267 (William Graham)

For	Against	Abstain
William Graham Elin Jones Darren Millar Lindsay Whittle	Leighton Andrews Rebecca Evans Lynne Neagle Gwyn Price David Rees Kirsty Williams	
4	6	0
Amendment 267 was not agreed.		

Section 144:

Amendment 464 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 465 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 47 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 48 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 548 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 49 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 549 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 148 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 145:

Amendment 268 (William Graham) was not moved.

Amendment 269 (William Graham) was not moved.

Amendment 270 (William Graham) was not moved.

Amendment 271 (William Graham) As Amendment 270 was not moved, Amendment 271 fell.

Amendment 550 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 272 (William Graham)

For	Against	Abstain
William Graham Elin Jones Darren Millar Lindsay Whittle	Leighton Andrews Rebecca Evans Lynne Neagle Gwyn Price David Rees Kirsty Williams	
4	6	0
Amendment 272 was not agreed.		

Amendment 273 (William Graham) was not moved.

Amendment 274 (William Graham) was not moved.

Amendment 50 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 51 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 146:

Amendment 415 (Lindsay Whittle)

For	Against	Abstain
William Graham Elin Jones Darren Millar Lindsay Whittle	Leighton Andrews Rebecca Evans Lynne Neagle Gwyn Price David Rees Kirsty Williams	
4	6	0
Amendment 415 was not agreed.		

Section 147:

Amendment 149 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 150 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 151 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 152 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 148:

Amendment 489 (Elin Jones)

For	Against	Abstain
William Graham Elin Jones Darren Millar Lindsay Whittle	Leighton Andrews Rebecca Evans Lynne Neagle Gwyn Price David Rees Kirsty Williams	
4	6	0
Amendment 489 was not agreed.		

Amendment 490 (Elin Jones)

For	Against	Abstain
William Graham Elin Jones Darren Millar Lindsay Whittle	Leighton Andrews Rebecca Evans Lynne Neagle Gwyn Price David Rees Kirsty Williams	
4	6	0
Amendment 490 was not agreed.		

Amendment 491 (Elin Jones)

For	Against	Abstain
William Graham Elin Jones Darren Millar Lindsay Whittle	Leighton Andrews Rebecca Evans Lynne Neagle Gwyn Price David Rees Kirsty Williams	
4	6	0
Amendment 491 was not agreed.		

Amendment 492 (Elin Jones)

For	Against	Abstain
William Graham Elin Jones Darren Millar Lindsay Whittle	Leighton Andrews Rebecca Evans Lynne Neagle Gwyn Price David Rees Kirsty Williams	
4	6	0
Amendment 492 was not agreed.		

Section 149:

Amendment 493 (Elin Jones)

For	Against	Abstain
William Graham Elin Jones	Leighton Andrews Rebecca Evans	

Darren Millar Lindsay Whittle	Lynne Neagle Gwyn Price David Rees Kirsty Williams	
4	6	0
Amendment 493 was not agreed.		

Section 150:

Amendment 153 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 470 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 251A (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 251B (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 251 (William Graham) was agreed in accordance with Standing Order 17.34(i).

Amendment 471 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 151:
No amendments were tabled to this section, therefore Section 151 was deemed agreed.

Section 152:
No amendments were tabled to this section, therefore Section 152 was deemed agreed.

Section 153:

Amendment 383 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 154:

For the purposes of voting, **Amendments 384, 385, 386, 387, 388, 389 and 390 (Gwenda Thomas)** were grouped and subject to a single vote, in accordance with Standing Order 17.36. The amendments were agreed in accordance with Standing Order 17.34(i).

Section 155:

Amendment 213 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 214 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 156:
No amendments were tabled to this section, therefore Section 156 was deemed agreed.

Section 157:

Amendment 391 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 392 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 393 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 394 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 158:
No amendments were tabled to this section, therefore Section 158 was deemed agreed.

Section 159:

Amendment 466 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 160:
No amendments were tabled to this section, therefore Section 160 was deemed agreed.

Schedule 3:

Amendment 405 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 406 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 407 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 161:
No amendments were tabled to this section, therefore Section 161 was deemed agreed.

New Section:

Amendment 52A (William Graham)

For	Against	Abstain

William Graham Elin Jones Darren Millar Lindsay Whittle Kirsty Williams	Leighton Andrews Rebecca Evans Lynne Neagle Gwyn Price David Rees	
5	5	0
As there was a tied vote, the Chair's casting vote was applied in the negative, in accordance with Standing Order 6.20(ii). Therefore, Amendment 52A was not agreed.		

Amendment 52B (William Graham)

For	Against	Abstain
William Graham Elin Jones Darren Millar Lindsay Whittle Kirsty Williams	Leighton Andrews Rebecca Evans Lynne Neagle Gwyn Price David Rees	
5	5	0
As there was a tied vote, the Chair's casting vote was applied in the negative, in accordance with Standing Order 6.20(ii). Therefore, Amendment 52B was not agreed.		

Amendment 52C (William Graham) As Amendment 52B was not agreed, Amendment 52C fell.

Amendment 52D (William Graham) As Amendment 52B was not agreed, Amendment 52D fell.

Amendment 52E (William Graham) As Amendment 52B was not agreed, Amendment 52E fell.

Amendment 52 (Gwenda Thomas)

For	Against	Abstain
Leighton Andrews Rebecca Evans Lynne Neagle Gwyn Price David Rees	William Graham Elin Jones Darren Millar Lindsay Whittle Kirsty Williams	
5	5	0
As there was a tied vote, the Chair's casting vote was applied in the negative, in accordance with Standing Order 6.20(ii). Therefore, Amendment 52 was not agreed.		

New Section:

Amendment 53 (Gwenda Thomas) As Amendment 52 was not agreed, Amendment 53 fell.

New Section:

Amendment 54 (Gwenda Thomas) As Amendment 52 was not agreed, Amendment 54 fell.

New Section:

Amendment 215 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

2.2 Sections 43 to 161 and Schedules 1 to 3 were deemed to be agreed.

3 Papers to note

3.1 Letter from the Deputy Minister for Social Services – Social Services and Well-being (Wales) Bill: direct payments

3a.1 The Committee noted the letter from the Deputy Minister for Social Services - Social Services and Well-being (Wales) Bill in relation to direct payments.

3.2 Letter from the Deputy Minister for Social Services in relation to the 'When I am ready' scheme

3b.1 The Committee noted the letter from the Deputy Minister for Social Services in relation to the 'When I am ready' scheme.

4 Motion under Standing Order 17.42 to resolve to exclude the public from the remainder of the meeting

4.1 The motion was agreed.

5 Consideration of the forward work programme

5.1 The Committee discussed its forward work programme for January – April 2014 and agreed to the programme's publication.

5.2 In accordance with Standing Order 17.34(ii), the Committee voted on the following motion, proposed by Darren Millar AM, and accepted by the Chair without notice in accordance with Standing Order 17.44:

> That the Health and Social Care Committee allocate time at a future meeting to scrutinise the Chief Executive and Chair of Hywel Dda Health Board, if available, on the provision of health services in its area.

The result of the vote was as follows:

For	Against	Abstain
William Graham Elin Jones Darren Millar Lindsay Whittle Kirsty Williams	Leighton Andrews Rebecca Evans Lynne Neagle Gwyn Price David Rees	0
5	5	0

As there was a tied vote, the Chair's casting vote was applied in the negative, in accordance with Standing Order 6.20(ii). Therefore, the motion was not agreed.

Health and Social Care Committee

Meeting Venue:	Committee Room 3 – Senedd
Meeting date:	Wednesday, 11 December 2013
Meeting time:	09:26 – 11:42

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

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Concise Minutes:

Assembly Members:	David Rees (Chair) Leighton Andrews Rebecca Evans William Graham Elin Jones Darren Millar Lynne Neagle Gwyn R Price Lindsay Whittle Kirsty Williams
Witnesses:	Gwenda Thomas, Deputy Minister for Social Services Julie Rogers, Welsh Government Mike Lubienski, Welsh Government
Committee Staff:	Llinos Madeley (Clerk) Helen Finlayson (Second Clerk) Sarah Sargent (Deputy Clerk) Joanest Jackson (Legal Advisor) Lisa Salkeld (Legal Advisor)

TRANSCRIPT
View the meeting transcript.

1 Introductions, apologies and substitutions

1.1 No apologies were received.

1.2 The Chair welcomed the Deputy Minister for Social Services and her officials to the meeting.

2 Social Services and Well-being (Wales) Bill: Stage 2 - Consideration of amendments

2.1 In accordance with Standing Order 26.21, the Committee disposed of the following amendments to the Bill:

New section:

Amendment 155 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

New section:

Amendment 156 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

New section:

Amendment 157 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

New section:

Amendment 395 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 162:

Amendment 216 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 217 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 218 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 396 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 163:

Amendment 158 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 159 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 160 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 161 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 162 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 163 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 164 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 165 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 166 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 167 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 168 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 164:
No amendments were tabled to this section, therefore Section 164 was deemed agreed.

New section:

Amendment 81 (William Graham) was withdrawn in accordance with Standing Order 26.66.

Section 165:

Amendment 169 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 170 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 171 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 172 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 173 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 174 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 175 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 176 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 177 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 61 (Kirsty Williams) As Amendment 60 was not moved, Amendment 61 fell.

Amendment 275 (William Graham) As Amendment 254 was not agreed, Amendment 275 fell.

Amendment 276 (William Graham) As Amendment 255 was not agreed, Amendment 276 fell.

Amendment 82 (William Graham) As Amendment 111 was not agreed, Amendment 82 fell.

Amendment 178 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 62 (Kirsty Williams) As Amendment 60 was not moved, Amendment 62 fell.

Section 166:

Amendment 183 (William Graham)

For	Against	Abstain
William Graham Elin Jones Darren Millar Lindsay Whittle Kirsty Williams	Leighton Andrews Rebecca Evans Lynne Neagle Gwyn Price David Rees	
5	5	0
As there was a tied vote, the Chair's casting vote was applied in the negative, in accordance with Standing Order 6.20(ii). Therefore, Amendment 183 was not agreed.		

Amendment 530 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 219 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 220 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 221 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 397 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 398 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 222 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 223 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 399 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 224 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 400 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 401 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 225 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 83 (William Graham) was not moved.

Amendment 498 (Lindsay Whittle)

For	Against	Abstain
William Graham Elin Jones Darren Millar Lindsay Whittle Kirsty Williams	Leighton Andrews Rebecca Evans Lynne Neagle Gwyn Price David Rees	
5	5	0
As there was a tied vote, the Chair's casting vote was applied in the negative, in accordance with Standing Order 6.20(ii). Therefore, Amendment 498 was not agreed.		

Amendment 179 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 531 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 228 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 229 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 467 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 55 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 402 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 230 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 403 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 167:

Amendment 404 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Section 168:

Amendment 58 (Kirsty Williams) As Amendment 60 was not moved, Amendment 58 fell.

Amendment 59 (Kirsty Williams) As Amendment 60 was not moved, Amendment 59 fell.

Amendment 184 (William Graham)

For	Against	Abstain
William Graham Elin Jones Darren Millar Lindsay Whittle Kirsty Williams	Leighton Andrews Rebecca Evans Lynne Neagle Gwyn Price David Rees	
5	5	0
As there was a tied vote, the Chair's casting vote was applied in the negative, in accordance with Standing Order 6.20(ii). Therefore, Amendment 184 was not agreed.		

Amendment 185 (William Graham)

For	Against	Abstain

William Graham Elin Jones Darren Millar Lindsay Whittle Kirsty Williams	Leighton Andrews Rebecca Evans Lynne Neagle Gwyn Price David Rees	
5	5	0
As there was a tied vote, the Chair's casting vote was applied in the negative, in accordance with Standing Order 6.20(ii). Therefore, Amendment 185 was not agreed.		

Section 169:
No amendments were tabled to this section, therefore Section 169 was deemed agreed.

Section 1:

Amendment 416 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 500 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 1 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 277 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 278 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 279 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 280 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 281 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 282 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 283 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 284 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 285 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 286 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 287 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 501 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 2 (Gwenda Thomas) As Amendment 52 was not agreed, Amendment 2 fell.

Amendment 3 (Gwenda Thomas) As Amendment 52 was not agreed, Amendment 3 fell.

Amendment 186 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 187 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 128 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

Amendment 288 (Gwenda Thomas) was agreed in accordance with Standing Order 17.34(i).

2.2 The Deputy Minister committed to write to the Committee in relation to ordinary residence, specifically establishing ordinary residence of British citizens who have been living abroad prior to returning to the UK, and for individuals who have been living in multiple different types of accommodation.

2.3 Sections 162 to 169 and section 1 were deemed to be agreed.

3 Papers to note

3.1 The Committee noted the minutes of the meetings of 21 and 27 November 2013.

3.1 Letter from the Chair of Hywel Dda Health Board dated 5 December 2013

3a.1 The Committee noted the letter.

3.2 Letter from the Minister for Health and Social Services and the Deputy Minister for Social Services – response to the Committee's letter on the Welsh Government's Draft Budget 2014/15

3b.1 The Committee noted the letter.

3.3 Letter from the Deputy Minister for Social Services - Social Services and Well-being (Wales) Bill and children's social care

3c.1 The Committee noted the letter.

3.4 The Committee's forward work programme: January - April 2014

3d.1 The Committee noted the forward work programme for the 2014 spring term.

4 Motion under Standing Order 17.42 (vi) to resolve to exclude the public for items 5 and 6 of today's meeting and from the meeting on 16 January 2014

4.1 The motion was agreed.

5 Unscheduled care - preparedness for winter 2013/14 - Consideration of draft letter to the Minister for Health and Social Services and the Deputy Minister for Social Services

5.1 The Committee considered and agreed a draft letter to the Minister for Health and Social Services and the Deputy Minister for Social Services on the unscheduled care - preparedness for winter 2013/14 inquiry.

6 Stroke risk reduction - follow-up inquiry - Consideration of draft letter to the Minister for Health and Social Services

6.1 The Committee considered and agreed a draft letter to the Minister for Health and Social Services on the stroke risk reduction follow-up inquiry.

Pwyllgor Cymunedau, Cydraddoldeb a Llywodraeth Leol

Communities, Equality and Local Government Committee

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Bae Caerdydd / Cardiff Bay
Caerdydd / Cardiff
CF99 1NA

Lesley Griffiths AM
Minister for Local Government and Government Business

12 December 2013

Dear Minister

Public Services Ombudsman for Wales

As you may be aware, the Public Services Ombudsman for Wales recently attended a meeting of the Committee to discuss his Annual Report 2012-13.

