Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Cyfrifon Cyhoeddus
The Public Accounts Committee

Dydd Llun, 12 Tachwedd 2012
Monday, 12 November 2012

Cynnwys
Contents

Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir trawsgrifiad o'r cyfieithu ar y pryd.

The proceedings are recorded in the language in which they were spoken in the committee. In addition, a transcription of the simultaneous interpretation is included.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Mohammad Asghar	Ceidwadwyr Cymreig Welsh Conservatives
Jocelyn Davies	Plaid Cymru The Party of Wales
Mike Hedges	Llafur Labour
Darren Millar	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)
Julie Morgan	Llafur Labour
Gwyn R. Price	Llafur Labour
Jenny Rathbone	Llafur Labour
Aled Roberts	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Claire Foster	Cyd-gadeirydd, Grŵp Gweithredu Gwasanaethau Mamolaeth Cymru Gyfan, Llywodraeth Cymru Co-chair, All Wales Maternity Services Implementation Group, Welsh Government
Dr Chris Jones	Dirprwy Brif Swyddog Meddygol (Gwasanaethau Iechyd), Llywodraeth Cymru Deputy Chief Medical Officer (Health Services), Welsh Government
Kath McGrath	Cyfarwyddwr Cynorthwyol Gweithrediadau, Bwrdd Iechyd Lleol Cwm Taf Assistant Director of Operations, Cwm Taf Local Health Board
Paul Roberts	Prif Weithredwr, Bwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg Chief Executive, Abertawe Bro Morgannwg University Local Health Board
David Sissling	Cyfarwyddwr Cyffredinol, Iechyd, Gwasanaethau Cymdeithasol a Phlant, Llywodraeth Cymru Director General, Health, Social Services and Children, Welsh Government
Dave Thomas	Swyddfa Archwilio Cymru Wales Audit Office
Huw Vaughan Thomas	Archwilydd Cyffredinol Cymru Auditor General for Wales
Yr Athro/Professor Jean White	Prif Swyddog Nyrsio a Chyd-gadeirydd Grŵp Gweithredu Gwasanaethau Mamolaeth Cymru Gyfan, Llywodraeth Cymru Chief Nursing Officer and Co-chair of the All Wales Maternity Services Implementation Group, Welsh Government
Allison Williams	Prif Weithredwr Bwrdd Iechyd Lleol Cwm Taf Chief Executive, Cwm Taf Local Health Board

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

Dan Collier	Dirprwy Glerc Deputy Clerk
Tom Jackson	Clerc Clerk

Dechreuodd y cyfarfod am 2.01 p.m.
The meeting began at 2.01 p.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **Darren Millar:** Good afternoon, everyone, and welcome to today's meeting of the Public Accounts Committee. The National Assembly for Wales is a bilingual institution and so people are free to contribute in either English or Welsh, as they see fit. There are headsets available to hear the translation, which can also be used for amplification for those who require it. I also ask everybody to turn off their mobile phones, BlackBerrys and pagers, because they can interfere with the sound and broadcasting equipment. In the event of an emergency, we should all follow the instructions of the ushers, who will take us to the nearest exit. We have not received any apologies for today's meeting, so we will go straight to item 2.

2.01 p.m.

Gwasanaethau Mamolaeth yng Nghymru–Tystiolaeth gan Lywodraeth Cymru a Chyd-gadeiryddion Grŵp Gweithredu Gwasanaethau Mamolaeth Cymru Gyfan
Maternity Services in Wales–Evidence from the Welsh Government and the Co-chairs of the All-Wales Implementation Services Group

[2] **Darren Millar:** We will be taking evidence from the Welsh Government and the co-chairs of the all-Wales implementation services group. To recap, the Wales Audit Office produced a report back in June 2009. The committee took evidence from the Welsh Government in November 2008, during the third Assembly, and published its own interim report into maternity services in February 2010. Since then, a lot has happened on the Welsh Government side, and we will be hearing about that in a few moments. We have lots of questions, and we know that other committees have been looking at some aspects of maternity services, and particularly neonatal services. We do not really want to tread on anybody's toes, but there are pertinent questions that we will want to ask.

[3] I welcome to the table today David Sissling, director-general and chief executive of the national health service in Wales, Dr Chris Jones, the deputy chief medical officer, Professor Jean White, chief nursing officer and co-chair of the all-Wales implementation services group, and Claire Foster, also co-chair of the all-Wales implementation services group. We are grateful for your attendance today and for the written update that you have provided, which is extremely useful in helping us to focus on those areas that we need to today.

[4] I will kick off with the first couple of questions. It has been over three years since the auditor general's report and we have been provided with an update from the Wales Audit Office that suggests that, while there has been some progress, it has been pretty slow in some areas. Can you tell us why is it taking so long to address the issues that were identified in 2009?

[5] **Mr Sissling:** Thank you for the opportunity to report on progress and describe the prospects for further improvements in the future. The first thing I should say is that the scale of what we are seeking to do should not be underestimated. We are trying to deliver sustainable and genuinely world-class maternity services for Wales. That will require a step change, almost a stride change, in standards and performance. It represents a break from the past. There are a number of enablers. First, we need to get professional buy-in, because the service is delivered by a range of different disciplines and professionals. We need good data and good national and local leadership. We need a focus on outcomes and, increasingly, we need pace. We also need to make sure that this is consistent with the overall approach that we are adopting, which is to make sure that we have local ownership, drive and responsibility but, importantly, national performance management and accountability arrangements.

[6] We were pleased to see the progress that the Auditor General for Wales reported to you in June. Some of the issues that we particularly want to highlight are the strategic framework, which has now been produced and established, the national leadership arrangements, and the focus on implementation. We are no longer in the design phase, but the implementation phase. This is unprecedented multidisciplinary working, and it is a real breakthrough. We have the professionals around the same table making agreements on things that previously were issues of divergent thinking. We have improved information, outcome indicators and performance measures. We have done an analysis of the informatics and workforce analysis. We have better workforce planning processes, better engagement with service users, which must always remain central in our thinking, and, for example, we have a toolkit to support improvements in caesarean section rates. We have local plans, local ownership and goals for improvement.

[7] The challenge now is the rapid translation of all those into action, and we are accelerating all our work. I am sure that the committee will be pleased to hear that. So, the data collection and the baseline issues, which we had indicated would require until July next year to complete, have been accelerated and will be concluded in December. In January, health boards will produce new delivery plans. It is very quick but we think that they merit that kind of work. Based on the baselines, those data will indicate and set out trajectories for improvements in year 1 through to year 3. In February, we will have workforce guidelines setting out the critical requirements for the development of a workforce capable of delivering improved services. We are also establishing a national delivery board to oversee enhanced and strengthened performance management arrangements to monitor progress, share good practice and trigger support, intervention and escalation. So, from April onwards, the focus is firmly on delivery.

[8] **Darren Millar:** I am grateful for that update. Obviously, if you have brought forward some of the dates, how might that impact on service reconfiguration proposals in different parts of Wales?

[9] **Mr Sissling:** The service reconfiguration proposals are taking account of the strategy. In a sense, what we are talking about is not dependent on service reconfiguration. A lot of this is to do with the quality of the care that is delivered in our maternity units across Wales. So, we are now focusing on the delivery of services, which should be embodied in all our service development and service change plans, both now and in the future.

[10] **Darren Millar:** We welcome the bringing forward of some of those dates. Obviously, you have an implementation group, which is trying to manage this process. When exactly was the implementation group established, and how do you see it ensuring the delivery of improved maternity services in the future? I do not know whether Jean or Claire wants to respond to that.

[11] **Professor White:** It is coming up to a year since we have been in existence, and

Claire and I act as the joint chairs of that. Our anticipation is that the last meeting will be held in February. Most if not all of the work is nearing completion. Some of it has already been completed and is being acted on. What was the second half of your question, sorry?

[12] **Darren Millar:** I was asking how you were going to monitor the implementation effectively, given that we have just heard from Mr Sissling that the eventual roll-out of everything will not be finished until April. So, if you are concluding your work in February, who is going to own the responsibility for driving the improvements?

[13] **Professor White:** The anticipation is that the implementation group will morph into the board, so there will be a seamless transfer from the implementation group to the board to take on a different stance. Our role currently is to make sure that the recommendations within the strategy are driven forward, and we are enabling the service to act quickly, because, as David says, we are talking about some serious and profound changes in the way in which we look at maternity services. We want to bring about real improvements for the health of mothers and babies in Wales and move away from gathering data in a quantitative way to look at driving some changes. Once we have finished our work in February or March time, and everything is issued, there will be a seamless transfer over to being a board with similar members around the table, because there are representatives from across the range of stakeholders already on that board.

[14] **Darren Millar:** There is a final question from me before I open it up to other Members. You say that the implementation board was established only a year ago. Is there any reason why there was a delay in the establishment of the board given that this is such a priority for the people of Wales and for the NHS to get to grips with?

[15] **Mr Sissling:** I can only comment from having come into post in May 2011. It struck me at that point that we needed very rapidly to translate all the good work into the publication of a strategy and then focus on implementation. That was the action that we took. I cannot comment on what happened previously, but from that point on there was a very determined and unwavering focus on turning all the ambitions and aspirations into actions. That is where we are up to. If anything, it is pushing up through the gears now and gaining more and more pace.

[16] **Aled Roberts:** Ydy cofnodion y grŵp ar gael yn gyhoeddus?

Aled Roberts: Are the minutes of the group available publicly?

[17] **Professor White:** We circulate them to stakeholders but, no, we do not put them on the website in the public domain.

[18] **Aled Roberts:** Who are the stakeholders?

[19] **Professor White:** They are professional groups, such as the heads of midwifery and the national service advisory group, which has obstetricians and gynaecologists sitting on it. We also have service users in the group and representatives from the heads of midwifery. Basically, it is the people who deliver the service as well as the people or professionals who give advice to it. It is more of a professional service mix of people who look at it, rather than being in the public domain.

[20] **Aled Roberts:** I am aware that, originally, in the neonatal field, the proposal was that health boards would prepare delivery plans that would be submitted to the Minister, and it would then be open to the Minister to be subject to political scrutiny. So, as far as political scrutiny is concerned, what opportunity is there for the political scrutiny of the discussions that go on in this group, which will then go before the national delivery board once the implementation starts?

[21] **Professor White:** When the vision for maternity services was developed, it was launched in a public way. There was a three-month consultation before publication, when the principles of the implementation were set out. We are not delivering anything now that has not already had public consultation on it, and the political scrutiny took place at that time, I would say.

[22] **Aled Roberts:** That would have been before any of the boards or delivery groups were established. I am concerned that there appears to be some confusion with regard to the purpose of the neonatal network. I question whether there is an opportunity for the proper scrutiny of proposals at a national level and to see the interface between the proposals coming forward from different health boards.

[23] **Professor White:** The next steps will take account of a lot of that. We will be requiring delivery plans to be submitted next year, once the implementation work has completed its progress. We will have a board that will look at the plans, working with the services to drive forward the implementation of what they anticipate will need to be done.

[24] **Mr Sissling:** These delivery plans will, of course, be in the public domain. They will be taken to boards in their public meetings and therefore will be matters of public discussion. They will be available to stakeholders, elected representatives and others, and they should be the subject of, in some cases, scrutiny, debate and discussion. There may well be some value in our bringing them together nationally to make sure that there is consistency, alignment and cohesion and that we are sharing good practice. It was a helpful suggestion in the question that we could bring these together into a suite of plans, so that we can see the national picture, in a sense. In some cases, the health boards will need to take account of cross-border issues and will need to work together to make sure that their plans are aligned and are mutually supportive. I would be happy to make sure that that is the case and that there is an opportunity for inquiry and for pursuing questions about aspects of the plans.

[25] **Jocelyn Davies:** So, the Welsh Government sets the strategy, and then it is your job to ensure that the delivery plans comply with the strategy's requirements and that they are delivered.

[26] **Professor White:** Yes.

[27] **Jocelyn Davies:** Who are you accountable to?

[28] **Professor White:** To David, and then to the Minister.

[29] **Jocelyn Davies:** Oh, right, so the buck stops with you, then.

[30] **Mr Sissling:** Then, through me to the Minister. There is a line of accountability, as there is in all areas.

[31] **Jocelyn Davies:** Okay, I will go on to my questions. The Welsh Government maternity services strategy was significantly delayed. Can you tell us the reason why?

2.15 p.m.

[32] **Mr Sissling:** It is difficult for me to comment because I was not in post at that point. I am not able to talk with any authority about the circumstances that applied before I took up post in May 2011. As I said earlier in response to the Chair, when I took up post, it seemed to be very much the case that we should proceed without any hesitation to publish this strategy, and there had obviously been an awful lot of work carried out to bring the strategy together,

to get it out and to start talking, thinking and working on implementation.

[33] **Jocelyn Davies:** You cannot tell us why it was delayed, and you would not be able to tell me what the impact of that delay was on service change.

[34] **Mr Sissling:** In terms of the impact, it is difficult to quantify. The health boards were clearly continuing to work to improve services. It would be wrong to say that everything went into some degree of suspended animation. Health boards were developing plans and aspirations and using their dashboards to monitor quality as best they could at that point, and they are now very much working to make sure that we deliver services in line with the strategy. It would be wrong of me to comment on issues of which I have no personal knowledge. Others may have views on it, but I simply could not comment, I am afraid.

[35] **Darren Millar:** Dr Jones, you were around at the time, were you not; is there any specific reason for the delay?

[36] **Dr Jones:** I do not recall that there was a long delay. It perhaps took us a couple of months longer than we may have anticipated to write this, but I was not aware that there was a long delay.

[37] **Darren Millar:** It was almost a year after it was due.

[38] **Jocelyn Davies:** The auditor general's June report said that the Welsh Government had committed to publishing its strategy by December 2010. It was not published until February 2011 and then there was a three-month consultation, so the final strategy was not published until September 2011. Do you not think that that is a significant delay?

[39] **Dr Jones:** I suppose that, once a strategy is written and goes out to public consultation, I would feel that we had written the first draft and that we had to then await responses. I appreciate that, with public consultation, that does sound like a long time.

[40] **Jocelyn Davies:** So, there would not have been an impact of the delay, because the draft strategy would have been put into practice, or people would have been already working towards that.

[41] **Dr Jones:** It is important with all services to remember that the NHS has to be in a state of continuous improvement. We have always monitored maternity services and have known numbers in maternity services in terms of births and caesarean section rates. As David mentioned, organisations monitor quality measures through the dashboard and these are reported to the boards. There may have been a delay in shifting the emphasis away from process-related markers of the service, in a sense, to more public-facing patient outcomes. There may have been a delay of a few months, as you described, but this is quite a profound and long-term change. So, overall, I would not say that that interrupted the process of continuous improvement in all organisations.