During the session, he raised a number of points that I would like to draw to your attention. Whilst most of these relate to matters of local government, a number of examples cited by the Ombudsman relate to the health service in Wales. On this basis, a copy of this letter goes to the Minister for Health and Social Services, as well as the Chair of the Health and Social Care Committee.

In general, the Ombudsman noted that 2015 will be the tenth anniversary of the Public Services Ombudsman (Wales) Act 2005. He told us that, although it had been "at the cutting edge" when introduced, the experience of operating the office over the last seven years had shown that there would be merit in reviewing the legislation. Further to this, he identified several areas where the legislation could be strengthened. He also drew our attention to a number of other issues that he believed should be addressed.

The Committee would be interested to hear your views on each of the matters set out below, and to have details of any work already undertaken by you in respect of these.

Croesewir gohebiaeth yn y Gymraeg a'r Saesneg / We welcome correspondence in both English and Welsh
Pwyllgor Cymunedau, Cydraddoldeb a Llywodraeth Leol / Communities, Equality and Local Government Committee
Gwasanaeth y Pwyllgorau / Committee Service
Ffôn / Tel : 029 2089 8032
Ebost / Email : CELG.Committee@wales.gov.uk

1. Own-initiative Powers

1.1 In his annual report, the Ombudsman noted that most public services ombudsmen throughout Europe and more widely, have the power to undertake investigations on their own initiative. He goes on to state that such a power already exists for the Ombudsman in the Republic of Ireland, and a similar power has been proposed in respect of Northern Ireland.

1.2 During the evidence session, he told us that, in his view, the power to undertake own-initiative investigations, where appropriate, was "fundamental" in order to enable future holders of his office to pursue issues that arise in the course of investigations.

2. Jurisdiction of the Ombudsman

2.1 In both his Annual Report and his oral evidence, the Ombudsman highlighted the issue of individuals' access to redress in cases where public services are delivered by private sector organisations. He noted that, in England, consideration is being given to extending the jurisdiction of the Health Service Ombudsman to include private healthcare.

2.2 He told us that, in his view, the taxpayer should not bear the cost of redress arrangements for private sector complaints, and he proposed a number of options for addressing this, including the introduction of a levy, similar to that operated by some private sector ombudsman schemes.

2.3 Related to this, the Ombudsman told us there was a need for public sector bodies to ensure that, when contracting services out to private contractors, those contractors were aware they were delivering services *on behalf of* a public body and the implications/obligations associated with that. Further to this, he talked of the need for an awareness raising campaign to ensure that individuals receiving services delivered by private contractors on behalf of public sector bodies were aware of their rights to complain to the Public Services Ombudsman for Wales. He said the focus of his concern here was in relation to the delivery of health related services, rather than local authority services.

3. 'Statutory bars': the relationship between the Ombudsman and other institutions for administrative justice

3.1 In his evidence, the Ombudsman told us there were some issues around the relationship between his office and the courts. He said that, in his opinion, there were many cases that had been referred to the administrative courts which could have been better dealt with by an Ombudsman, but that he was unable to investigate complaints where the complainant had, or could have, recourse to the courts.

3.2 This 'statutory bar' is referred to in the 2011 report of the Law Commission, which states that there is now "considerable overlap between the word of the ombudsman and judicial review. The effect of the statutory bars is that where there is an overlap, so a court or an ombudsman could deal with the matter, there is a preference in favour of the court." The report concludes that such preference

"removes choices from citizens" and recommends repealing the statutory bars in order to enable citizens to choose the mechanism that is most appropriate for their particular complaint.

4. Binding remedies

4.1 In relation to private sector bodies, the Ombudsman highlighted the need for binding remedies so that such bodies would be required to comply with the recommendations of the Ombudsman. On this point, he said "with a public body, you can hold them to account if they do not do what I have asked them to do; with a private body, there is not the same responsiveness." He cited the example of the Financial Ombudsman Service, which can require compliance with its recommendations.

In addition to his suggestions for areas in which the legislation could be reviewed, the Ombudsman also raised a number of more general points, which will be of particular interest to the Minister for Health and Social Services, as well as our colleagues on the Health and Social Care Committee.

5. Complaint handling, particularly within the health service

5.1 In both his annual report and his evidence to us, the Ombudsman expressed "considerable concern" with the continuing rise in health complaints. He noted that since the establishment of his office in 2006/07, complaints about health bodies have increased by 257%. Whilst noting that this rise could have been the result of a number of factors, including an increase in awareness of the role of his office, in his view, "this continued significant increase has to lead to the conclusion that there is greater dissatisfaction with health service delivery."

5.2 He told us that, whilst mistakes were inevitable in any organisation, particularly complex organisations such as a local health boards, leadership within those organisations was critical in terms of effective complaint management. He went on to say that "the measure of difference is what you do when something has gone wrong" and that the officers within an organisation who are responsible for handling complaints must have sufficient authority or seniority to enable them to do so effectively. He told us there was "huge scope for improved leadership" by Chief Executives and Chairs in order to address this.

5.3 The Ombudsman acknowledged the "tremendous pressure" imposed on the health service as a result of an increasingly aging population but suggested there were two main problems facing the health service in managing complaints. He told us that the first problem related to resources; that there were insufficient numbers of staff dealing with complaints locally, thereby causing an increase in the number of complaints to his office. The second problem related specifically to more serious complaints, where health boards were not taking independent advice in order to resolve a complaint, despite being able to do so.

6. Oversight of complaints

6.1 In his evidence, the Ombudsman told us "the oversight of the complaints function across the public sector in Wales is very limited. If you want to see comparable statistics about how local authorities or health boards deal with complaints in the last year, you will not be able to find them."

6.2 He said there was a need for proper statistical analysis of the complaints being made by individuals to public sector organisations in respect of the services they deliver; the stage at which such complaints were being deal with; and the decisions taken in respect of each complaint. Further to this, he told us he had proposed a standardised mechanism for collecting and reporting data about such complaints across the public sector in Wales.

6.3 He suggested that the collection and publication of such data would enable the relevant Assembly committees to hold public sector organisations, including local authorities and local health boards, to account for their performance on complaints. It would also enable the relevant individuals within an organisation to judge how well that organisation was performing, in comparison with others, in relation to managing complaints.

For convenience, I have included a link to the transcript of the evidence session with the Ombudsman below—
http://www.senedd.assemblywales.org/documents/s21529/6%20November%202013.pdf

I look forward to hearing from you in due course.

Yours sincerely

Christine Chapman AC / AM

Cadeirydd / Chair

Cc. Mark Drakeford AM, Minister for Health and Social Services
David Rees AM, Chair, Health and Social Care Committee

Y Pwyllgor Deisebau
Petitions Committee

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

David Rees AM
Chair
Health and Social Care Committee
National Assembly for Wales
Tŷ Hywel
Cardiff
CF99 1NA

Bae Caerdydd / Cardiff Bay
Caerdydd / Cardiff
CF99 1NA

Our ref: P-04-520

12 December 2013

Dear David

The Petitions Committee has received the following petition submitted by Kate O'Dell, which has collected almost 500 signatures.

We the undersigned believe the cancellation of all orthopaedic surgery except trauma, during the Winter months 2013/14 undermines the human rights of patients and discriminates against disability. We demand that this decision be urgently revisited. All decisions regarding the priority of patient needs should be made by clinicians rather than the administration making decisions based on financial restrictions.

There are seriously urgent cases, other than trauma, already on the waiting list who without surgery are in danger of losing mobility and consequently their livelihood.

In a political climate where patients should be listened to, in this case they have not even been informed let alone been consulted, the Hywel Dda decision would appear to be directly in conflict with this principle.

Neither can we understand why orthopaedic patients should be targeted. This seems an over simplistic approach to addressing financial problems. Not only are patients affected by such decisions but specialist staff and trainees are not allowed to do the job they are paid for and wish to do.

We call upon the Welsh Government to reverse this decision..

Bae Caerdydd / Cardiff Bay
Caerdydd / Cardiff
CF99 1NA

Ffôn / Tel: 029 2089 8242
E-bost / Email: William.powell@wales.gov.uk

The Committee considered this petition for the first time at our meeting on 10 December and agreed to draw it to the attention of your Committee for information. The Committee also agreed to write to the Minister for Health and Social Services and to Hywel Dda Health Board asking for their urgent views on the issues raised by the petition. I attach a copy of the letter to the Minister for your information.

Yours sincerely

William.

William Powell AC / AM
Cadeirydd / Chair

Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref SF/MD/4012/13

David Rees AM
Health and Social Care Committee
National Assembly for Wales
Ty Hywel
Cardiff Bay
Cardiff
CF99 1NA

13 December 2013

Dear David

I am writing to inform and update you on the work to review the Continuing NHS Healthcare (CHC) Framework.

Since its introduction in 2010, the Framework has provided a number of benefits including greater governance on CHC within Local Health Boards, improved consistency regarding assessment and eligibility decisions and stronger arrangements for reviewing assessments. However, I also recognise the need for a further review of these arrangements. This was reflected in the recent report by the Auditor General for Wales, although the report made clear that a complete rewrite of the Framework is not necessary. I agree with this view.

Considerable work has been undertaken, involving a number of themed Task and Finish groups, with experts drawn from across the health and social care sector, as well as staff from the Auditor General's office, to look at how we can ensure future arrangements remain fit for purpose. These views have contributed to a draft revision of specific aspects of the Framework and it has been issued for consultation today, for a period of 12 weeks. The intention is for the final version of the revised Framework to be published in the Summer.

I am copying my letter to the Chair of the Public Accounts Committee, Chair of the Petitions Committee, Andrew R T Davies, Kirsty Williams and Leanne Wood.

Best wishes

Mark

Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

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English Enquiry Line 0845 010 3300
Llinell Ymholiadau Cymraeg 0845 010 4400
Correspondence.Mark.Drakeford @wales.gsi.gov.uk

Welsh Government

Consultation Document

insert front cover photo or link to image, if required

Continuing NHS Healthcare (CHC) – The 2014 National Framework

Date of issue: **13 December 2013**
Responses by: **13 March 2014**

Overview	This document seeks views on what arrangements the Welsh Government should put in place to support the effective delivery of Continuing NHS Healthcare (CHC) by the NHS. These arrangements will be set out in the 2014 National Framework for Continuing NHS Healthcare. The consultation poses a number of questions about the best way forward.
How to respond	You can respond to this consultation by completing, **by 13 March 2014**, the consultation response form at the back of this document and returning it by post to: Continuing NHS Healthcare Team Integration, Policy and Delivery Division Social Services and Integration Directorate Welsh Government 4Th Floor Cathays Park Cardiff CF10 3NQ Alternatively, the consultation response form is available on our website (http://wales.gov.uk/consultations/?lang=en) and can be returned to us by e-mail to : CHCFrameworkConsultation@wales.gsi.gov.uk
Further information and related documents	There are Easy-to-Read and Easy Read versions of this consultation document available. Large print and Braille versions are also available on request.
Contact details	For further information: Continuing NHS Healthcare Team Integration, Policy and Delivery Division Social Services and Integration Directorate Welsh Government 4Th Floor Cathays Park Cardiff CF10 3NQ E-mail: CHCFrameworkConsultation@wales.gsi.gov.uk Telephone: Cardiff (029) 2082 5860 or 2082 6950

Data protection

Any response you send us will be seen in full by Welsh Government staff dealing with this consultation. It may also be seen by other Welsh Government staff to help them plan future consultations.

The Welsh Government intends to publish a summary of the responses to this document. We may also publish responses in full. Normally, the name and address (or part of the address) of the person or organisation who sent the response are published with the response. This helps to show that the consultation was carried out properly. If you do not want your name or address published, please tell us this in writing when you send your response. We will then blank them out.

Names or addresses we blank out might still get published later, though we do not think this would happen very often. The Freedom of Information Act 2000 and the Environmental Information Regulations 2004 allow the public to ask to see information held by many public bodies, including the Welsh Government. This includes information which has not been published. However, the law also allows us to withhold information in some circumstances. If anyone asks to see information we have withheld, we will have to decide whether to release it or not. If someone has asked for their name and address not to be published, that is an important fact we would take into account. However, there might sometimes be important reasons why we would have to reveal someone's name and address, even though they have asked for them not to be published. We would get in touch with the person and ask their views before we finally decided to reveal the information.

Contents

Summary

Arrangements for the delivery of Continuing NHS Healthcare (CHC) are set out in the existing guidance *The 2010 National Framework for Continuing NHS Healthcare in Wales* (the Framework), published in May 2010.

The Framework covers adults and sets out the Welsh Government's revised policy for eligibility for CHC and the responsibilities of Local Health Boards (LHBs) and Local
Authorities (LAs). It sets out a process for the NHS, working with local authority partners, to assess health needs, decide on eligibility for CHC and provide appropriate care.

Our new Framework will be published this June and will replace the 2010 Continuing NHS Healthcare: The National Framework for Implementation in Wales. The new Framework will not be a complete re-write of existing arrangements. Instead, it will provide further robustness, clarity and assurance on areas identified for improvement by stakeholders. This consultation therefore focusses only on the proposed updated areas.

The new Framework will provide clear, practical and user-friendly guidance based on the views of stakeholders, including CHC nursing leads, the Wales Audit Office and Public Service Ombudsman for Wales.

The Framework will be accompanied by the CHC Toolkit, which will act as a web-based resource, as well as an implementation and training plan. Further work will be undertaken during the consultation period to pilot new processes and refine the content of the Toolkit, such as policies, protocols, resources, practical examples and Frequently Asked Questions.

All LHBs and Local Authorities in Wales will be required to follow it. The new Framework will sets out a process for the NHS, working together with local authority partners, to assess health needs, decide on eligibility for CHC and provide appropriate care.

We therefore welcome your views in shaping the proposed Framework, in order to deliver more effective CHC arrangements.

Section 1

Purpose of this consultation

1. The purpose of this consultation is to revise the Framework to provide a consistent foundation for assessing, commissioning and providing CHC for adults across Wales. This is to ensure that there is a consistent, equitable and appropriate application of the process for determining eligibility. This framework is not intended to replace existing joint commissioning strategies.

2. We have identified various questions for you to consider in your response to the Framework. These are set out in detail in Section 4 of this consultation, and you are asked for your views on which option you support.

3. The options set out in this consultation will need to be developed further and fully costed before any final decision is taken. The Welsh Ministers will make a decision in June 2014 following this consultation.

4. The Welsh Government will want to monitor the impact of the Framework to make it is robust and practical. We would welcome your views on the best way to do this.

Section 2 Background and context

Definition of Continuing NHS Healthcare

5. Continuing NHS Healthcare (CHC) is a package of care arranged and funded solely by the NHS, where it has been assessed that the individual's primary need is a health need.

General Principles of CHC

6. CHC is just one part of a continuum of services that local authorities and NHS bodies need to have in place to support people with health and social care needs. CHC is one aspect of care which people may need as the result of disability, accident or illness to address both physical and mental health needs.

7. The Framework makes it clear that the whole process of determining eligibility and planning and delivering services for continuing NHS healthcare should be 'person centred'. This is vital since individuals going through this process will be at a very vulnerable point in their lives. There may well be difficult and significant choices to be made, so empowering individuals at this time is essential. The ongoing assessment and review process should therefore be explained to the individual and/or their representative from the outset and confirmed in writing. Communication tools and template letters for various stages of the process can be accessed via the CHC Toolkit.

8. Where an individual lacks capacity to make informed choices, under the Mental Capacity Act Code of Practice, staff may disclose information about the individual, providing it is in the best interests of the person concerned, or there is a lawful reason to do so.

9. CHC should not be viewed as a permanent arrangement. Care provision should be needs-led and designed to maximise ability and independence. Any care package, regardless of the funding source, should be regularly reviewed in partnership with the individual and/or their representative to ensure that it continues to meet their needs. CHC is just one part of a continuum of services that local authorities and NHS bodies need to have in place to support people with health and social care needs. CHC is one aspect of care which people may need as the result of disability, accident or illness to address both physical and mental health needs.

Responsibilities of the NHS and Local Authorities

10. The NHS is responsible for assessing, arranging and funding a wide range of services to meet the health care needs, both short and long term, of the population. In addition to periods of acute health care, some people need care over an extended period of time, as the result of disability, accident or illness to address physical and mental health needs. These services are normally provided free of charge.

11. An individual is eligible for CHC when they are assessed as having a primary health need. They then receive a package of support that is fully funded by the NHS. There are around 5,700 people in Wales who receive CHC at an annual cost to the LHBs of approximately £280 million. By its very nature, the provision of CHC is often long term and costly, although it can be episodic in nature, with some people moving in and out of eligibility. Given these pressures, CHC was identified as an area of healthcare that would benefit from a nationally co-ordinated approach and since 2010 has been supported by the National Framework for Implementation in Wales guidance, published by Welsh Ministers.

12. Local authorities also provide a range of services to support their local population, including people who require extended care. These services include accommodation, education, personal and social care, leisure and other services. Local authorities must charge for residential care in accordance with the Charging for Residential Care Guidance (CRAG) and they may charge for other care services subject to any guidance or regulation by the Welsh Government.

13. When an individual has been assessed as having a primary health need and is therefore eligible for CHC, the NHS has responsibility for funding the full package of health and social care. Where the individual is living at home, this does not include the cost of accommodation, food or general household support.

14. NHS bodies and local authorities have responsibilities to ensure that the assessment of eligibility for, and provision of, CHC takes place in a consistent fashion and the process is actively managed to avoid unnecessary delays.

15. If an individual does not meet CHC eligibility, they can still access a range of health and social care services that are likely to be both part of mainstream services or individually planned to meet specific need.

Issues

Wales Audit Office Review of the Framework

16. Over the last two years the Wales Audit Office (WAO) undertook a study into the implementation of the Framework and its effectiveness in ensuring individuals are dealt with fairly and consistently. The study did not examine in any detail the operational delivery of CHC, such as service redesign.

17. The WAO published their report, "*Implementation of the National Framework for Continuing NHS Healthcare"* in June this year. It recognised the current Framework delivered a number of benefits, including governance issues, arrangements for continuing eligibility and the basis for a consistent assessment of care needs. The Report raised concerns over the effectiveness of the implementation of the Framework as well as the fairness and consistency in decision-making on CHC by LHBs. In summary the Report noted:

- CHC governance issues within Health Boards had been strengthened, but provided limited assurance that people are being dealt with consistently and fairly;
- the effectiveness of joint working between health and social services was highly variable;
- there was a fall in the number and expenditure of CHC cases, albeit the impact of the Framework in this was not clear. The report noted mixed evidence on the extent and consistency that individuals and their families are involved in the assessment process
- despite additional funding provided, there was a perceived risk that processes to deal with backdated claims for CHC would not be processed to completion to meet the deadline of June 2014; and,
- Many of the challenges to CHC eligibility decisions not dealt with promptly, there is currently no deadline set for the cases that individual Local Health Boards are dealing with.

18. The Report also advocated the introduction of a Screening Tool, as used in England, would ensure clarity and consistency in the criteria used to assess people.

Public Service Ombudsman for Wales

19. Following a number of complaints received, the Public Service Ombudsman for Wales ("the Ombudsman") has raised concerns over the consistency and fairness of these eligibility decisions, and a large number of backdated claims ("retrospective reviews") have been made to Local Health Boards challenging earlier decisions. Following his investigation into the administration of some of those claims, the Ombudsman received legal advice from Queen's Counsel on the funding and provision of CHC, which proposed a number of improvements to the Framework. These

include; “fast-tracking” cases, the issuing of refunds guidance, guidance to Local Health Boards on where their financial liabilities start, and setting out expectations on Local Health Boards where there has been inaction or delay in progressing a claim.

20. Some of those measures have already been taken. For example, over the last twelve months Welsh Ministers have issued interim guidance to clarify and strengthen arrangements relating to eligibility for CHC.

The Proposed 2014 Framework for CHC

21. These new measures are built into the proposed 2014 National Framework for Continuing NHS Healthcare. They aim to strengthen the guidance and strategic oversight given to LHBs. The proposed Framework is fairly complex in terms of detail but a breakdown of the areas in which it has been revised is set out in Section 3. The proposed Framework replaces the previous arrangements set out in the 2010 National Framework for Continuing NHS Healthcare and is supported through:
    - communication tools;
    - an online ‘CHC Toolkit’ to assist CHC staff, including template documentation for LHBs on contracts, policies and protocols;
    - structured opportunities for shared learning, through annual conference, newsletters and an online staff forum for problem-solving; and,
    - a National Performance Framework, to be implemented from the date of the launch of the updated Framework.

22. It should be noted that the proposed Framework refers to various legislation, regulations and statutory guidance. It should be borne in mind that some of these will be revised over the course of time. The interpretation of the guidance in this document should therefore take into account future changes.

Assessment

23. An individual’s eligibility for CHC is comprehensively assessed through a Multi Disciplinary Team (MDT) and in discussions with the person and/or their family. The complexities and unique circumstances surrounding each person’s claim for CHC mean that the entire process can take up to several weeks to proceed.

24. The LA should usually be represented on the MDT completing the CHC eligibility process. This means that, in most cases, the key assessment information needed for LA support is already available to prevent a delayed discharge. Therefore, where an individual is found to be ineligible for continuing NHS healthcare, the LA should be in a position to respond and action their responsibilities quickly.

25. Central to CHC arrangements is the multidisciplinary team's (MDT) assessment of the individual's care needs which inform the completion of a Decision Support Tool. Throughout the assessment process, the assessment team must keep the individual informed and detail the individual's view of their own care/support needs. This should all be done through a care co-ordinator, employed by the LHB. As part of the 'person-centred approach', individuals, their family, or their chosen representatives, should be actively involved in the process.

26. The differing levels of need and risk to the individual should be identified and reflected within an Integrated Assessment and the care planning and management approach must consider a number of care options, which should be recorded within the service delivery plan. Examples of these care options may include (but are not confined to):

The role of the DST

27. The purpose of the Decision Support Tool is to help identify eligibility for continuing NHS healthcare; it is not designed as an assessment tool in its own right. A good quality multidisciplinary assessment may well identify care/support needs requiring a response by the LHB or LA regardless of eligibility for continuing NHS healthcare.

28. Any new CHC arrangements will need to be fully integrated into the new Integrated Assessment process. This is set out in Chapter 7 of the Framework.

Section 3

The Revision of the Framework

29. We recognise the existing CHC arrangements need to be looked at. We have acted on this, taking on board the views of the WAO and other parties to produce a plan for revising those arrangements, in partnership with stakeholders. In doing so, we have acknowledged their consensus that a complete rewrite of the Framework is not necessary. Instead we have revised certain areas, adopting best practice as appropriate, to ensure the Framework provides clear, practical and user-friendly guidance.

30. The proposed Framework sets out the underpinning principles where practitioners must be able to demonstrate that they have adopted good practice in the following areas:

    - Putting the needs of the individual first (“People first”).
    - ‘No decisions about me without me’; involving the individual, or their families or carers.
    - No delays in meeting an individual’s needs due to funding discussions.
    - Focus on need not diagnosis.
    - Co-ordinated care.
    - Communication.

31. In implementing the principles detailed above, the proposed Framework clarifies the roles and responsibilities of those being assessed, their carers/representatives, the lead professional (“care co-ordinator”) responsible for the assessment, the multi-disciplinary team members (MDT) who assess and recommend any package of care and the panel that commissions the persons required services.

The proposed Framework also provides contains the following excerpts:

Underpinning Principles – Welsh Language

32. The updated Framework contains a new provision reinforcing that for Welsh speakers, effective communication through the medium of Welsh is a key requirement of assessment and the provision of any support required.

Chapter 2 - Governance and Strategic Ownership

33. Chapter 2 of the proposed Framework strengthens LHB ownership of CHC by setting out, at Director Level, responsibility for monitoring CHC performance and maintaining strategic oversight.

34. Under the new Framework, each LHB must identify a named executive, at Director level, who is responsible for monitoring CHC performance and maintaining strategic oversight. They should present, as a minimum, a quarterly CHC performance report to their Board, as well as an annual report based on the CHC Toolkit. They will escalate required actions for which the LHB will be held to account. LHBs are required to utilise the national CHC Performance Framework which can also be accessed via the CHC Toolkit and the Self-Assessment Tool developed by the Wales Audit Office.

35. The Welsh Government will collate a national report and will provide the support mechanisms required to share learning

Chapter 7 – The Assessment process and Decision Support Tool (DST)

a) *The Assessment Process*

36. The proposed Framework notes that the guidance document 'Creating a Unified and Fair System for Assessing and Managing Care' (National Assembly for Wales 2002)[1] has now been replaced in relation to older people by the new interim guidance – Integrated Assessment, Planning and Review Arrangements for Older People. This interim guidance aims to simplify and minimise administrative burdens so the professional can spend more time working directly with people to better understand their needs and act earlier in helping them. It should also serve to integrate assessments more effectively by rationalising processes for gathering and recording information to avoid duplication of effort. More effective assessments should, for example, reduce the burden concerning the application of the 'decision support tool' used for CHC purposes.

37. The proposed Framework stipulates that the new assessment process should utilise, not duplicate, the integrated or unified assessment framework and align with good discharge practice, as detailed in Welsh Government Guidance[2] and *Passing the Baton*[3].

38. The Multi-Disciplinary Team also consider the optimum environment in which the assessment for longer-term care should take place in order to maximise the individual's potential for independence. Care must be taken to ensure that no premature presumptions are made. regarding the requirements for long-term care whilst the individual is acutely unwell. 'Home first' should be the default position and rehabilitation/ reablement to support the retention of as much independence as possible, must

[1] Creating a Unified and Fair System for Assessing and Managing Care, National Assembly for Wales 2002
[2] NAFWC 17/2005 Hospital Discharge Planning Guidance
[3] Passing the Baton: A Practical Guide to Effective Discharge Planning (2008)

always be considered. Options to be considered include step-down/intermediate assessment facilities in the community, or the person's own home with intensive short-term support.

b) The Decision Support Tool (DST)

39. We have carefully considered the findings of the WAO report and agree that there are benefits of adopting the English DST, including its user-friendly approach. We shall therefore adopt this as part of the new Welsh arrangements. Our new DST will address the anomalies highlighted in the WAO report and facilitate seamless cross-border delivery of CHC. We will monitor this through the Performance Framework.

40. The focus must be on a rounded and holistic assessment of the individual rather than DST scores. If the integrated assessment and care plan are sufficiently robust there is no requirement to duplicate paperwork by copying information into the DST document. It will be acceptable in these circumstances to only complete the DST matrix plus the summary record of the MDT discussion and recommendation on eligibility. We have also stipulated that the final discussion and recommendation on CHC eligibility should be undertaken in a formal MDT meeting, to which the person and/or their carers must be invited.

41. Finally, the proposed Framework requires LHBs to have robust quality assurance mechanisms in place to ensure consistency of decision making. A decision not to accept the recommendation must not however be made by one person acting unilaterally. In such circumstances the nominated manager should refer the case to the decision Panel. We have also made clear in the proposed Framework that LHB's responsibility for the funding of CHC commences at the point at which the Panel makes the final decision on behalf of the Board.

Chapter 8 - Care Provision and Monitoring

42. The Proposed Framework sets out the support carers must have provided to them and also stipulates the responsibilities LHBs have in commissioning and delivering the care package for the individual. This section also sets out the requirements for the contracts and service specifications for registered settings and the operational procedures to ensure its responsibility for commissioned services are effectively secured and monitored, where care is provided by external agencies. The chapter also notes the need for a written agreement between t he LHB and the individual and/or their representative, clearly setting out what is covered

by CHC funding. It also expects that LHBs and local authorities must work together to identify gaps in current and future service provision

43. The Chapter also instructs LHBs to have regard to compliance with statutory guidance, including '*Escalating Concerns With, and Closures of, Care Homes Providing Services for Adults*' (8.13)

44. The proposed Framework also sets out new arrangements for additional Personal Contributions from a person who is eligible for CHC, including additional services and extras, as well as retaining an existing provider. It also clarifies the use of Direct Payments and CHC as well as joint funding arrangements.

Chapter 9 - Reviews

45. Chapter 9 strengthens arrangements for existing reviews, stipulating that the individual and/or their representative and the service provider must be provided with the contact details of a named care co-ordinator/lead professional, so that any changes in the person's condition or circumstances can be promptly addressed.

46. Those receiving NHS Funded Nursing Care in a care home must also be reviewed on at least an annual basis. It adds that such a review should include the completion of the CHC Checklist Screening Tool in order to identify those whose needs may now indicate eligibility for CHC. The LHB must ensure that the individual, their family/representative and care home provider have the information and contacts available to enable them to identify changes in need which indicate a timely review is required. Care home providers should be encouraged to complete the Checklist themselves and alert the health board when a full assessment for CHC eligibility is required.

Chapter 10 - Other Policies and Specialist Areas of Practice

47. The proposed Framework now also contains a section highlighting how it will link to other areas, such as:

- Mental Health Act 1983 After Care Services;
- Deprivation of Liberty Safeguards;
- The Transition from Child and Young Persons to Adult Services;
- Applying the CHC Framework to adults with a Learning Disability;
- Entitlement to other NHS Funded Care;
- Community Equipment; and,
- Joint Training.