[42] **Jenny Rathbone:** In terms of performance management, having accurate data is essential. Your paper is a little bit thin on what the informatics sub-group gets up to, or how far it has got, but I was concerned to read in the auditor general's report that the vast majority of data inputting is done manually. If that is being done by midwives, I am hugely worried about it. I wondered where we are on that and who has to do that manual inputting.

[43] **Professor White:** Up until now, data have been collected through the statistical department within Welsh Government on the things that are clearly quantifiable, such as the number of births, where births took place, whether they were induced or whether they were caesarean sections. Those electronic systems are well in place. There is a dashboard that is set

against the standards of the Royal College of Obstetricians and Gynaecologists that every health board across Wales uses. Our work has been to look at the performance measures and outcome indicators that will show the step change. So, instead of looking at the caesarean section rates, we are going to start looking at things like obesity in pregnancy, which means that we have to start measuring women's weight at the beginning and at the end of pregnancy. We have to look at motivational interviewing skills and talking to women in a better way about their weight and their practices. Those systems at the moment, where they are recorded, are in the patient's notes, so the informatics group is working with the service to turn those things into an electronic way of recording.

[44] Today—and this is a coincidence, Chair—the impact assessment tool was issued to service, asking organisations how much of their current systems are in place electronically, how much is being recorded on paper, and what step changes will be needed to make the system consistent within the health board. We are not looking for a consistent method across Wales, just as long as it is consistent within the health board, so that, by using existing systems, people can gather information, to make it effective. We will know the answer to that by the first week of December. That evidence will then give us sufficient knowledge to know what our next steps need to be to drive improvements in this area. At present, we do not know how much the health boards can collect consistently, and which bits they are going to need some help on. NHS Wales Informatics Service is leading this piece of work for us. It will help us to come up, locally, with the informatics tools needed to record the information. You are right to say that some of this information is only available in a written form, and we need to have a step change in processes to make it consistent. Do you wish to add anything, Claire?

[45] **Ms Foster:** No.

[46] **Jenny Rathbone:** So, it is being done manually by midwives.

[47] **Professor White:** They record a lot of the data in the woman's record. So, if we wanted them to start reporting on it consistently—you must remember that this is a new type of practice that we are driving here. At present, we do not ask anything about obesity; all we do is measure things such as place, number, types—do you see what I mean?

[48] **Jenny Rathbone:** However, in order to have performance measures available, we have to do it efficiently, effectively and accurately.

[49] **Professor White:** Yes, that is absolutely right.

[50] **Jenny Rathbone:** The briefing paper that we have received states that this information will not start to become available until next July. Is that accurate?

[51] **Professor White:** As David mentioned in his opening remarks, we have accelerated that work, so our anticipation is that, well before next July, every health board will be able to consistently provide these data for us. We will know by 1 December what gaps there are in current processes, and what systems do not exist, so that we can put things in place to correct that, for them to be able to report next year. That is the step change that we will need.

[52] **Jenny Rathbone:** I wish to ask you specifically about one of the data sets. How will you assess confident and knowledgeable parents? What measure will you use to assess that, in order to get consistency?

[53] **Professor White:** Do you wish to answer that, Claire?

[54] **Ms Foster:** We are working with the maternity services liaison committees to address that, and to talk to those people about what their service users expect to see coming through

the services, and what confident and knowledgeable parents look like. We are negotiating with them to see what they currently collect and what would be ideal. So we are looking at that group of people. Some work needs to be done in relation to that to ensure that it is consistent.

[55] **Jenny Rathbone:** So, you are yet to define how you will be able to measure that. All the others are straightforward, but—

[56] **Ms Foster:** Yes, they are. However, from a user perspective, that is almost one of the most important issues. So, we need to engage with other users to find out how we can capture that; just because it is hard to collect does not mean that it should not be on our radar. We need to work out a sensible way of capturing what 'good' looks like, and how improvement is shown. We are not just capturing data for the sake of it, but we need to show progression, and to show that women and families are confident and capable at the end of their engagement with maternity services.

[57] **Jenny Rathbone:** This is an important issue, so we are interested in knowing how you will resolve it. I wish to ask you about lay involvement in this whole process. You have the implementation group, and we are told by the auditor general that you now have maternity services liaison committees in every health board. How good is the lay representation on the MSLCs, and what is the link between the MSLCs and the implementation board?

[58] **Professor White:** If I may answer that—

[59] **Jenny Rathbone:** I would rather hear from Claire, as the lay person.

[60] **Professor White:** Okay.

[61] **Ms Foster:** On the implementation group itself, I am a lay person—I am not medical.

[62] **Jenny Rathbone:** That is why I am keen to hear your views.

[63] **Ms Foster:** There is another lay representative, who is also an MSLC chair, who is a member on the group, and there is also a voluntary sector representative—a dad—who does some of the lay representation work as well. The MSLC chairs are up and running. With regard to reporting back to the Welsh Government, because I do not sit in Welsh Government, I am not sure of that level of reporting back. I do not know how that works, to be honest.

[64] **Jenny Rathbone:** Okay, we will ask Jean for that in a moment. How are you managing to get a strong lay voice in all the MSLCs? Is that part of the implementation group's remit?

[65] **Ms Foster:** It is less part of the implementation group's remit and more part of enabling the MSLC chair, who talks to other MSLCs, to make sure that she brings their voices forward to the group itself. So, it is kind of her role as a member of the group to talk to her peers in other health boards and to bring that information forward to us. That does happen.

[66] **Jenny Rathbone:** How do you ensure that there is strong lay representation? It is key to so many of these issues.

[67] **Professor White:** Absolutely. I am planning to have a meeting with the chairs of the MSLCs next week, which will be the first time that I will have seen them all in a room together, to explore how well it has been going. We have had feedback from all the health boards confirming that the committees exist and that they have lay chairs and lay

involvement, but I want to hear from them about their perspective of how well it is going, to see whether there is anything that needs to be firmed up. It has been over a year since we wrote to the health boards requiring them to strengthen this arrangement, so now is an appropriate time for us to see how well it is going from the chairs' perspective and from the lay users' point of view, because I often get to hear the health board's voice rather than the lay person's voice directly. I wanted to speak to them as a group, and that will take place next week, I think.

[68] **Jenny Rathbone:** So, you are going to make sure that they are properly supported and that they get the resources that they need to have proper papers to facilitate good discussions.

[69] **Ms Foster:** Yes, absolutely; that is the purpose of it.

[70] **Aled Roberts:** I want to ask a question so that we do not have unrealistic expectations of what you are going to do by December. Initially, I thought that you were saying that you would have the baseline data available by December, but subsequently it appears that you are talking about clarification from the health boards as to what gaps exist. Which is it? Will we have the baseline data in December or will we have a response from the health boards as to what they can provide?

[71] I also have a quick follow-up question. The auditor general's paper mentions—I am interested in this because of previous evidence that we have had—that the Welsh Government had identified a performance measure with regard to the rates of women whose initial assessment had been carried out by the tenth week of pregnancy. I see nothing on that in the outcomes that you have agreed. If there is an outcome on that, is it for the assessment to be carried out by the tenth week or for a request being made for the assessment by the tenth week? I have casework that suggests that it is the latter, rather than the former, in certain health boards.

[72] I am also concerned about the body mass index. Can you tell me where you stand with regard to BMI figures? I am aware that, in other fields, the use of BMI in Wales is not as generous as it is in England, Scotland or Northern Ireland. We tend to have higher thresholds. Given your views on obesity, is that the case with the obesity in pregnancy issue, as well?