Chapter 11 - Dispute Resolution

48. Chapter 11 of the proposed Framework sets out the expectation that LHBs and their partners work together to deliver the best possible outcomes for the citizens of Wales through effective partnership working and integration. It specifies where the MDT is unable to reach a consensus view on CHC eligibility, they should escalate the dispute to the appropriate manager and access objective expertise from within, or outside of, their LHB. Where the individual and/or their representative disputes the clinical assessment of the MDT, external peer review should be offered to avoid escalation to the formal disputes or complaints procedure and applications for retrospective reviews.

49. This chapter also notes that LHBs are expected to participate in an annual case review exercise which will be co-ordinated by Welsh Government and supported with materials in the CHC Toolkit.

Chapter 12 - Independent Review Panel (Appeals Process) and Complaints

50. The proposed Framework sets out the need for consistency in the operation of Independent Review Panels and that the deliberations must be properly recorded and communicated.

Chapter 13 - Retrospective Claims for Reimbursement.

51. The final chapter of the Framework is a new one, devoted to backdated ("retrospective") claims for when an individual paid for their care but met the eligibility criteria for CHC which were applicable at that time. It notes an individual or their representative(s), may request a retrospective review where they contributed to the cost of their care, but have reason to believe that they may have met the eligibility criteria for CHC which were applicable at that time. If eligibility is demonstrated for either the full or part period of the claim, the principles of good public administration demand that timely restitution be made. No retrospective claim should take more than two years to process.

52. This section outlines the process for making a claim and the cut-off dates by which a claim must be made, as well as the responsibility for managing such claims.

Section 5 Questions

1. The Wales Audit Office concluded elements of the existing Framework lacked clarity. Does the updated Framework successfully address this? Are there areas which require further attention?

2. Does the Framework provide a clear overall road map to help you understand where you are within the process?

3. Does the proposed Framework provide sufficient assurance about the responsibility, ownership and governance of CHC by Welsh Government, LHBs and their partners?

4. Are the proposed Assessment Process, Checklist/Screening Tool and Decision Support Tool, fit for purpose?

5. Do you think it is helpful to move from the existing Welsh Decision Support Tool (DST) within the existing Framework, to the new proposed version, which will be based on the English DST?

6. Do you think that individuals and their families are involved enough in the updated assessment process? If not, in which additional ways would you like to see the process improved?

7. In your view does the proposed Framework link effectively with other health and social services policy and guidance? Are there any other linkages to good guidance or innovative practice we should be making?

8. An online-based toolkit of resources to support the implementation of CHC will be developed (the contents list is annexed to the Draft Framework). Are there other products you would wish to see addressed in such a toolkit?

9. The Framework is a technical document aimed at specialist professionals who oversee assessment and care provision. We would welcome your thoughts on the potential publication of a simplified Framework for frontline practitioners (e.g. ward staff) and service users. Comments on its appropriateness, including suggested format, content and style are welcome.

Consultation Response Form

Your name:

Organisation (if applicable):

email / telephone number:

Your address:

Responses to consultations are likely to be made public, on the internet or in a report. If you would prefer your response to remain anonymous, please tick here: ☐

If you are responding on behalf of your organisation, please tick here: ☐

Question 1: The Wales Audit Office concluded elements of the existing Framework lacked clarity. Does the updated Framework successfully address this? Are there areas which require further attention?
Comment:

Question 2: Does the Framework provide a clear overall road map to help you understand where you are within the process?
Comment:

Question 3: Does the proposed Framework provide sufficient assurance about the responsibility, ownership and governance of CHC by Welsh Government, LHBs and their partners?
Comment:

Question 4: Are the proposed Assessment Process, Checklist/Screening Tool and Decision Support Tool, fit for purpose?
Comment:

Question 5: Do you think it is helpful to move from the existing Welsh Decision Support Tool (DST) within the existing Framework, to the new proposed version, which will be based on the English DST?
Comment:

Question 6: Do you think that individuals and their families are involved enough in the updated assessment process? If not, in which additional ways would you like to see the process improved?
Comment:

Question 7: In your view does the proposed Framework link effectively with other health and social services policy and guidance? Are there any other linkages to good guidance or innovative practice we should be making?
Comment:

Question 8: An online-based toolkit of resources to support the implementation of CHC will be developed (the contents list is annexed to the Draft Framework). Are there other products you would wish to see addressed in such a toolkit?
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Question 9: The Framework is a technical document aimed at specialist professionals who oversee assessment and care provision. We would welcome your thoughts on the potential publication of a simplified Framework for frontline practitioners (e.g. ward staff) and service users. Comments on its appropriateness, including suggested format, content and style are welcome.
Comment:

Pwyllgor Cyfrifon Cyhoeddus
Public Accounts Committee

David Rees AM
Health and Social Care Committee

10 December 2013

Dear David,

Maternity Services in Wales

At our meeting on 3 December 2013 the Public Accounts Committee considered an update from the Welsh Government on our report on Maternity Services in Wales.

We agreed there was merit in sharing the correspondence with the Health and Social Care Committee to inform the Committee's future work programme.

A copy of the correspondence is attached.

Yours sincerely

Darren Millar AM
Chair
Public Accounts Committee

Our ref:

Date: 31 July 2013

Darren Millar AM
Chair – Public Accounts Committee
National Assembly for Wales
Cardiff Bay
Cardiff
CF99 1NA

Dear Mr Millar,

Public Accounts Committee Recommendation 12: Maternity Performance Board Meetings

I have pleasure in enclosing an update on the Maternity Performance Board meetings held in spring this year. This is to meet the requirements of Recommendation 12 of the Public Accounts Committee report on Maternity Services

Yours sincerely

Professor Jean White
Chief Nursing Officer
Nurse Director NHS Wales

UPDATE ON THE MATERNITY PERFORMANCE BOARD MEETINGS SPRING 2013

MATERNITY PERFORMANCE BOARDS - TERMS OF REFERENCE

BACKGROUND

The remit of the Performance Boards is to hold Health Boards to account for delivery of maternity services in line with the key actions within the Strategic Vision for Maternity Services in Wales by:

- Reviewing and monitoring delivery plans;
- Reviewing outcome indicator and performance measure data;
- Discussing areas for concern where performance is not improving;
- Agreeing an action plan for improvement;
- Promulgating good practice across Wales;
- Providing feedback to performance management at WG to inform their processes.

Membership

Professor Jean White - Chief Nursing Officer – Chair
Polly Ferguson – Nursing Officer Maternity and Early Years
Dr Heather Payne – Senior Medical Officer Maternal and Child Health
Committee secretariat

Process

Welsh Government will meet with the Maternity Service leads of each Health Board to review performance.

Prior to each Health Board meeting, and to inform the discussions, the CNO will ask for written evidence from the following organisations:

- The Health Board under review
- Chair of the respective MSLC
- Royal College of Midwives
- Healthcare Inspectorate Wales
- Local Supervising Authority
- Royal College of Obstetricians and Gynaecologists

Following each Health Board meeting, the Health Board will receive a written report from Welsh Government identifying where progress has been made and where improvements are required.

Frequency of Meetings

Twice a year.

Health Board Representatives

The Health Board will be represented by:

- Head of Midwifery
- Clinical Director for Maternity
- Directorate Manager
- User Chair or representative of Health Board's Maternity Services Liaison Committee (MSLC)

SUMMARY OF MATERNITY PERFORMANCE BOARD MEETINGS – SPRING 2013

All Health Boards have attended a Performance Board meeting. There was good engagement from the maternity leads who demonstrated a clear understanding of the challenges ahead and a commitment to improve services.

As data collection is a challenge, the Head of Information from each Health Board was invited to attend this first meeting to discuss how they will support maternity services to collect the required data by autumn.

Whilst the terms of reference state that prior to each Health Board meeting the CNO will ask for written evidence from relevant organisations, it was agreed that, for the first 'scene-setting' meeting, this would not take place. Organisations will be offered the opportunity to submit written evidence at all subsequent meetings.

Successes

- Maternity Services Liaison Committee (MSLC)
  The User Chair from each MSLC was invited to attend the Performance Board to demonstrate Welsh Government's commitment to listen and respond to the user voice.

  All meetings were attended by the Chair or deputy if the Chair was unavailable. There was good user participation at the meetings.

- User Satisfaction
  There is clarity on an all Wales approach to survey user satisfaction with an expectation that there will be feedback on results at the autumn Performance Board meeting.

- Midwifery workforce
  6 out of 7 Health Boards comply with Birth Rate Plus workforce planning tool, which demonstrates that they have the right number of midwives to run a safe and effective service. The one non-compliant Health Board has a shortage of 4 midwives and will review their midwifery requirements once service reconfiguration has been agreed.

Challenges

- **Caesarean section rates**
  Whilst all Health Boards have plans in place to reduce rates, they still remain high (over 25%) in all Health Boards apart from Cardiff and Vale. All Health Boards are actively working at reducing rates and have been asked to report the rates monthly. Plans for improvement will be reviewed at the autumn Performance Board meetings.

- **Data collection**
  All Health Boards were asked to bring their lead for maternity information to their first Performance Board to discuss how improvements were being made to the electronic data collection.

No Health Board was able to present a complete data set although there had been significant progress in some Health Boards.

Both BCU and Powys have no method of capturing data electronically although Powys is now working closely with NWIS to enable Myrddin Maternity to be functioning by October 2013.

A specific project, with PHW and NWIS, set up in December 2013, is working with all Health Boards to support them to be able to collect data on all performance measures by October 2013. This may not be achieved by BCU.

- **Improving health of pregnant women**
  Health Boards have been asked to contribute to a reduction in pregnant women's BMI, smoking, alcohol consumption and substance misuse.

  This will require changes in both practice and in data collection and whilst Health Boards are aware of this, it is likely that they will first focus on data collection. Ultimately, there will need to be some investment in developing midwifery skills to encourage behaviour change. This will be discussed at the autumn Performance Board meetings.

- **Improving mental health in pregnancy and the puerperium**
  In order to address the challenge of ensuring women have appropriate planning and support for mental health problems that may occur or get worse during maternity, Health Boards have been asked to report on their progress with this. As it is a new measure, there is necessarily a period required for agreement of appropriate care pathways for referral. These are being put in place and Health Boards will be expected to report this at the autumn Performance Board meetings.

- **Compliance with RCOG guidelines on Consultant presence on Labour Ward**
  Aneurin Bevan, Betsi Cadwaladr (BCU) and Hywel Dda Health Boards all report compliance against RCOG guidance although BCU stated that, as a result of service change implementation, Wrexham will soon require an increase from 40 to 60 consultant hours.

  Cardiff, ABMU and Cwm Taf are not compliant and are waiting for the outcome of the South Wales Programme and the impact the reconfiguration will have on meeting the standard for consultant cover. Workforce analysis is currently underway as part of South Wales programme. This situation will be reviewed at the autumn Performance Board meeting.

  The situation will be discussed at the autumn Performance Board meetings, when reconfiguration plans will have been agreed. All Health Boards will then be expected to have plans in place to ensure that they do comply.

Good Practice in Maternity Services

Health Boards were asked to say what specific parts of their service they were proud of and these examples will be posted on the Health Board websites so that good practice can be shared.

ABERTAWE BRO MORGANNWG UNIVERSITY HEALTH BOARD

Maternity Services Liaison Committee – written by a user member.
The committee offers a real opportunity for those that use maternity services to have a voice and to learn more about the way in which the services are developed. It's given me a true insight and a better understanding of the challenges that face the NHS every day. Our group is made up of health professionals from varied backgrounds, which give the MSLC great input from the many departments that are involved with Maternity care such as Midwives, Student Midwives, Health Visiting, Anaesthetics and Gynaecology to name just a few. Other professionals are invited to come and present to the group when covering topics, for example the NSPCC came to speak about Shaken Baby Syndrome a few weeks ago.

We have strong representation from service users in the MSLC for the ABMU Health Board. We have a Doula, A father involved with post natal depression support for partners. We have representation for families that have experienced the loss of a child, Breastfeeding Peer Support and Parent Advocacy representing women and their families that may find using maternity services difficult due to learning difficulties or social situations. We are always discussing the group with other third sector agencies and charities that support women and families to get as many involved as possible. The suggestions from the lay members of the MSLC are really listened to and their viewpoints are important. Our MSLC have been supportive of a card designed by a Breastfeeding Peer Supporter for health professionals to use as a conversation prompt to help support women during the first few days of breastfeeding. Without an open, strong Maternity Service Liaison Committee, unique ideas like these would never culminate.

I feel the relationship between the service user and those involved with creating and managing maternity services needs to be open and equal. I feel the ABMU MSLC has that and will unite both health professional and the people that they care for to mould good quality services for the future.

Use of technology
The introduction of Social Media has meant two-way communication between staff and patients happens more often and is a lot easier.

The Maternity Team, along with the Communications Team at ABM Health Board have taken advantage of social media as a way of engaging with and communicating with mums-to-be and their families by setting up the ABM child and family health Facebook page. The child and family page is a sub-page of the main ABM Facebook page which currently has over 2,100 followers. At the last count the child and family page had 671 followers which is similar to, and in some cases more than, the main Facebook page for some organisations.

The Team use the child and family page, along with Twitter, to maintain a continuous relationship with patients, providing them with information, advice and guidance such as 'Top Ten Tips for a normal birth', ' Is home birth safe?', the importance of the MMR vaccination during the measles outbreak, plus new equipment and service improvements. It has also proved very beneficial answering general queries from mums and mums-to-be, putting minds at rest. As well as forming a community for people to share their own experiences and groups such as Breastfeeding Awareness to contribute information and support.

ANEURIN BEVAN HEALTH BOARD

Caesarean section rates

As part of maternity services ongoing service monitoring a rise in the emergency caesarean section rate has been noted throughout 2012. In response to this, the lead labour ward obstetricians and the senior midwifery managers for high risk, have been conducting an in depth audit into the incidences and decision making process for each emergency caesarean section within their areas to ensure the maintenance of best practice. Their observations and findings have been presented at the service multi professional clinical forum for discussion. Any training requirements identified as part of this process have been incorporated into the agenda or undertaken as part of the planned training sessions within the service. The Maternity Services Board is continually updated on progress via presentations of the services labour ward dashboard and from individual presentations from clinicians involved.

Practice changes implemented include the introduction of a 'fresh eyes' approach which was commenced in early 2012 within the labour ward environment. A senior midwife or medical clinician is asked to review a Cardiotocograph (CTG) tracing hourly when continuous CTG monitoring is taking place, at this time a review of the woman's identified risks is undertaken. This ensures best practice within the labour ward and early deviations from the normal can be escalated to the senior medical staff and acted upon appropriately. The Caesarean Section Toolkit has been revitalisation and a task and finish group set up to complete identified work streams. The aim of this work is to ensure that women are commenced on the appropriate maternity pathway and that she receives the safest maternity care for her and her family.