[73] **Professor White:** I will take the first point. The second performance measure asks that a proportion of women have their initial assessment carried out by the tenth complete week of pregnancy. It is associated to the outcome. It is one issue that we felt quite strongly needed to be put in place, because it is a point at which you can pick up so many issues about the mother's health. It is a chance for you to try to start tackling some of the public health issues that we are talking about. It is a point at which motivational interviewing would kick in, to talk about smoking and diet behaviours and so on. We can also tie in some of the things around the stillbirth work that we talked about earlier in the summer—preparing women to think about baby's movement, looking after their health and that sort of thing, which also kick in at that stage. It is definitely one thing that we will be recording.

[74] I am afraid that I do not have an answer for the BMI question.

2.30 p.m.

[75] **Ms Foster:** I have an answer. I was on the outcome indicators and performance measurements group, as well as the co-chair of the implementation group. We did some extensive work with Public Health Wales to get real benchmarks for what was good, what we need to be measuring, what the difference was going to be, and what 'good' looks like. I know it did some extensive research on worldwide evidence around BMI. The data around

BMI and pregnancy are very limited, to be honest, but what we did get we got through Public Health Wales and its research. I do not have the specific numbers.

[76] **Darren Millar:** That could help sharpen up why caesarean rates are higher in some areas, could it not, because of risk factors et cetera? Is that all of the points covered, Aled?

[77] **Aled Roberts:** Yes. Perhaps we could have a note, or perhaps you could tell us where we could get the information, if there is research available.

[78] **Professor White:** Indeed.

[79] **Mike Hedges:** The auditor general concluded that, while there has been significant progress, not all health boards are meeting the recommended staffing levels for nursing and medical staff. What assurance can you give the committee that there are sufficient numbers of well-trained medical and nursing staff working in maternity services across Wales and that that will continue?

[80] **Mr Sissling:** I will ask Chris Jones to talk about the doctors and maybe Jean would like to talk about the midwives and nurses, if that is okay.

[81] **Mike Hedges:** Yes, sure.

[82] **Dr Jones:** I think we can, as a result of our quality monitoring of maternity services, give you an assurance that there are adequate numbers of doctors to support the maternity services that we have. Clearly, it is a health board responsibility to make sure that its services are staffed. I know that, in some areas, that comes at a cost, but I believe that those staff are in place in the services. Our quality measures do not indicate any reason not to provide you with that assurance.

[83] **Professor White:** There is fluctuation every year in the number of midwives and the evidence we provided only takes you up to 2011. We have followed that up to look at staffing as at August 2012 and there were 65 more midwives in Wales at that point than at the same time last year. So, again we are seeing fluctuation in the number of midwives across Wales. We require all health boards to comply with the Birthrate Plus guidance—the toolkit that is given out—and we periodically review compliance by health boards with that.

[84] When we did a review in May, there were two health boards that were not fully compliant—Betsi Cadwaladr University Local Health Board and Hywel Dda Local Health Board. When we followed up with those health boards recently, Betsi Cadwaladr LHB confirmed that it will be recruiting all 13 midwives that it recognises that it is short of. Hywel Dda health board has recruited some, and will be just four short. We are monitoring that through the quality and safety committee. So, we robustly review how well the health boards comply with Birthrate Plus and, at the moment, apart from the one health board that is just a few midwives short, that is in place.

[85] We also do annual workforce plans to see how many midwives we should train, and the numbers this year are slightly more than last year. We have a young midwifery workforce; there are no problems of recruiting to the posts and we do not see or anticipate a great exodus due to age and retirement.

[86] **Mike Hedges:** May I move on to electronic fetal monitoring, Chair? I do not know much about it, so if there is ignorance in my question, please give me some leeway. What is being done with regard to it? You said that it will be completed in 2013. How much training does it take to get somebody competent in this? How quickly can you train people? When in 2013 do you expect it to be up and running so that everybody who needs to be trained is

trained? Also, what are you doing in the interim to ensure some level of staff competence and clinical safety in relation to electronic fetal monitoring?

[87] **Professor White:** Okay. Where do I start with this? There is training already in existence; I do not like to suggest that there is no training out there. There is already a variety of training tools that have been used across Wales for some considerable time. The Welsh Risk Pool, when it looked at performance in this area, found that there was variability, so I agreed to chair the group to look at having consistent training across Wales and at the last meeting that I chaired a few weeks ago we agreed that the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives' training tool would become the gold standard of training across Wales. Most of the health boards currently use that to a degree. Some will supplement it with other training packs. So it will be a very quick move to standardised training across Wales. That will happen almost immediately.

[88] The area of debate for us at the moment is what should go into training posts for medical practitioners. All the midwives and registrar level medical practitioners will have this standard training across Wales. What we are debating at the moment is what to do with the lower grades of training posts for those who may work on the units, particularly medical practitioners. We are working on determining what that should be. There is already training available; it is electronic-based training. Every year, the RCOG adds different scenarios. You have a graph tracing what the fetus' heart is doing. It shows whether it is under stress. The graphs are quite difficult to read and you need proper training to do it. So, every year, new scenarios are added and, each year, you can pick new scenarios to check that you are still competent. It is not a matter of training once and then forgetting it; you have to keep up to date on its use. We are going to use that package as the standard and require everyone who is in charge of a maternity unit to have competence, and demonstrated competence, in it before they are allowed to sign it off.

[89] **Mike Hedges:** Thank you for that response, which probably made a lot more sense than my question. You said this would be done almost immediately. Does that mean by Christmas or by early in the new year, for example?

[90] **Professor White:** For those areas that already have the RCOG/Royal College of Midwives pack in place, it is immediate. It is just a matter of changing over those areas that are using other packs to make it a requirement. It will happen in the next few months. I cannot give a specific date, because I do not have the data with me on how many places need to be changed over, but it will happen very quickly.

[91] **Mike Hedges:** Are those data available?

[92] **Professor White:** I can get the information for you. I do not have it with me.

[93] **Mike Hedges:** Would it be possible to send it to us?

[94] **Professor White:** Yes.

[95] **Mike Hedges:** Thank you.

[96] **Darren Millar:** I have a couple of questions. Going back to the staffing issues, obviously, we welcome the news that places are approaching the Birthrate Plus staffing ratios. That is very good news. Indeed, your paper sets out the fact that the medical workforce has also been growing in terms of your responsibilities, Dr Jones. Neonatologists were not covered in the response you sent in. Can you tell us where things are on the recruitment of sufficient numbers of neonatologists in Wales, Dr Jones?

[97] **Dr Jones:** Yes. We have been working very closely this year with health boards and the neonatal network on overseeing and driving forward improvements in neonatal services, as you know. We asked the health boards to provide us with detailed plans in May this year. Following receipt of those plans, Jean and I went round all health boards ourselves and met everyone to discuss areas where further work was needed. In some parts of Wales, medical staffing is clearly one of those areas. The neonatal network is now working to support the health boards as they get closer to reaching service standards. As you know, the problem is greater in some parts of Wales than others. We are nowhere near reaching adequate numbers of neonatologists in some areas.

[98] **Darren Millar:** Are you able to provide the committee with some figures on the trend in neonatologist numbers over the past few years in the same way you have been able to provide numbers for midwifery, gynaecology and obstetrics? It would be very helpful.

[99] **Dr Jones:** Yes, certainly. I can provide a note on that.

[100] **Darren Millar:** Okay. Thank you for that. A couple of Members want come in on this. Aled is first, then Jenny and then Julie.

[101] **Aled Roberts:** I have two questions, one of which concerns consistency of staffing levels across health boards. I have some concerns about consistency despite the fact that the same toolkit is being used. Are you satisfied on that issue? In particular, are long-term sickness and maternity leave included in staff rotas in some health board areas? Secondly, moving on to the issue of neonatologists, you will be aware that, over the summer, the Children and Young People Committee was particularly concerned about the numbers in Betsi Cadwaladr LHB, given that there is ongoing reconfiguration and there is nothing in the reconfiguration plans with regard to the deanery's announcement, subsequent to the publication of the reconfiguration plans, that it would withdraw training from those areas that no longer have level 3 services. I would like to know whether or not there was any oversight, as far as any implementation boards are concerned, to ensure that configuration plans accurately reflect the impact on staffing rotas, for example. My understanding is that trainee doctors figure quite prominently on staffing rotas at Glan Clwyd and Wrexham hospitals, and yet there was no mention of any potential impacts. It is not that I am questioning the reconfiguration plans, but there needs to be honesty with regard to recruitment that might have to occur as a result of the removal of those trainee doctors from rotas.

[102] **Darren Millar:** Perhaps I could ask you to be brief on this. We do not want to go into any detail on the north Wales plans in particular.

[103] **Mr Sissling:** Do you want to take the first part of the question, Jean?

[104] **Professor White:** Yes. Birthrate Plus does include within the calculations an uplift of so much for mandatory training and that sort of thing. I have not delved into the details of how it is being interpreted. Our conversations tend to be whether or not they are meeting the standard of Birthrate Plus compliance. So, that is the level of confirmation that I have had back and they tell me whether they are so many midwives short or not.

[105] The workforce activity that we are doing through the implementation group is looking around skill mix and how the teams can be better configured. We have introduced maternity support workers, so there is quite a lot of work to do with the workforce in support of how Birthrate Plus is actually used within the health boards. I do not want to take up too much time, Chair. Is that sufficient?

[106] **Aled Roberts:** You might want to look to see what interpretation lies behind the data because, obviously—

[107] **Darren Millar:** I think that the issue of consistency is the one that we would be keenly interested in.

[108] **Professor White:** I will take that forward and do that. Thank you very much.

[109] **Mr Sissling:** In terms of the second issue it would be inappropriate to go into the details, but, in general terms, and in process terms, we are obviously very much looking to the boards to take forward their reconfiguration plans. Our requirement of them is that they can assure us that they have taken account of sustainability issues, that they are consciously planning on the basis of known pressures on workforce, that they have discussed relevant issues with the deanery and other authoritative bodies, and that they can demonstrate a robustness of evidence-based planning that shows that their plans will provide for quality services for three months, three years or six years ahead. That is the time frame. Our role is to quality assure that and to make sure that they are taking into account exactly the kind of factors that you have just raised in their planning processes.

[110] **Darren Millar:** Okay. Jenny wishes to speak. I will then call on Oscar.

[111] **Jenny Rathbone:** It is an issue with a younger workforce that they go off to have babies occasionally. One of the issues that the auditor general flagged up was not being able to unpick how many of the midwifery complement were actually agency staff, as opposed to permanent staff with a full understanding of what the protocols were et cetera. That is quite a significant issue, and it does not seem to be possible to know, from the figures, whether you have the complement of permanent staff or whether many agency staff are being brought in to give the appearance of the numbers being up to complement. That is one question.

[112] My second question is on electronic fetal monitoring. I just want to know whether this bid to improve people's accurate assessment of the monitoring means that women will have to be strapped up throughout their labour.

[113] **Darren Millar:** In terms of the staffing issue that was raised initially there, there is also reliance in some areas on locums, is there not? Perhaps you could also touch on that in your response to Jenny's question. I do not know to which side of the table to address that question.

[114] **Professor White:** From a midwifery point of view, agency staff are not used very often. I do not have the figures before me, but I can certainly get them for you. It is not a big feature of the maternity workforce; they tend to be employed staff. We are seeing a better skill mix being introduced as we have maternity support workers and first-level nurses doing some work there. Nursery nurses have a role to play in supporting breastfeeding and that sort of thing. So, that is the kind of change that we are seeing, rather than having to use agency staff.

2.45 p.m.

[115] **Jenny Rathbone:** And what about electronic fetal monitoring?

[116] **Darren Millar:** We will come to that in a second. Could you first address the locum issues?

[117] **Dr Jones:** I just want to acknowledge that you are right that a number of obstetric services are being maintained through the use of locums. That is most likely to be the case where you have relatively small rotas, so if someone is missing, the gap is very noticeable; you do not necessarily have people within that rota to cover, which means that you may have

to employ a locum. The total costs for locums in obstetrics are over £2 million a year, and it is true that the presence of those locums, in a way, hides a problem with maintaining rotas in those services.

[118] **Darren Millar:** Of course, the skill levels required for a locum can be different than for a permanent post.

[119] **Dr Jones:** No, not at all. A locum clearly has to have the same level of skill and competence and the health boards have a responsibility to ensure that that is the case.

[120] **Darren Millar:** Okay, thank you for that. In terms of the shortfall, then, what is being done to recruit sufficient permanent staff, rather than having to fill the gaps with locums as happens at the moment?

[121] **Dr Jones:** I do not think that we have a significant number of vacant posts on a long-term basis. The issue is that the gaps in rotas often arise for a day or two, or a week.

[122] **Darren Millar:** Did you want to follow up on the electronic fetal monitoring?

[123] **Professor White:** Part of making sure that people understand how to read the graphs is about learning when it is appropriate to use foetal monitoring. The last thing that we would want to do is to move away from our explicit policy that pregnancy and childbirth is a normal human process; it should not be medicalised unless it is absolutely necessary to do so. So, this is part of the ongoing dialogue about the appropriateness of its use. Be reassured that we are not seeking to introduce it as a mandatory requirement for everybody, but only when it is appropriate.

[124] **Mohammad Asghar:** I want to ask you about midwives. The number of registered midwives has been reduced by, I think, 82 between 2007 and 2011. What is the reason for that, because the birth rate has not decreased or anything like that? Has that had an impact on childbirth services or maternity services? What steps are you taking to attract people to this profession?

[125] **Professor White:** Our numbers show that there has been an increase this year on last year by 65, as I mentioned before. What we have seen from 2007 to now, over a five-year period, is that there has been a fluctuation. The health boards determine what they need in order to deliver services. So, there has been some correction of numbers against Birthrate Plus, when that was introduced, that will account for some of this. We do not have any difficulty recruiting to the posts. Vacancies do not happen for any great length of time. We have no evidence to suggest that people are not attracted to the profession and, in fact, midwifery is seen as a very attractive profession. I was talking to the head of school at Cardiff University recently who told me that she had something like 60 applicants for every training place for midwifery. So, we can pick the cream of the crop to be trained in Wales; we have almost a 100% attainment rate at the end of the programme, because we are able to pick the best people to be trained. So, at the moment, I would say that midwifery practice is very robust in Wales. Employment rates just fluctuate.

[126] **Mr Sissling:** I was really interested to hear about maternity support workers and the development of those to support midwives to make sure that they can really practice at the appropriate level. The fact that we have some quite exciting training development programmes to provide this new workforce that can make sure that we have the right blend of different skills is fantastic.

[127] **Julie Morgan:** I want to ask you about neonatal services, which we have already touched upon. There have been some quite strong and clear reports on neonatal services

recently, including the auditor general's report in June this year and the report from the Children and Young People Committee, on which I also sit. How are you getting on with developing an overall, all-Wales strategic framework?