A multi disciplinary approach to training

Aneurin Bevan Health Board maternity service has worked collaboratively through 2012/2013 to improve the uptake of staff training with a resultant increase in training compliance of 20%. This increase has been achieved through a multi disciplinary approach in delivering statutory and mandatory training. The service benefits from an all day monthly maternity and gynaecology clinical forum which incorporates audit activity, lessons learnt from clinical incident reporting, the sharing of new initiatives and good practice and training sessions. The training is provided by clinicians within the service and guest speakers from the Health Board.

Routine monitoring of statutory and mandatory training is undertaken by senior midwifery and medical staff with quarterly reports generated for the service to identify progress. Training reports are shared at the monthly clinical forum and the Maternity Services Board. An annual training needs analysis, taking into account both local and national requirements, informs the service training programmes.

More recently the maternity service has been working to implement Welsh Government All Wales development of Cardiotocography Training for maternity staff in line with Royal college Of Obstetricians and Gynaecologists guidance. This has involved setting up multidisciplinary Cardiotocography training sessions which commenced in April 2013.

BETSI CADWALADR UNIVERSITY HEALTH BOARD

Prevention Work and Early Years Focus

BCUHB has prioritised early years health and disease prevention, especially health in pregnancy and preparing for pregnancy. A wide range of health staff have been trained to help mothers understand the importance of not smoking in pregnancy, and all midwives now have carbon monoxide monitors which can show blood levels for both mothers and unborn babies. Obesity in pregnancy is recognised as just as dangerous as smoking, and local authority partners have used health improvement grants to provide exercise in pregnancy schemes through their leisure centres. Counter assistants in pharmacy shops have been trained to advise on key early years health topics, including how to get as healthy as possible before pregnancy and between pregnancies.

First Point of Contact Achievement

In 2009 BCUHB commenced work to improve their compliance with direct access to a midwife. Gaining direct access to a Midwife has also improved our compliance with booking women by 10 weeks gestation. As part o the work we have taken the following steps:-

1. There has been significant work with GP surgeries to ensure that women who present at the GP reception and identify themselves as being pregnant are signposted to their community midwife. The women are either given contact numbers or an appointment to see their community midwife. The majority of referrals to book for maternity care are now made by community midwives.
2. There has been extensive use of posters within GP surgeries, local pharmacies, play groups, community centres etc to inform women that they can make direct contact with a midwife when thy discover that they are pregnant and the posters advertise local contact details.
3. The majority of teams have drop in sessions during the week when women can access their midwife directly.
4. All postnatal women are give a credit card sized card as they are discharged from community care which informs them that they can contact their midwife directly when they next become pregnant, there are contact details of their local midwife on the cards.
5. Every team has a visible base within the local community setting.

CARDIFF AND VALE UNIVERSITY HEALTH BOARD

Caesarean Section Rates

Cardiff and Vale Health Board currently has a caesarean section rate of 21.99%, which is the lowest in Wales. The clinicians who work in maternity services are very

proud of this and are committed not only to keeping the rate below 25%, which is the Welsh Government target but to further reduce the rate.

One of the most important reasons for this success is the excellent multidisciplinary team working that has developed a culture where normal birth is considered a measure of a successful maternity unit. Women remain at the centre of care throughout their pregnancy and birth and are supported to have a normal birth wherever possible.

They have a thriving Midwifery Led Unit located within the maternity department, where women with low risk pregnancies are encouraged to use the birthing pools during labour. The midwives who work in this unit are highly experienced in providing women with supportive care during labour and this has contributed hugely to the low caesarean section rate.

The safety of women and their babies is paramount and the Obstetricians and Midwives undergo rigorous training to ensure they remain skilled in managing high risk labour, particularly in the interpretation of fetal heart monitoring which is key in reducing caesarean section. The introduction of STAN monitoring (ST analysis of fetal ECG) has provided additional information regarding the fetal condition to determine whether obstetric intervention is warranted; information which in turn helps the clinician make the right decision at the right time. STAN monitoring is a salient factor in maintaining a low caesarean section rate.

For babies who present in the breech position, an External Cephalic Version service is offered to women. Babies who are successfully turned to a head down position, decreases the need for caesarean section. Women who have had a previous caesarean section are counselled and supported to consider a vaginal birth after caesarean (VBAC), when clinically appropriate. This group of women can avoid a repeat caesarean section for their current and future pregnancies.

These practices all contribute to sustaining a caesarean section rate below 25% and more initiatives are planned to further reduce the current rate.

CWM TAF HEALTH BOARD

Maternity Information

The Maternity Information Technology System (MITS) is a robust Maternity Statistical Reporting Tool, developed as a result of close effective partnership working between maternity and IT services within Cwm Taf HB**.** Information generated, facilitates benchmarking across the health board and provides robust data to clinicians to: monitor monthly activity (including out of area activity), project activity levels, plan services, with the ability to localise the system making changes as and when required, in response to service/audit needs etc**.** MITS will be key to providing the information required by the Welsh Government against the Maternity Outcome Indicators and Performance Measures.

User Involvement

The current Cwm Taf Maternity Services Liaison Committee (MSLC) has been in situ since September 2010. The past couple of years have seen major developments

within Cwm Taf maternity services, for which we are delighted that the MSLC has been a part of and has in some cases, instigated some of these changes and improvements.
The main areas of focus and development by the MSLC are as follows:

- Transfer of the Early Pregnancy Clinic from antenatal to the gynaecological ward in both RGH and PCH.
- Fathers are now permitted to remain on ward with women who give birth after visiting hours.
- Promotion and championing breastfeeding amongst midwives.
- Evaluation of care updated and now consistent across health board.
- The creation of an intranet site for healthcare professionals leading the way to an internet site for pregnant women and new parents.

HYWEL DDA HEALTH BOARD

Normal Midwifery

Hywel Dda Health Board has implemented a Pathway through Normal Midwifery Services. This is an evidenced based pathway to assist midwives in planning and delivering care to low risk women through the antenatal, delivery and postnatal period. The pathway encourages health professionals to make 'Every Contact Count' to positively influence the health promotion agenda for women and their families. Key principles are embedded throughout the woman's journey where individual plans of care can be agreed in partnership with women. The aim of the pathway is to promote normality, refer as appropriate, prepare, advise and support women throughout the entire episode of care. The document is hyperlinked to allow health professionals to access the evidence to support their decision making. It is a comprehensive to provide consistency, and reduce both duplication of effort and prevent conflicting advice given to women.

POWYS HEALTH BOARD

Offering students an experience of community based services

Powys Maternity Services have recently played to host to three German Midwifery students who having 'Googled' home birth, birth centre identified Powys as an area where they were likely to gain experience in both, a rare event in Germany. They were also keen to come to the UK to experience British Midwifery. They had the opportunity to gain experience in managing a caseload, promoting normality particularly within a community setting, providing complete antenatal care to all women on a caseload. Preparing women for birth through antenatal education and birth plans and providing an on call facility for low risk women who birth in Powys either at home or in one of the birth centres. They participated in the provision of normal labour and birth care. They also observed postnatal care of all women on the caseload, predominantly home visits, breastfeeding support, newborn screening and emotional wellbeing support before observing the handover process to the health visiting team.

In addition to experiencing managing a caseload in the community they were also be able to attend local support groups and the antenatal road shows and were

encouraged to participate in Transforming Care process and improving quality principles. During their time with us we also facilitated them to attend a two day Obstetric emergency in the community course. All three students evaluated the placement well and were excited by the births they had observed that allowed women the freedom to birth in positions of their choosing – notable on all fours with the support of the midwife at all times reducing the need for pharmaceutical pain relief.

ABMU – Monday 25 March

1. Performance Data

i. Caesarean section rates:

April 2013 – 24.1%

Caesarean section rates are under 25%. To further improve rates, the Health Board wants to explore how they can raise the normal birth rates. They will be looking at their statistics more thoroughly and will report back in the October Performance Board meeting.

ii. Proportion of women whose initial assessment has been carried out by 10 completed weeks of pregnancy:

April 2013 - 50–60% seen by 10 weeks

The Health Board had previously set themselves a target of 12 weeks but are keen to explore how improve services and focus on 10 completed weeks.

They will report progress at the October Performance Board meeting.

iii. Rates of women with existing mental health conditions who have a care plan in place:

The Health Board are unable to report this at present.

The midwife records whether women have one of 5 specific mental health problems but is unable to record care plans.

It was agreed that the Heads of Midwifery and WG would discuss how this could be recorded and reported in future.

iv. Percentage of women and partners who said they were treated well by the maternity services:

April 2013 - Overall satisfaction level of 90%.

The Health Board will use the all Wales approach once it has been issued as a questionnaire, which will require asking all women who give birth if they would like to complete the questionnaire.

ABMU also ensure that feedback from users is made public on their

Twitter and Facebook accounts.

v. Rates of women who gave up smoking, drinking more than 5 units of alcohol, gain no more than the recommended weight, gave up substance misuse:

April 2013 – As this is new information that has been requested by WG the data is incomplete until electronic systems have been amended to support collection.

Smoking
At present, the Health Board record the number of women referred but not the number of women who gave up.

Weight gain
This requires a change in practice as women will need to be weighed at end of pregnancy to gauge effectiveness of healthy eating messages.

Alcohol and substance misuse
This is recorded at the beginning of pregnancy but not at the end.

2. Data Collection

Informatics issues need to be resolved in relation to recording mental health problems.

3. Maternity Services Liaison Committee (MSLC)

The committee is working well and now reports annually to the Board through an annual report. Training opportunities have been offered to members and representatives have set up sub-groups to look at specific issues e.g. Stillbirth.

4. Staffing

Midwifery
Birth Rate Plus compliant.

Medical
Not RCOG standard compliant.
The Health Board is waiting for the outcome of the South Wales Programme and the impact the reconfiguration will have on meeting the standard for consultant cover. Workforce analysis is currently underway as part of South Wales programme.

This situation will be reviewed at the autumn Performance Board meeting when there will be clarity on the medical staffing required to meet the RCOG standards.

ANEURIN BEVAN – Wednesday 27 March

1. Performance Data

i. Caesarean section rates:

April – 29.7%

As the rates are above 25% the Health Board has started looking at figures monthly and to analyse each maternity unit separately. They will report progress at the October Performance Board meeting.

ii. Proportion of women whose initial assessment has been carried out by 10 completed weeks of pregnancy:

No data were available as the electronic system does not enable this to be collected. However the Health Board states that they committed to gathering in the future through the Evolution/Protos system used. They will report progress at the October Performance Board meeting.

iii. Rates of women with existing mental health conditions who have a care plan in place:

Minimal data are currently being collected. It was agreed that the Heads of Midwifery and WG would discuss how this could be recorded and reported in future.

iv. Percentage of women and partners who said they were treated well by the maternity services:

The Health Board will use the all Wales approach once it has been issued as a questionnaire, which will require asking all women who give birth if they would like to complete the questionnaire.

v. Rates of women who gave up smoking, drinking more than 5 units of alcohol, gain no more than the recommended weight, gave up substance misuse:

Smoking
Midwives now receive mandatory training around smoking cessation. Recording at the end of pregnancy needs to be introduced.

Weight gain
This requires a change in practice as women will need to be weighed at end of pregnancy to gauge effectiveness of healthy eating messages.

Alcohol and substance misuse
This is recorded at the beginning of pregnancy but not at the end.

2. Data Collection

A Task and Finish group is exploring how to improve data capture of women giving birth in Nevill Hall.

The use of digi-pens being looked at as community based midwives cannot access maternity systems remotely.

3. Maternity Services Liaison Committee (MSLC)

The MSLC is in early stages of development but promising progress has been made. Discussions at the meetings are linked to Implementation of the Maternity Strategy and the committee are working on how to promote MSLC further i.e. website, generic email address.

4. Staffing

Midwifery
Birth Rate Plus compliant

Medical
RCOG standard compliant.

The RCOG training has been reviewed and now different levels of training provided for different grades of staff. Uptake has increased from 60% last year to 90% in 2013.

POWYS – Thursday 28 March

1. Performance Data

As the Health Board does not have an electronic maternity information system there is very little accurate data available.

The Health Board reported that they are waiting for NHS Wales Information Services (NWIS) to set up the Myrddin Maternity System. CNO agreed to speak with NWIS to speed up this process.

i. Caesarean section rates:

Ranges from 13% to 45% (emergency only)

All women who require any intervention in labour are transferred outside Powys to a district general hospital. However, to support normal birth, active birth sessions have been introduce and to increase the uptake of Vaginal Birth After Caesarean (VBAC), midwives discuss this option, with all women who have had a previous Caesarean section, at their first appointment for a subsequent regency.

The normal birth rate in Powys is now 96%.

ii. Proportion of women whose initial assessment has been carried out by 10 completed weeks of pregnancy

All women are currently being seen by 12 weeks and plans are in place to ensure initial assessment by 10 weeks although data capture is not in place yet.

iii. Rates of women with existing mental health conditions who have a care plan in place

There are strong existing links between maternity services and mental health although that absence of electronic data capture makes this hard to measure.

Data capture will be considered as part of the introduction of the Myrddin Maternity System

iv. Percentage of women and partners who said they were treated well by the maternity services

The current questionnaire has a satisfaction scale of 1-10 scale, with 95% scoring 5 and above.

The Health Board will use the all Wales approach once it has been issued as a questionnaire, which will require asking all women who give birth if they would like to complete the questionnaire.

v. Rates of women who gave up smoking, drinking more than 5 units of alcohol, gain no more than the recommended weight, gave up substance misuse

Smoking
Current services to support smoking cessation, alcohol, substance misuse and weight management make contact women using a withheld number, so women are unlikely to answer the phone call. This is being discussed to find solutions.

Weight gain
This requires a change in practice as women will need to be weighed at end of pregnancy. A system has been set up to measure weight in the 3rd trimester.

Alcohol and substance misuse
This is recorded at the beginning of pregnancy but not at the end. Kaleidoscope (substance misuse team in Powys) record referral as opposed to the ceasing of misuse.

2. Data Collection

There is much work to be done in order for the Myrddin maternity system to produce data. However, there is an expectation that data will available at the autumn Maternity Performance Board.

3. Maternity Services Liaison Committee (MSLC)

Whilst there is an active committee, the geographical spread makes meeting a challenge. Currently discussions are held via email and meeting face-to-face once per year.

The MSLC's annual report went to Board in 2012.

4. Staffing

Birth Rate Plus compliant.
A system of visiting obstetricians is in place.

CWM TAF – Tuesday 2 April

1. <u>Performance Data</u>

i. Caesarean section rates:

April 2013 – 37%:

The Health Bards stated that letters are sent to parents following caesarean section, advising that they could have a normal birth when next pregnant. Women have a 'de-briefing' with a midwife following caesarean section.