[128] **Mr Sissling:** One of the things on which we would want to comment is that this has become a real priority for the NHS in Wales. First, that is just a matter of how it is positioned and its profile, so the Minister and I have ensured that chairs and chief executives are aware that it is a priority. Neonatology is a subject that we talk about in every meeting that we have, which is important in order to make sure that it is seen as something on which there should be no reduction in effort or focus. To support that—because that is fine, in the sense that it creates a bit of background significance—there has been very important engagement with the health boards. Chris Jones described the plans that were sought and produced in May. We inquired about those plans, not on the desktop, but both Chris and Jean visited health boards to make sure that the plans were robust from every point of the compass, and some had to be strengthened considerably. We have ensured that if there are resource issues, those are taken into account in health board plans.

[129] We are also introducing the BadgerNet facility to make sure that we have the appropriate data for neonatology. Committee members will be aware of the investment in neonatal services over recent years, and I suspect that that will continue. We are also working at all points with an ever-increasing awareness of the British Association of Perinatal Medicine standards, and we are reflecting those in plans for the future. The neonatal network that acts as our guide in many of these matters is telling us that there is acceptable progress, but it is not 'job done', it is a work in progress, and we will continue to focus on it over the coming years. The other thing to say is that we are also using the necessary process of audit to make sure that outcomes are as we would want them to be for newborn babies. I do not know whether anybody wants to add anything.

[130] **Darren Millar:** A couple of people want to come in.

[131] **Julie Morgan:** Shall I go on with these first? There have been a lot of warnings about this; the matter has been raised consistently. Why has it taken so long to respond?

[132] **Mr Sissling:** It depends on what the length of time to respond is. My sense is that, over the last year, this has been escalated up the list of priorities and it is now very much in our premier division of priorities, and we are focusing on it in a determined way for all the reasons that I know that this committee would share. Again, it is difficult for me to comment on what happened previously.

[133] **Julie Morgan:** The previous report from the auditor general in 2009 highlighted some of these issues.

[134] **Mr Sissling:** I suspect that attention has been paid to some of them, but there has now been an escalation of attention. Certainly since the auditor general's reports of more recent times, I think that it is fair to say that we have redoubled our efforts to make sure that there have been proper improvements in this area.

[135] **Julie Morgan:** To ask about the finances, you said that you have been making sure that the appropriate finance was there. The Welsh Government told the Children and Young People Committee that any additional costs incurred in order to comply with the all-Wales neonatal standards will be met from existing programme budgets. What does that mean?

[136] **Mr Sissling:** I cannot say. I am not entirely sure what it means for programme budgets. The requirement will be on health boards to ensure that they build this into their plans. We sometimes hear health boards talk about what are called 'savings figures', of 5% or

4%. Part of the reason that they reach quite significant levels is that the boards undertake an assessment before the year begins of those areas where they need to invest in resources and whether it is an appropriate investment. So, if there are some shortfalls in their neonatal staffing, that will be one of the areas where they need to create the funding to allow appropriate investment in those areas in-year and for future years.

[137] **Julie Morgan:** So, the additional costs that arise will have to be catered for from within their budgets as they are.

[138] **Mr Sissling:** Exactly, yes. As I said, there is sometimes an assumption that the savings figures that we talk about are simply to stand still; however, more often than not, there are significant elements in them that represent the health boards' means of developing a pool of funding that they can invest in services. So, we are recycling and reprioritising money in areas of important and necessary development.

[139] **Darren Millar:** The Minister for Health and Social Services said that she had £50 million stashed in the bank, perhaps to be used in circumstances such as this, where there might be a need to invest in services in order to improve them, did she not?

[140] **Mr Sissling:** Absolutely. That is a very good point: there is. I think that it was in the Health and Social Care Committee that there was a communication of a contingency reserve, which would obviously be used judiciously, to support health boards both in a general and, at times, specific sense.

[141] **Jocelyn Davies:** Just on that point, you made it sound quite rosy, but a number of Members on this committee sat on the neonatal inquiry, and just a couple of months ago we received evidence that was contrary to what you are saying. I know that you have been here since May 2011, so you would have seen the evidence that was given to us. There have been many reports over the years that clearly demonstrate that things are different on the ground, and in fact the service is running on the goodwill of the current staff, who are at full stretch. Many of us would say that the Welsh Government has been monitoring the neglect of the service. One of the problems that we came up against was the fact that extra training or upskilling was impossible because people could not leave their posts in order to attend training sessions. So, even if more money is available, without there being any slack in the chain at all, it would be very difficult for people to undergo that training. You could bring yourself up to date by looking at the report that was produced just a few months ago. Are you suggesting that the picture is different to that which we described in the conclusions of our report?

[142] **Mr Sissling:** I would not contest the conclusions that you drew. What I said was that it is a work in progress, and we are not there yet. I would also draw this committee's attention to the work that we are doing with health boards to make sure that there is an improvement. We have established this as a priority across Wales, and for every health board. We are engaging with health boards, and they have plans that identify the scale and nature of the challenge. We are, again, overseeing processes of implementation. So, no, I would not in any sense seek to say that the position anywhere is at an end point. We are engaging with these challenges and there is increasing evidence that the health boards are making progress in a number of different areas, and that will continue. In some cases, it requires quite significant change in matters of staffing or even matters of structure, and that will happen over time. I recently visited a neonatal unit in a Cardiff and Vale hospital, the Heath, and there is a requirement there to provide a better environment for the provision of services. Some things we can do immediately and other things will take a bit longer.

[143] **Jocelyn Davies:** So instead of just asking health bodies to count if there is a shortfall, you are now expecting them to take action in order to fill that gap; rather than just monitoring

what is going on, there is now an expectation of improvement, which could be the sea change that we need to see improvements in the service.

[144] **Mr Sissling:** That has been in place for a number of months now. Sorry I did not convey that earlier. We are not simply passively monitoring. It is very much to do with improvement trajectories and paths of improvement, and clearly seeking evidence and information that shows that there will be improvement. That covers all kinds of issues—staffing levels, capacity and the deployment of capacity. There are process issues in terms of the way that demand is managed, and there are leadership issues, so it is multifactoral because, as we know, these services are complex and we need to make sure that we are addressing all areas of service planning and delivery. However, it is very much based on delivery; it is not planning.

[145] **Aled Roberts:** You might need to update yourselves with regard to the position in north Wales in the next month. I want to talk about the process and resist the temptation to become parochial—let us put it that way. So that I may understand it properly, the local delivery plans deal with the current situation, do they not, or do they also deal with any post-reconfiguration situation? Obviously, the scenario that we have currently within certain health boards is very different to what the scenario will be if their neonatal reconfiguration proposals are seen through. So that we are perfectly clear, may I just ask you to explain whether local health boards' information with regard to meeting BAPM guidance is actually with regard to their current configuration, their future reconfiguration if their preferred strategy is adopted, or both?

[146] **Mr Sissling:** I think that it has to be both. Their plans for their current service arrangements obviously have to meet standards, as we would expect them to, and it is implicit if not explicit that their plans for the future, whether through reconfiguration or just a process of improvement, equally have to meet the required standards.

3.00 p.m.

[147] **Aled Roberts:** Will those checks have been carried out by the neonatal network and the National Clinical Forum?

[148] **Mr Sissling:** Yes, they will. They will be asking the questions of the health boards to make sure that is the case.

[149] **Aled Roberts:** Do you mean that they will be asking or that they will have asked those questions before the plans were submitted?

[150] **Mr Sissling:** Do you mean the reconfiguration plans?

[151] **Aled Roberts:** Yes.

[152] **Mr Sissling:** They will be doing it as part of a continuing process. They are there as a continuing source of advice to the health boards as part of the planning process, and that will continue right through to any decisions and beyond any decisions about the outcomes of the planning process.

[153] **Aled Roberts:** However, you are not saying that, before those reconfiguration plans were shown either to the forum or the network that there was an understanding as to how the individual health board would meet the BAPM guidance going forward, were those plans to be achieved.

[154] **Mr Sissling:** This is quite detailed in terms of the—

[155] **Aled Roberts:** I am just wondering what reassurance we have, because the BAPM guidelines have been in place since 2008 and there was little or no movement in certain health boards to meet that guidance in the first four years, so what reassurance do we have with regard to the issue going forward?

[156] **Mr Sissling:** The plans that the health boards are developing have within them the guiding principles of sustainability and equality. So, the plans have to be able to demonstrate—not just the neonatology bit, but all areas—that they allow compliance with appropriate standards. That applies to all areas of care delivery. Part of our role is to seek assurance from the health boards at board level that they have taken that into account and that they can demonstrate that in their plans. Clearly, in different areas, they have different points of advice, whether the neonatal network or the National Clinical Forum, that can provide them with advice at all points about the risks and the challenges to meeting those particular standards.

[157] **Darren Millar:** We have the clock against us, but I want to ask one final question on neonatal services. In terms of the standards, obviously, we have the all-Wales neonatal standards. Some of the health boards will be working on a cross-border basis, so, if they are procuring services from an NHS trust over the border and if that hospital service is working to a different set of standards than the all-Wales neonatal standards, what is the implication for the quality of service for Welsh patients? Has that been considered?

[158] **Mr Sissling:** It would be for each health board to consider. However, the thing that drives us forward is our responsibility for the population. So, there would need to be satisfaction that appropriate standards were being provided to those using services through the arrangements that the health board puts in place.

[159] **Darren Millar:** However, you accept there is the potential for conflict there, is there not, with regard to hospitals working to standards that have been developed in England that may be better or worse than the standards that we have been developing in Wales?

[160] **Mr Sissling:** I can see the potential for conflict, but it is for the health boards to work through that to make sure that Welsh residents receive the right standard of care.

[161] **Darren Millar:** Okay. Thank you for that.

[162] **Gwyn R. Price:** What is the Welsh Government doing to help to achieve a reduction in the number of stillbirths?

[163] **Professor White:** As you know, we had a stillbirth inquiry in the summer, and we reported at that inquiry that, in May 2012, we established an all-Wales group to look at trying to improve stillbirth rates. We have had a static level of stillbirths for probably 20 years or so—it is around 5.3 per 1,000 births. If we compare that with the figure for the rest of the UK, we see that it is about the same. If we compare ourselves with Scandinavian countries, we see that they are a little better than us. So, the group is currently looking at giving advice to mothers about looking at foetal movement, and is looking at the predisposing factors. In fact, some of the public health work that we are doing through the maternity vision will have an impact on that, because things like obesity and smoking are the factors that cause or can contribute to stillbirth. So, the two areas should feed off each other.

[164] The group is looking at whether or not there are specific things we can do to change practice. However, to be honest, it is very difficult to make improvements in this area. By looking at the Scandinavian work, we are hoping that there may be some instances of significant change. However, it is likely that we need to get a grip on the make-up of our

population and some of the predisposing factors around public health before we see some changes in the stillbirth rate. That is the honest truth.

[165] **Jocelyn Davies:** You mentioned earlier that the number of women being seen in the first 10 weeks of their pregnancy will be one of the indicators, and that having good support early in pregnancy would reduce the stillbirth rate. These figures have not been collected yet, but what percentage do you think would be a good percentage of women being seen in the first 10 to 12 weeks of their pregnancy?

[166] **Professor White:** We are aiming towards all of them being seen, so our target is that unless a woman chooses to present late for—

[167] **Jocelyn Davies:** Just before I came down, I had a look at the Cwm Taf health board's freedom of information log. A freedom of information request showed that, last year, in 2010-11, 29% were seen in the first 12 weeks. Are you surprised that the figure could be as low as 29%?

[168] **Professor White:** I had not seen that figure so I cannot comment on it. I admit that it does sound low.

[169] **Jocelyn Davies:** It is a simple freedom of information request, but when that indicator is produced you will expect to see high numbers.

[170] **Professor White:** We would expect to see a figure that is a lot better than that.

[171] **Darren Millar:** Julie, you wanted to come in, and then I will bring Aled in.

[172] **Julie Morgan:** Do the stillbirth rates differ a lot throughout Wales?

[173] **Professor White:** No, it is fairly consistent. Given that they are very small numbers, when you start breaking it down by health board, it becomes statistically difficult to make any comment. So, we look at it on a population basis, because we are talking about such very small numbers across Wales. What we would like to see are comparators to Scandinavian countries with a similar population to try to improve our performance against theirs, rather than just saying that it is worse in one health board than other; the numbers just do not allow us to do that.

[174] **Aled Roberts:** Moving to caesarean sections, the figures that we were provided with were drawn from the auditor general's letter, and which were taken from the StatsWales webpages. The figures that you have provided in your evidence are different. Are you able to explain that difference? Secondly, we have been talking this afternoon about delays. The Welsh Government had intended in June 2011 to identify progress made by health boards against the implementation of the toolkit. We are now told that that has been deferred while the Welsh Government considers its approach. Could you tell us when we are likely to have a decision on that and whether you feel, based on the current information available to you, that health boards will be able to reduce caesarean section rates in line with the intention of the toolkit?

[175] **Professor White:** The difference between the two sets of statistics simply is Powys. Powys mums do not have caesareans in Powys—they go out of the county. Our statistics included deliveries within health board areas and the other statistics included those outside of health board areas. That is the difference; it is a matter of 0.6%, and that explains it.

[176] **Aled Roberts:** It is just to show that we read your evidence.

[177] **Professor White:** I am very impressed. [*Laughter*.]

[178] **Darren Millar:** Just testing.

[179] **Professor White:** Following the implementation of the toolkit, we now have quite detailed reports from all of the health boards showing the action they have been taking in delivering the elements of the toolkit, what progress they have made and what they feel are the things that are still difficult for them to achieve. For example, one health board looked at vaginal birth after caesarean. It is often the case that when a woman has had one caesarean section, she will seek to have another and another, rather than considering having a vaginal birth. All of the health boards are looking at holding clinics. One health board has had a midwifery consultant to lead a clinic, and its rates have gone from 41% up to 71% just by having the clinic. So, more women are choosing that. The evidence that we are seeing is that some of the interventions that have already started—by having clinics, for example—will have a significant effect on the caesarean rate. We have some of that data and would be happy to share it in detail. However, it is appropriate in this meeting to say that we have a clear understanding of what they have chosen to do and what they feel are the things that are holding them up.

[180] **Jenny Rathbone:** Nevertheless, based on the figures that you have provided, the caesarean rates have gone in the wrong direction in four of the seven health boards. What assurance can you give us that we are going to see major improvements from now on?