The Board suggested that high rates are, in part, related to poor general health of the population.

They are now in the process of developing a standard evidence based approach to plan of care and decision making process and this will be explored at the next Performance Board in autumn.

ii. Proportion of women whose initial assessment has been carried out by 10 completed weeks of pregnancy:

This data are not currently held by the Heath Board. However, in many areas, pregnant women are seen by a midwife straight away as GP receptionists give out midwife number rather than book a GP appointment.

The Health Board were asked to present data at the next Performance Board in autumn.

iii. Rates of women with existing mental health conditions who have a care plan in place:

No data were available as this is a new requirement.

The Health Board were asked to present data at the next Performance Board in autumn.

iv. Percentage of women and partners who said they were treated well by the maternity services:

The Health Board use a current questionnaire and results are seen by clinicians and senior midwives and used to discuss how to improve services.

The Health Board will use the all Wales approach once it has been issued as a questionnaire, which will require asking all women who give birth if they would like to complete the questionnaire.

v. Rates of women who gave up smoking, drinking more than 5 units of alcohol, gain no more than the recommended weight, gave up substance misuse:

Carbon monoxide training is now mandatory for midwives. Around 26% of pregnant women in Cwm Taf smoke at the start of pregnancy.

A high percentage of women have a raised high BMI. Weight is measured in antenatal clinics and some women are referred to Slimming world.

2. Data Collection

A bespoke IT system is in place which allows statistics to be broken down into teams. New data fields will have to be incorporated to enable performance data to be extracted.

3. Maternity Services Liaison Committee (MSLC)

The meetings alternate between the North and South area but there is not much consistency of attendance and it is easier to find users who want to join MSLC who have had bad experience.

Breastfeeding peer support groups are in abundance.

4. Staffing:

Midwifery
Birth Rate Plus compliant

Medical
Not RCOG standard compliant
The Health Board is waiting for the outcome of the South Wales Programme and the impact the reconfiguration will have on meeting the standard for consultant cover. Workforce analysis is currently underway as part of South Wales programme.

This situation will be reviewed at the autumn Performance Board meeting when there will be clarity on the medical staffing required to meet the RCOG standards.

CARDIFF AND VALE – 2 April

1. <u>Performance Data</u>

i. Caesarean section rates:

April 2013 – 19% (consistently below 25% including high risk women from other areas)

Still monitoring rates monthly via their dashboard

ii. Proportion of women whose initial assessment has been carried out by 10 completed weeks of pregnancy:

Electronic data are not yet available for this measure. Posters are now being used in clinics to promote early access to a midwife which detailing midwives contact numbers.

iii. Rates of women with existing mental health conditions who have a care plan in place:

No data available for this yet. Health Board will report progress at the next performance board meeting.

Consultant with interest in peri-natal mental health is considering whether to take the lead.

iv. Percentage of women and partners who said they were treated well by the maternity services:

Currently using '2 minutes of your time' survey.

The Health Board will use the all Wales approach once it has been issued as a questionnaire, which will require asking all women who give birth if they would like to complete the questionnaire. The MSLC are committed to completing the all Wales survey with patients.

v. Rates of women who gave up smoking, drinking more than 5 units of alcohol, gain no more than the recommended weight, gave up substance misuse (We will require a comparison of %age of women who initially smoked, drank more than 5 units, BMI over 30 and misuse substances and measure 5):

New electronic maternity system 'Euroking' will be able to capture smoking data and midwives are now using of carbon monoxide monitors.

Substance misuse data more readily available as Cardiff and the Vale have specialist midwife.

Plans are in place to re-weigh women at 36 weeks.

2. Data Collection:

'Euroking' maternity system is being introduce in the Health Board in July and the organisation are committed to working with Cardiff and the Vale to write suitable programmes to enable robust data capture. 3 months implementation plan to take place.

There are also plans to pilot digi-pens for community midwives.

3. Maternity Services Liaison Committee (MSLC)

Terms of Reference have been recently been re-written and maternity staff within Cardiff and the Vale are supportive of the MSLC and are encouraging the setting up of 'Mums groups' in communities to help harder-to-reach groups.

4. Staffing

Midwifery

Not Birth Rate Plus compliant at the time of the Performance Board but they committed to address this by June. Welsh Government now has confirmation that they have appointed more midwives and are Birth Rate Plus compliant.

Medical

Not RCOG standard compliant

The Health Board is waiting for the outcome of the South Wales Programme and the impact the reconfiguration will have on meeting the standard for consultant cover. Workforce analysis is currently underway as part of South Wales programme.

This situation will be reviewed at the autumn Performance Board meeting when there will be clarity on the medical staffing required to meet the RCOG standards.

BCU – 18 April

1. **Performance Data**

The Health Board have no electronic maternity system in place and so all data has to be captured through a trawl of the Hand Held Maternity Record.

i. Caesarean section rates:

April 2013 - 26%

Overall rates are 26% but there is wide variation across the 3 sites with rates of 30% rate in Glan Clywd.

Whilst some aspects of the Caesarean Section Toolkit have been introduces there does need to be more work done on understanding the high rates. The Health Board will be expected to report progress at the autumn Performance Board meeting.

ii. Proportion of women whose initial assessment has been carried out by 10 completed weeks of pregnancy:

80% of women are currently seen by 10 weeks with direct access to a midwife estimated at around 90% - highest across Wales.
Midwife contact cards are placed in GP surgeries and leisure centres and vouchers for exercise opportunities are available for pregnant women in Anglesey.

iii. Rates of women with existing mental health conditions who have a care plan in place:

A strategy is currently being developed to ensure that women are referred for care planning. An interim measure for data capture is being addressed through the use of paper based forms completed at birth.

iv. Percentage of women and partners who said they were treated well by the maternity services:
Patient stories are fed into a Quality and Safety report and the MSLC has contributed to the all Wales satisfaction strategy.

v. Rates of women who gave up smoking, drinking more than 5 units of alcohol, gain no more than the recommended weight, gave up substance misuse:

A wellbeing strategy has been in place for 18 months, which focuses on maternal smoking and obesity.

Smoking cessation effectiveness only has a success rate of 3.1%.

The Health Board has recently invested in bariatric scales to weigh women more accurately.

2. Data Collection

Data are still collected manually which is time consuming for midwives and less accurate than electronic systems.

The Health Board were asked to ensure that this situation is improved by the autumn Performance Board meeting.

3. Maternity Services Liaison Committee (MSLC)

There is a commitment to rotate meetings across central, west and east areas and 'Voices' training for users has taken place.

4. Staffing

Midwifery
Birth Rate Plus compliant

Medical
Currently RCOG compliant however, as a result of service change implementation Wrexham will soon require 60 consultant hours.

This situation will be reviewed at the autumn Performance Board meeting.

HYWEL DDA – Friday 7 June

1. Performance Data

i. Caesarean section rates – April 2013 - 32%

Ceredigion high caesarean section rate when compared to amount of births. The Health Board is actively working with mums to opt for VBAC.

ii. Proportion of women whose initial assessment has been carried out by 10 completed weeks of pregnancy.

The majority of women are seen by 12 weeks, however these data are not recorded electronically yet

iii. Rates of women with existing mental health conditions who have a care plan in place:

Not yet recording any data.

iv. Percentage of women and partners who said they were treated well by the maternity services:

The Health Board stated that a very high percentage of women report that they are treated well – although no data were presented (72% return rate).

Every patient is given 'My Diary' throughout hospital stay which is more focussed on being treated well.

v. Rates of women who gave up smoking, drinking more than 5 units of alcohol, gain no more than the recommended weight, gave up substance misuse.

No data available. Because of high obesity rates the Board have set their own targets for reducing the rates.

2. Data Collection

Using Myrddin Maternity module across all 3 units and work being done to stop duplication of data entry.

3. Maternity Services Liaison Committee (MSLC):

Geographical issues - Hywel Dda MSLC is split into 2 groups. Good professional attendance. Meeting held every 2 months.

4. Staffing

Midwifery
The Board is not Birth Rate Plus compliant, (by about 4 midwives), but reported that are carrying out a review in summer. The results and action plan will be reported to Welsh Government.

Medical
The Health Board is RCOG compliant.

Yr Adran Iechyd a Gwasanaethau Cymdeithasol
Department for Health and Social Services
Prif Swyddog Nyrsio – Cyfarwyddwr Nyrs GIG Cymru
Chief Nursing Officer – Nurse Director NHS Wales

Llywodraeth Cymru
Welsh Government

Darren Millar AM
Chair – Public Accounts Committee
National Assembly for Wales
Cardiff Bay
Cardiff
CF99 1NA

27 November 2013

Dear Mr Millar

Public Accounts Committee Recommendation 12: Maternity Performance Board Meetings

I have pleasure in enclosing an update on the Maternity Performance Board meetings held in autumn of this year. This is to meet the requirements of Recommendation 12 of the Public Accounts Committee report on Maternity Services

Yours sincerely

Professor Jean White
Chief Nursing Officer
Nurse Director NHS Wales

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UPDATE ON THE MATERNITY PERFORMANCE BOARD MEETINGS AUTUMN 2013

MATERNITY PERFORMANCE BOARDS - TERMS OF REFERENCE

Background

The remit of the Performance Boards is to hold Health Boards to account for the delivery of maternity services in line with the key actions within the Strategic Vision for Maternity Services in Wales by:

- Reviewing and monitoring delivery plans;
- Reviewing outcome indicator and performance measure data;
- Discussing areas for concern where performance is not improving;
- Agreeing an action plan for improvement;
- Promulgating good practice across Wales;
- Providing feedback to performance management at WG to inform their processes.

Membership
Professor Jean White - Chief Nursing Officer – Chair
Polly Ferguson – Nursing Officer Maternity and Early Years
Dr Heather Payne – Senior Medical Officer Maternal and Child Health
Committee secretariat

Process
Welsh Government will meet with the Maternity Service leads of each Health Board to review performance.

Prior to each Health Board meeting, and to inform the discussions, the CNO will ask for written evidence from the following organisations:

- The Health Board under review
- Chair of the respective MSLC
- Royal College of Midwives
- Healthcare Inspectorate Wales
- Local Supervising Authority
- Royal College of Obstetricians and Gynaecologists

Following each Health Board meeting, the Health Board will receive a written report from Welsh Government identifying where progress has been made and where improvements are required.

Frequency of Meetings
Twice a year.

Health Board Representatives
The Health Board will be represented by:

- Head of Midwifery
- Clinical Director for Maternity
- Directorate Manager
- User Chair or representative of Health Board's Maternity Services Liaison Committee (MSLC)

SUMMARY OF MATERNITY PERFORMANCE BOARD MEETINGS – AUTUMN 2013

All Health Boards have attended a Performance Board meeting. There was good engagement from the maternity leads who demonstrated a clear understanding of the challenges ahead and a commitment to improve services.

The CNO wrote and asked for evidence from all relevant organisations prior to the autumn meetings. Information was received from the Royal College of Midwives and two of the MSLCs.

Successes

- **Data Collection**
  Whilst it remains a challenge to collect robust data we recognise that significant progress has been made to introduce new systems across all Health Boards. We are confident that by April 2014 all Health Boards will be able to collect data on all of the performance measures and indicators set by Welsh Government with the assistance of Public Health Wales. Once we have robust data sets this will enable a shift in focus to monitoring improvements in service provision.

  A positive consequence from us collecting data is that the scale of the public health challenge is becoming clearer. This greater understanding of the problems is enabling Health Boards to consider the implementation of appropriate interventions to encourage healthy lifestyles.

- **Midwifery Workforce**
  There continues to be safe staffing levels in midwifery services across all Health Boards. All are committed to maintaining compliance with the levels recommended through the Birthrate Plus acuity tool and regularly review their status. Only one Health Board is Wales is currently not compliant – Hywel Dda Health Board who is short 3.37 wte. The Health Board has plans in place to be compliant by the spring 2014 and currently uses Bank and Agency staff to maintain the right level.

Challenges

- **Caesarean section rates**
  Caesarean section rates remain stubbornly high in many units. This is a complicated issue and improvement relies upon a multitude of factors not least an improvement in the general health of pregnant women and a shift in the culture of intervention which has developed in some areas.

- **Compliance with RCOG guidelines on Medical Consultant presence on Labour Ward**
  Whilst all Health Boards report that their services operate safely, only Aneurin Bevan reports being RCOG compliant. Decisions around service reconfiguration are imminent and workforce plans will be addressed as part of this process.

Abertawe Bro Morgannwg University Health Board – 23 September

1. <u>Performance Data</u>

i. Caesarean section rates:

August 2013 – 26.8%

Caesarean section rates have been consistently higher than 25% since the previous performance board meeting. This is attributed to a culture of intervention which needs to be challenged. The Health Board has been tasked with transforming this culture in order to improve rates.

ii. Proportion of women whose initial assessment has been carried out by 10 completed weeks of pregnancy:

August 2013 – 50% seen by 10 weeks

The collection of these data is now more robust and the Health Board is continuing to work on improving this rate.

iii. Rates of women with existing mental health conditions who have a care plan in place:

The Health Board is unable to report this at present.

The midwife records whether women have one of 5 specific mental health problems but is unable to record the subsequent care plans.

The recording of this information continues to be a challenge. The health board is reviewing their processes and considering the use of 'digi-pens' to electronically capture data to reduce duplication and improve data collection.

Welsh Government expects to see better data at the 2014 performance board meetings and this will be discussed at the all Wales Heads of Midwifery Advisory Group in November.

iv. Percentage of women and partners who said they were treated well by the maternity services:

August 2013 - Overall satisfaction level of 90%.

The Health Board collect their own data and have set a target of 95% satisfaction.

v. Proportion of babies exclusively receiving breast milk at 10 days after birth

These data are not yet collected in the Myrddin patient administration system and a change request has been submitted to NWIS. Three month data supplied by Child Health Department shows that the figure is 22% (between January and March 2013).

vi. Rates of women who gave up smoking; drinking more than 5 units of alcohol; gain no more than the recommended weight; and gave up substance misuse:

The Health Board is unable to record this information on their current system and has made a request to NWIS for a change in the Myrddin system. Welsh Government will raise this issue with NWIS.

Smoking
At present, the Health Board records the number of women who smoke and have been referred to cessation services but not the number of women who gave up.

Weight gain
Data collected by the Health Board shows that approximately 20% of the pregnant population has a BMI of over 30. The Health Board recognises this as an issue and is working to find effective interventions.

Alcohol and substance misuse
The Health Board is currently unable to collect robust data due to the current system. The data are currently collected manually by a substance misuse midwife.

Welsh Government is currently developing a business case for implementing motivational interviewing training for midwives. Motivational Interviewing techniques should give midwives the ability to discuss the above issues with pregnant women and encourage behaviour change.

2. Data Collection

Informatics issues need to be resolved in relation to the Myrddin system to enable Health Boards to collect robust data. The Health Board is seeking opportunities to introduce ‘digi-pens’ for midwives.

3. Maternity Services Liaison Committee (MSLC)

The committee continues to work well and the Health Board keeps the MSLC informed of issues of interest.

4. Staffing

Midwifery
Birth Rate Plus compliant.

Medical
Not RCOG standard compliant.

A plan is in place to raise consultant hours at Singleton Hospital. The Health Board does not use locum staff.

The Health Board continues to wait for the outcome of the South Wales Programme and the impact the reconfiguration will have on meeting the standard for consultant cover.

ANEURIN BEVAN – 4 October

1. <u>Performance Data</u>

i. Caesarean section rates:

September – 23.9%

The high rates of Caesarean section are attributed to a culture of intervention within the health board and low rates of External Cephalic Version (ECV). The Health Board officers have visited Cardiff and Vale University Health Board to look at their practices and as a result will be introducing new CTG equipment in March 2014. In addition, trial Vaginal Birth After Caesarean (VBAC) clinics will be running from October 2013.

ii. Proportion of women whose initial assessment has been carried out by 10 completed weeks of pregnancy:

The Health Board has been unable to collect this data, however the MSLC has completed a piece of work to determine where women are seen for their initial assessment. They found that 100% of women went to their GP first. The Health Board is working with midwives and practices to ensure better promotion of direct access.

iii. Rates of women with existing mental health conditions who have a care plan in place:

Data are not currently collected, however a referral is made to either a specialist midwife or the GP and the Health Board is confident that women are receiving appropriate care.

iv. Percentage of women and partners who said they were treated well by the maternity services:

The Health Board started collecting data from patients in April 2013 using '2 minutes of your time'. The Health Board reports a challenge in collecting data from new mothers and agreed to use and report on the Welsh Government All Wales Service User Experience Survey at the next performance board meeting.

v. Proportion of babies exclusively receiving breast milk at 10 days after birth

July 2013 - 26%. Work is underway to develop an antenatal pathway to encourage women to breastfeed.

vi. Rates of women who gave up smoking,; drinking more than 5 units of alcohol; gain no more than the recommended weight; and gave up substance misuse:

<u>Smoking</u>

Data are not yet available on the percentage of women smoking at the end of pregnancy. The Health Board is currently piloting a smoking cessation scheme which, if successful, will be rolled out across their area. Data will be available at the next meeting.

Weight gain
This requires a change in practice and further investment in weighing scales. The Health Board is in the process of carrying out an audit and will take action to improve data collection in time for the next performance board meeting.

Alcohol and substance misuse

The Health Board employs a designated lead midwife in these areas. A recent health initiative promoting more open and honest responses from woman has shown more accurate data are being collected. A pilot is underway to help women understand their alcohol consumption.

The Health Board should be able to provide further data at the next meeting in the spring.

2. Data Collection

The Health Board has significantly improved its data collection and acknowledges the further work which is required. The MSLC has input on data collection issues also.

3. Maternity Services Liaison Committee (MSLC)

The MSLC is developing and has good involvement with Health Board issues. They now have a Facebook page and use online tools. They have chosen specific issues to tackle such as parent-craft and access to water for labour and birth.

4. Staffing

Midwifery
Birth Rate Plus compliant

Medical
RCOG standard compliant.

POWYS – 7 October

1. Performance Data

The Health Board began using the Myrddin system from 1 October. It is acknowledged that there remain some gaps in the system. Welsh Government will continue to work with NWIS to resolve this.

i. Caesarean section rates:

July 2013 – 21%

All women who require any intervention in labour are transferred outside Powys to a district general hospital. The health board is in regular contact with the external DGHs on this issue.

The normal birth rate in Powys remains around 95%

ii. Proportion of women whose initial assessment has been carried out by 10 completed weeks of pregnancy

All women are currently being seen by 12 weeks and work continues to ensure initial assessments by 10 weeks.

iii. Rates of women with existing mental health conditions who have a care plan in place

87% of women with an existing mental health condition had a plan in place.

iv. Percentage of women and partners who said they were treated well by the maternity services

The Health Board added the question to their own comment cards as of August 2013 and will use the all Wales approach once it has been issued.

v. Proportion of babies exclusively receiving breast milk at 10 days after birth

July 2013 - 52% of the total population of babies in Powys, not separated by place of birth. Powys midwives offer home visits over a 24 hour period to help with breastfeeding.

vi. Rates of women who gave up smoking; drinking more than 5 units of alcohol; gain no more than the recommended weight; and gave up substance misuse

Smoking

At present data are collected at the initial booking and on referrals but not at the end of pregnancy. The Health Board is working on improving data collection through the implementation of Myrddin.

Weight gain
Women are weighed at the start of their pregnancy but not at the end. The Health Board is currently investigating the implementation of a healthy diet scheme for women with a BMI over 35 with consideration given to low income families.

Alcohol and substance misuse
Data supplied by the Health Board includes both alcohol and substance misuse. Kaleidoscope (substance misuse team in Powys) record referral as opposed to the cessation of misuse.

2. Data Collection

The Myrddin system went live on 1 October. While there are still some gaps in the system further improvements in data collection are anticipated at the next meeting.

3. Maternity Services Liaison Committee (MSLC)

The MSLC has recently held its first video conference with good feedback from members. The development of a Facebook page is underway.

4. Staffing

Birth Rate Plus compliant.
A system of visiting obstetricians is in place.

CWM TAF – 8 November

Significant progress has been made by the Health Board in the collection of the data required.

1. <u>Performance Data</u>

i. Caesarean section rates:

April 2013 – 33.9%

An audit was taken of all caesareans which were carried out in April 2013 when the rate peaked at 37%. Work is underway to tackle the high rates. The Health Board is undertaking continuous audit of all inductions along with a birth environment audit. In addition a multi-disciplinary team is being developed to review requests for Caesareans, Midwife led VBAC clinics are being put in place and training in providing aromatherapy has been provided to midwives.

ii. Proportion of women whose initial assessment has been carried out by 10 completed weeks of pregnancy:

49.6% of women are currently seen before 10 completed weeks of pregnancy. The Health Board is currently targeting teams with low compliance to consider what actions need to be taken to improve early access.

iii. Rates of women with existing mental health conditions who have a care plan in place:

Progress has been made in capturing data with further improvement planned for the next meeting. The Health Board has systems in place to enable midwives to refer women – usually to their GP for a care plan/review of existing plans. It was acknowledged that a copy of the care plan needs to be available in the notes for obstetric purposes.

iv. Percentage of women and partners who said they were treated well by the maternity services:

The 2 maternity related questions will be added to the Health Board's own survey. Feedback on services is already gathered through this survey and care is improved based on feedback. One example of this is where visiting times for partners were changed.

v. Proportion of babies exclusively receiving breast milk at 10 days after birth

September 2013 – 23%. This data is provided from Child Health Department. More robust data will be available for the next meeting. The Health Board has invested in nursery nurses as part of the midwifery team to support and encourage women to breastfeed.

vi. Rates of women who gave up smoking, drinking more than 5 units of alcohol, gain no more than the recommended weight, gave up substance

misuse:

Smoking
Rates of women smoking are high but there has been some progress in quit rates. Further improvements have been made to collect data which will be made available at the next meeting. The Health Board is working with Communities First and Public Health Wales (PHW) to support women to quit. CO monitors are being used – well received by mothers.

Alcohol
Midwives are increasing awareness around alcohol consumption and are recording data, however, at present there is no specialist midwife in post and there are no accurate data on women who have reduced their intake.

Weight
The Health Board report rates of around 29% of pregnant women with a BMI of over 30 at initial assessment. BMI is discussed with women to offer them support in healthy eating and exercise to support them to maintain a healthy weight gain in pregnancy. The Health Board also provides women with the 'Tommy's' healthy weight gain in pregnancy booklet. Data are not yet recorded on weight at the end of the pregnancy.

2. Data Collection

Significant progress has been made.

3. Maternity Services Liaison Committee (MSLC)

At present there is no chair in place, however, meetings are still going ahead which alternate between two sites within the Health Board area.

4. Staffing:

Midwifery
Birth Rate Plus compliant

Medical
Not RCOG standard compliant, however, labour ward is prioritised to ensure a safe service.. The Health Board is waiting for the imminent outcome of the South Wales Programme and the impact the reconfiguration will have on meeting the standard for consultant cover. Workforce analysis is currently underway as part of South Wales programme.

CARDIFF AND VALE – 5 November

1. Performance Data

i. Caesarean section rates:

September 2013 – 20.6%. The rate is consistently below 25% and includes high risk women from other Health Board areas. The Health Board's proportion of normal births is 65%

ii. Proportion of women whose initial assessment has been carried out by 10 completed weeks of pregnancy:

It is estimated that around 17% of women are being seen at 10 weeks although the majority of women are seen by 12 weeks. New systems are being implemented to increase direct access to a midwife within the community to address this. The provision of antenatal services is to be moved back out into the communities in order to promote early direct access to midwives.

iii. Rates of women with existing mental health conditions who have a care plan in place:

The Health Board reported that data are not yet collected, however, with the introduction of the Euroking system it is hoped this will be available for the next meeting. The Health Board is in the process of appointing a perinatal mental health midwife and a lead obstetrician with mental health interest to ensure a pathway of referral and care is in place.

iv. Percentage of women and partners who said they were treated well by the maternity services:

This information is not currently collected, however, it will be added to the standard questionnaire to ensure data are available for the next meeting. Work has been undertaken by the MSLC to encourage the collection of feedback by midwives on the Midwifery Led Unit.

v. Proportion of babies exclusively receiving breast milk at 10 days after birth

September 2013 – 39.1%. The Health Board estimates a 70% initiation rate but many move to bottle feeding by day 10. The Health Board is considering initiatives to encourage women to continue breast feeding.

vi. Rates of women who gave up smoking; drinking more than 5 units of alcohol; gain no more than the recommended weight; gave up substance misuse

Smoking, Alcohol and Substance Misuse
The Health Board has some data starting in July 2013, when Euroking was introduced, however it is not robust enough to report any trend. More accurate

data will be available for the next meeting. A referral mechanism is in place to a specialist midwife for alcohol, smoking and substances.

Weight
Around 20% of women are recorded as having a BMI above 30%. Work is underway to introduce interventions and pathways of care are already in place for those women with a BMI above 35. Investment had been made in scales to allow midwives to weigh women at 36 weeks to enable the availability of more robust data.

2. Data Collection:

The Health Board implemented a new data collection system, Euroking, in July 2013. Ten weeks of data was available for this meeting. More robust data will be available for the spring 2014 meeting.

3. Maternity Services Liaison Committee (MSLC)

The MSLC Chair reported good support from maternity services within the Health Board, particularly from midwifery services and from the Head of Midwifery. Meeting attendees include representation from gynaecology, obstetrics, Public Health Wales and midwifery at MSLC meetings. A Facebook page has also been started.

4. Staffing

Midwifery
Birth Rate Plus compliant.

Medical
Not RCOG standard compliant, plans are in place to relocate a Consultant from Llandough to UHW. Locum staffing are rarely used; locums are used that already work within the Health Board.

The Health Board is waiting for the imminent outcome of the South Wales Programme and the impact the reconfiguration will have on meeting the standard for consultant cover. Workforce analysis is currently underway as part of South Wales programme.

BETSI CADWALADR – 8 November

1. **Performance Data**

i. Caesarean section rates:

September 2013 – 26%. The rate is skewed by the high rates in the central area of North Wales. A culture of intervention has been identified. Work is underway to address the high rate across the Health Board with targeted action at Ysbyty Glan Clwyd.

ii. Proportion of women whose initial assessment has been carried out by 10 completed weeks of pregnancy:

The rate of women seen by 10 completed weeks is high in Betsi Cadwaladr at around 70%. This reflects the work which has been put into engaging with GP practices. The Health Board continues audit the data to ensure the high rate is maintained and improved. Training has been provided for pharmacy staff in healthy lifestyles advice and in directing pregnant women to maternity services as early as possible.

iii. Rates of women with existing mental health conditions who have a care plan in place:

The numbers of women with an existing mental health condition are very low and it is not clear whether the data are accurate or reflect under reporting by women. Women are referred to appropriate health care professionals but action needs to be taken to ensure the plan of care is available in the handheld records. The Health Board will provide more robust information at the next meeting.

iv. Percentage of women and partners who said they were treated well by the maternity services:

The Health Board enjoys high rates of return of satisfaction surveys, at around 70%, with good feedback from mothers. A summary of the negative comments are fed back each month to midwives to enable improvements in service provision.

v. Proportion of babies exclusively receiving breast milk at 10 days after birth

Initiation rates are reported at around 80%, however, drop off is high with 10 day rates at 36%. The Health Board is considering ways to improve support in the community to promote the continuation of breast feeding.

vi. Rates of women who gave up smoking; drinking more than 5 units of alcohol; gain no more than the recommended weight; and gave up substance:

Smoking

The percentage of women who smoked at the start of their pregnancy was 20% in September 2013. All midwives now use CO monitors and all have had some brief interventions training related to smoking. Accurate data are not available on quit rates, however, it is believed they are rising, Health Care Support Workers have been trained to support women who want to quit. Accurate data will be available for the spring 2014 meeting.

Alcohol
These data are not yet collected but should be available for the next meeting.

Substance Misuse
These data are collected at birth and the percentage of women who declare this is small. There is appropriate referral for all women and further improvement in capturing this data will be made for the next round of meetings.

Weight
Around a quarter of pregnant women have a BMI of over 30 at the start of their pregnancy. Data has been collected since May 2013 which shows that around half of all women gain more than the recommended weight. Dietetic support is used but the resource is not enough. There has been a lot of work developed to try and support women to maintain a healthy weight. An integrated pathway will be used from November 2013 with a training package to support midwives in discussing exercise and healthy eating.

2. Data Collection:

There has been a huge improvement in the collection of data, however, this is still being done manually by midwives.

3. Maternity Services Liaison Committee (MSLC)

The MSLC is meeting regularly and uses video conferencing to address some of the geographical challenge. Encouraging women to breast feed will be the focus of some of their future work.

4. Staffing

Midwifery
Birth Rate Plus compliant.

Medical
This is a challenge on the Ysbyty Glan Clwyd site within the Health Board, however, consultants have been moved from other parts of the Health Board to ensure adequate cover. Locums are being used to backfill until such time as a permanent staffing solution can be found. [The situation is being monitored weekly at present.]

HYWEL DDA – 4 November

1. Performance Data

i. Caesarean section rates:

September 2013 – 27%. The Health Board is disappointed that their rate has not improved. This is partially due to the care of high risk women from Powys. Attendance at VBAC clinics is encouraged. The Health Board collects data by individual consultant and will review the transfer of care and outcomes of patients from Powys.

ii. Proportion of women whose initial assessment has been carried out by 10 completed weeks of pregnancy:

September 2013 – 78% however this figure is measured against a 12 week target and not the 10 weeks as set by Welsh Government. The Health Board will ensure data reported is in line with the measure of 10 weeks at the next meeting. Culture was discussed as the main issue.

iii. Rates of women with existing mental health conditions who have a care plan in place:

Hywel Dda has a midwife for vulnerable families that currently reports on the number of women with serious mental health conditions. The Health Board does not, at present, report whether a care plan is in place but will ensure that this is achieved and reported on at the spring meeting.

iv. Percentage of women and partners who said they were treated well by the maternity services:

September 2013 – 91%. Survey cards were introduced in April 2013 across the three maternity units. A feedback board is also in place for women to see where improvements have been made as a result of their feedback.

v. Proportion of babies exclusively receiving breast milk at 10 days after birth

September 2013 – 66%. This information was generated by the Child Health Department. The Health Board recently achieved Phase 2 of the UNICEF Baby Friendly accreditation and is working closely with Flying Start to improve rates in deprived areas.

vi. Rates of women who gave up smoking; drinking more than 5 units of alcohol; gain no more than the recommended weight; and gave up substance misuse:

Smoking

September 2013 – 18% of women reported as smoking at the initial consultation. Staff are undertaking training from Stop Smoking Wales. Data on quit rates are not yet available but will be provided at the next meeting.

Alcohol and Substance Misuse
A midwife for Vulnerable Families is currently keeping records of the number of women in her care and data are now being collected by community midwives. Data are expected at the next meeting.

Weight
The Health Board reported that 30% of women have BMI over 30 at initial assessment. Data are available for August and September which show that around 25% of women stay within the recommended weight gain. The Health Board gave assurances that robust care plans were in place for women and the appointment of a lead midwife was discussed. Further, more robust, data will be provided at the next meeting.

2. Data Collection:

The Health Board is now using Myrddin. A new form, designed by community midwives, is also being used to collect all indicators which will improve data collection further.

3. Maternity Services Liaison Committee (MSLC)

The Board are now holding MSLC meetings in community areas every quarter to encourage more engagement. The Chair reported some challenges for the MSLC around attendance and securing new recruits.

4. Staffing

Midwifery
The Health Board is currently not Birth Rate Plus compliant (by 3.37 midwives). In implementing the Clinical Service strategy this will be reviewed. They intend to be compliant by the next Maternity Performance Board meeting in the spring. Bank and Agency staff are used to ensure the right staffing levels.

Medical
They are not RCOG compliant however assurance was given that staffing levels are safe.

PAC RECOMMENDATIONS

Recs (No. of elements)	Recommendation Summary (number of separate elements listed to meet recommendation in full)	Target date	Progress / Update
1	**Recommendation 1.** We recommend that the Welsh Government makes publicly available the Terms of Reference of the Maternity Services National Delivery Board, including details of how the Board is fulfilling these Terms and its programme of work. We also recommend that the output and recommendations of the Maternity Services Implementation Group and its sub-groups should also be made publicly available.	Completed in February 2013	A section of the Chief Nursing Officer's (CNO) web page now contains a section specifically for Maternity Services. This is used to update readers on progress in implementing the Strategic Vision for Maternity Services as well as informing them of new initiatives related to maternity services. The Terms of Reference of the Maternity Board and its programme of work are available on the Welsh Government website along with the second edition of a newsletter 'Maternity News'. Aimed at Midwives and Users the newsletter provides a brief update on the actions to implement the Strategic Vision. The newsletter will be produced 3 times a year with the next edition due in December. Evaluation of the uptake of the newsletter will take place in 2014. The recommendations of the Maternity Services Implementation Group and the final reports from the five sub-groups are also available on the CNO's web page.
2	**Recommendation 2.** We recommend that the Welsh Government ensures that there is greater clarity on the implementation of Local Delivery Plans and that a clear timetable for the production of these plans is published.	Completed	We have received a Local Delivery Plan from every Health Board. These have been scrutinised by officials and performance against the plans is discussed at the Maternity Performance Board meetings. The Autumn meetings have recently been held and dates have been agreed for the meetings in Spring 2014.

Recs (No. of elements)	Recommendation Summary (number of separate elements listed to meet recommendation in full)	Target date	Progress / Update
3	**Recommendation 3.** We recommend that the Welsh Government, in collaboration with the Informatics Sub-Group, develops and implements a consistent and robust electronic data collection process for maternity services in each Welsh health board in order to remove the need for inefficient manual data collection.	Completed Report published on WG Web site in June.	All Health Boards now have plans in place to refine and extend the use of current operational maternity systems or to replace them in order to collect consistent and robust electronic data, reducing the burden of ineffective manual data collection. Health Boards reported on their progress at the recent Maternity Board meetings. To date all Health Boards except Betsi Cadwaladr have implemented an electronic system. In addition Public Health Wales will provide a full report for each Health Board against all of the performance measures and indicators in readiness for the Spring meetings.
4	**Recommendation 4.** We recommend that the Welsh Government clarifies and publishes its definition of "confident and knowledgeable parents" and ensures that: • this definition is communicated to all Health Boards to ensure that the data collection against this performance measure is consistent across Wales; and that • good practice is shared amongst Health Boards to assist in measuring against the definition.	Completed	Two specific questions have been agreed and added to the all Wales Service User Experience Survey bank of questions. All women who give birth in Wales will be asked to complete the survey including those that give birth at home. The survey will be provided following birth and can be returned up to one year after. Health Boards also have existing processes in place to seek user opinion on the care they receive; This will be presented at each Maternity Performance Board. Health Boards have been asked to make this information available to the public through their local web sites and notice boards.
5	**Recommendation 5.** We recommend that the Welsh Government provides clarification on its expectations of the minimum staffing requirements to ensure safe and sustainable midwifery and obstetrics services and that it provides an explanation as to how data collected from health bodies on their midwifery staffing levels provides sufficient detail to determine whether these expectations are being met.	Completed Report published on WG Web site in June.	The Royal College of Obstetricians and Gynaecologists recommends that consultant presence should be 40 hours per week on a unit unless the unit has over 5,000 births per annum, in which case it should be 60 hours per week. The Royal College of Midwives recommend the use of Birth-rate Plus to determine midwifery staffing levels. To date NHS organisations have been able to provide us with accurate information on compliance with Birth-rate Plus requirements and the number of medical staff in post when requested.

Recs (No. of elements)	Recommendation Summary (number of separate elements listed to meet recommendation in full)	Target date	Progress / Update
			Our expectation is that all Health Boards will comply with these standards. In order to ensure this is maintained they are required to report on their staffing levels at the twice-yearly Maternity Performance Board meetings.
6	**Recommendation 6.** We recommend that the Welsh Government works closely with Health Boards to ensure that the use of locums and agency staff is managed efficiently in order that the reliance on using temporary staff to fill long-term gaps in staffing provision is minimised. We also recommend that the Welsh Government work with Health Boards to disaggregate the medical staffing costs associated with maternity services from costs associated with Gynaecology.	Completed	The Welsh Government works closely with all NHS organisations to monitor and scrutinise spend on locum and agency staff throughout the financial year at Health Board Level. As a result of the efforts made within Health Boards the spend on Locum and Agency staff in the year ending 31 March 2013 reduced by 18%, saving some £8.9 million. Discussions have taken place with Health Board colleagues. Because of the way Obstetricians/Gynaecologists work it would be difficult and not useful to disaggregate information in the way suggested. In order for Health Boards to have assurance that there is a safe level of cover for maternity services Job Planning processes need to be improved. The Welsh Government have established, with NHS employers, a Task and Finish group to strengthen Consultant Job Planning arrangements across Wales, and in particular, will be developing revised All Wales guidance and documentation, including updated training material, for implementation in 2014. This guidance will reinforce the importance of discussing service modernisation and improving clinical and patient care, during the job planning process.
7	**Recommendation 7.** We recommend that the Welsh Government works closely with Health Boards to monitor and regularly review the training needs and competency of all maternity unit staff to ensure that more staff are able to interpret Electronic Fetal Heart Rate Monitoring data.	Training package completed. CNO/CMO letter sent to Health	The Chief Nursing Officer has led an all Wales Task and Finish Group to agree the most appropriate training package, which will for the first time, include an assessment of competence. All Health Boards are expected to introduce this training and assessment package from September 2013 with full compliance by

<table>
<tr><th>Recs
(No. of elements)</th><th>Recommendation Summary
(number of separate elements listed to meet recommendation in full)</th><th>Target date</th><th>Progress / Update</th></tr>
<tr><td></td><td></td><td>Boards in September 2013.</td><td>March 2014.

Health Boards will report their progress at the Maternity Board meetings. They will be expected to keep records of staff training and assessment as well as information on the number of serious incidents related to misinterpretation of CTGs to ensure that the training and assessment package is improving interpretation.</td></tr>
<tr><td>8</td><td><u>Recommendation 8.</u>
The Committee endorses the recommendation of the Children and Young People Committee to address the shortage of staff in neonatal units and recommends that the Welsh Government takes action to ensure that Health Boards throughout Wales improve their workforce-planning arrangements for neonatal care. In particular we recommend that it addresses the delivery of neonatal services in north Wales when developing work-force plans.</td><td>The Neonatal Network is making progress to resolve workforce issues</td><td>Workforce Levels

There has been improvement in neonatal workforce levels across Wales. This is demonstrated in the nurse shortfall figures collated by the All Wales Neonatal Network. Local Health Boards have produced Neonatal workforce plans which have been scrutinised by the All Wales Neonatal Network. The next data capture exercise will be in November with the Network reporting in January and we will expect to see further progress.

WTE Nursing Shortfall (Gap between total WTE needed to be BAPM Compliant)
Figures prepared by the All Wales Neonatal Network

<table><tr><td>November 2011</td><td>November 2012</td><td>July 2013</td></tr><tr><td>82.64</td><td>46.29</td><td>26.34</td></tr></table>
Service Reconfiguration

The structure of neonatal services across Wales will be determined following this phase of service reconfiguration. The future shape of services will further dictate the workforce requirements.

North Wales

As the committee will be aware on 28 March the First Minister issued a statement indicating the Royal College of Paediatrics and Child Health</td></tr>
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<tr><th>Recs
(No. of elements)</th><th>Recommendation Summary
(number of separate elements listed to meet recommendation in full)</th><th>Target date</th><th>Progress / Update</th></tr>
<tr><td></td><td></td><td></td><td>would conduct a review into neonatal services within North Wales. The RCPCH completed their report in September 2013. The First Minister accepted the recommendations of the RCPCH and is establishing a panel to advise on the location of a new sub-regional neonatal intensive care centre. The model, which includes workforce requirements, is included in the final report.</td></tr>
<tr><td>9</td><td><u>Recommendation 9.</u>
We recommend that the Welsh Government clarifies and publishes its definition of a “significant reduction” in Caesarean section rates along with a timetable by which it expects such a reduction to be achieved.</td><td>Completed.

Health Boards reporting twice a year to Welsh Government</td><td>Current data has been received from the Health Boards on their Caesarean rates (shown in the table below). Reporting is completed on a monthly basis from April 2013.

<table><tr><th>Health Board</th><th>Caesarean Section Rate</th></tr><tr><td>Aneurin Bevan</td><td>23.9%</td></tr><tr><td>Abertawe Bro Morgannwg</td><td>26.8%</td></tr><tr><td>Betsi Cadwaladr</td><td>26%</td></tr><tr><td>Cardiff & Vale</td><td>20.6%</td></tr><tr><td>Cwm Taf</td><td>33.9%</td></tr><tr><td>Hywel Dda</td><td>27%</td></tr><tr><td>Powys</td><td>N/A</td></tr></table>
Where rates are 25% or higher Health Boards have provided plans to reduce rates and these are discussed at the Maternity Board meetings.

Caesarean section rates reflect both the health of the population and the culture within maternity services. Both need to be addressed to reduce rates. Welsh Government are working with Health Boards and holding them to account to address these challenges.</td></tr>
<tr><td>10</td><td><u>Recommendation 10.</u>
We recommend that the Welsh Government establishes a more rigorous system for collecting and reviewing information from Health Boards on their Caesarean section rate performance. We also recommend that more regular and meaningful feedback be provided to assist</td><td>Completed.

Health Boards reporting twice a year</td><td>As detailed above Welsh Government now expects monthly reports on Caesarean Section Rates from Health Boards with accompanying narrative when rates are reported above 25%. This is explored further with all Health Boards at the Maternity Performance Board meetings to identify both good practice and weaknesses. Following each meeting, Health Boards will receive feedback from the Chief Nursing Officer.</td></tr>
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Recs (No. of elements)	Recommendation Summary (number of separate elements listed to meet recommendation in full)	Target date	Progress / Update
	Health Boards to manage progress in reducing rates where possible. This feedback should reflect challenges posed by NICE guidance on caesarean sections.	to Welsh Government	Where there has been significant improvement in rates, Health Boards will be asked to share good practice through the Innovations Board set up by the Minister for Health and Social Services as well as through all Wales committees such as Heads of Midwifery Advisory Group Wales and the National Specialist Advisory Group for Women's Health. All Health Boards use local Dashboards to report their Caesarean Section rates to the Health Board so that continuous improvements can be discussed by the executive team.
11	**Recommendation 11.** We recommend that the Welsh Government clarifies that the data reported by Health Boards on initial antenatal assessments carried out within the first ten weeks of pregnancy is consistent and robust, and specifically that the data should: • include assessments by GPs as well as midwives; and • not include assessments which have been scheduled but which may not have been undertaken.	Completed. Health Boards reporting twice a year to Welsh Government	This performance measure was set to ensure that women have early access to appropriate services so that they can receive information, advice and support as soon as is possible. This includes carrying out an initial assessment, taking blood and the writing of a care plan for the pregnancy. At the Maternity Performance Board meetings, Health Boards are asked to report the proportion of women whose initial assessment has been carried out by 10 completed weeks of pregnancy. Health Boards also report on the systems they are putting in place to meet this requirement.
12	**Recommendation 12**. We recommend that the Welsh Government provide an update to the Public Accounts Committee by July 2013 on each Health Board's progress in improving maternity services.	Completed. Summary of Maternity Performance Board meetings prepared following spring meetings.	A summary to the maternity performance board meetings from Spring 2013 was provided to the Committee and the Minister for Health and Social Services. (SF/MD/2801/13)