[181] **Professor White:** We have decided that the best way to look at caesarean section rates is to look at whether the treatment is appropriate. In some cases, it might be very appropriate that a person should have a caesarean section. That will be determined by things such as obesity, or other factors whereby we need to ensure that it is appropriate. However, in those areas where the rate is over 25%—and there a quite a number of those—we would want reassurance from the board that that rate is appropriate. For those where the rate is 30% and above, we have already been having conversations to ask whether they think that that is too high and they have agreed that it is, hence the use of the toolkit. We are already starting to see some movement in that area. Our stance is that we will expect the health boards to explain why their rates should be anything more than the expected number—which is a percentage in the low 20s. If the rate is 25% or over, they have to explain what they are doing to look into and how they might change their practices.

[182] **Jenny Rathbone:** However, our target is 15% under the World Health Organization, is it not?

[183] **Professor White:** The WHO has withdrawn that figure, I believe. It is about its appropriateness. Our problem is that the NICE guidance states that women may have a choice about whether they want a caesarean section—we may offer advice or counselling, if they are anxious—but the person still has a choice if they want to go forward with that. The health boards have all recognised that the NICE guidance has added another dimension to this, which will act as a pull in the wrong direction if we want to reduce the rates. There is a rather complicated mix of factors around public health challenges, as well as the guidance that says that it is a woman's choice and that if she wants to have a caesarean section, she can have one.

[184] **Mr Sissling:** It is important to get the right blend between performance management and ownership of improvement. We were encouraged to see, in response to the inquiry that Jean just described regarding the use of the toolkit, that some health boards are committing to improvement themselves. Betsi Cadwaladr University Local Health Board is committing to a 1% reduction, year on year, on a sustained basis. That is what we want to hear; rather than us providing an arbitrary figure from the Welsh Government, it is great that it is saying that. It

knows what the variations are between the different parts of the health board. It is saying that that is its target; it owns it. If it owns it, there is much more of a chance that it will deliver it.

[185] **Ms Foster:** Further implementation of the maternity strategy and the vision for maternity services should also improve public health messages. Later down the line—it will be a bit of a slow burn—that should also have an impact on caesarean section rates, when it is fully implemented.

[186] **Darren Millar:** By reducing the risk factors.

[187] **Ms Foster:** Yes.

[188] **Mohammad Asghar:** What exactly does the Welsh Government mean when it says that a review of the breastfeeding programme is under way to support fast progress to complete all-Wales breastfeeding data introduced in September 2012? Did all the health boards receive a specific grant to appoint a breastfeeding co-ordinator? Has the Welsh Government confirmed that where the grant funding was received, it was used for the intended purpose?

[189] **Professor White:** We have appointed an all-Wales breastfeeding co-ordinator who sits in Public Health Wales. Her role is to work with each of the health boards to seek to implement the baby-friendly initiative, which is a UNICEF accreditation that promotes breastfeeding and good practice in breastfeeding. We have been working on this for a number of years. All the health boards have been given money to support this initiative—each health board is given £9,800 for co-ordination and £4,300 for strategic management. We have been reassured, through the all-Wales co-ordinator, that that money is being spent appropriately. I will be chairing UNICEF UK's baby-friendly initiative conference in a few weeks' time and we will now be starting to explore things around breastfeeding for neonatal services, which is an expansion of the current breastfeeding initiative, which is in maternity services only.

3.15 p.m.

[190] **Darren Millar:** On that note, we thank you for your attendance today. We are grateful to you for coming in to help us with our inquiry. You will be sent a copy of a transcript of today's proceedings; if there are any things in there that need to be changed, please let us know and we will make sure that it is corrected. Thank you very much.

[191] Given the time, we will not now go into private session as we were planning to do; we will move on with our evidence session. We will move into private session later.

3.16 p.m.

Papurau i'w Nodi
Papers to Note

[192] **Darren Millar:** May I take it that all the papers that have been circulated are noted? I see that you are in agreement.

3.17 p.m.

Gwasanaethau Mamolaeth yng Nghymru—Tystiolaeth gan Fyrddau Iechyd Lleol
Maternity Services in Wales—Evidence from Local Health Boards

[193] **Darren Millar:** We will continue with our inquiry into maternity services in Wales. This time, we will be taking evidence from the local health boards. I am delighted to be able to welcome Paul Roberts, chief executive of Abertawe Bro Morgannwg University Local Health Board, Allison Williams, chief executive of Cwm Taf Local Health Board and Kath McGrath, assistant director of operations, Cwm Taf Local Health Board. I understand that Angela Hopkins was going to be joining us, but you are very welcome in her place, Kath.

[194] Thank you for agreeing to attend the meeting today. If any of you want to make introductory remarks on behalf of local health boards in general, please do so. We will then move to questions. We have not received a paper from the LHBs collectively.

[195] **Mr Roberts:** I have some very brief, general remarks to make, just to put one or two things in context. First, we can all welcome—and, as health boards, we certainly welcome—the attention being paid in Wales to maternity services. We all see it as being a high priority for our health boards. We can also welcome the fact, as the Wales Audit Office acknowledges, that giving birth has never been safer in the history of the health service. That is great, but not a cause for complacency. Looking at the previous report, certainly in my board, we have an action plan in place and are focused on a number of areas that were brought to our attention by the Wales Audit Office in the past. We have made progress, but we would acknowledge, having seen the update that you have had from the Wales Audit Office, that we have further things that we need to focus on, such as the obstetric presence on labour wards, caesarean section rates, making sure that there is a good, consistent workload and model within community midwifery services, the staffing and capacity of neonatal services, and, importantly, some of the public health issues in maternity services as well. Before we got into questions, I just wanted to assure the committee that we are focused on those areas.

[196] **Darren Millar:** I am grateful for that. You have told us, as the auditor general found, that things are improving, albeit slower than everybody would like. What do you see as being the main improvements that have been introduced in your own individual health boards since 2009 when the report was published? Do you want to answer first, Allison?

[197] **Ms Williams:** First, having the national strategy that emerged as a consequence of the original audit work has been incredibly powerful. The infrastructure that has been put in place around the implementation of that, particularly the focus on user involvement in driving improvements through local health boards, has been instrumental locally. I know that, if any of my colleague chief executives were here, they would also acknowledge that as a very significant part of that improvement journey.

[198] We have made significant progress with some of the practical issues, such as compliance with Birthrate Plus. Understanding some of the data, the indicators and the work that has been done nationally to get a core set of indicators that I, as a chief executive, am able to drill down into regularly to get assurance about the quality of the service provision have been very positive outcomes of this work, as have the concentrated efforts across health boards working together. What we have found since the new health boards came into place, and particularly in the last 18 months, is the high degree of co-operation between and across health boards, which is particularly relevant to us in south Wales in terms of medical manpower and planning, consistency of quality and standards of delivery, and around the reconfiguration plans that will ultimately deliver the safe, sustainable services for our populations.

[199] **Darren Millar:** Do you have anything to add to that, Mr Roberts?

[200] **Mr Roberts:** Yes. It must be appreciated that the Welsh NHS came through a period of quite a lot of reorganisation, with trust mergers and the mergers into health boards. I think that one of the most important things has been to stabilise the position and get some consistency. In my own board, we have had different models of managing and running services, and we focused a lot on trying to get some of that consistency. For instance, we had different information systems being used by maternity services at each end of the patch. Now, we have managed to get that into one system as well. Also, some of it has been focusing on the governance arrangements that a new board can bring. So, we have been looking at making sure that we have a very good handle on things such as the statutory and mandatory training that are vital to ensure quality in maternity services. In the same way as Allison, we have been making sure that we have the staffing arrangements that are compliant as well. I think a great deal of progress has been made, but it is quite important to put it into the context of where we have come from in terms of organisational arrangements within the NHS.

[201] **Darren Millar:** We will touch on some of the consistency issues in a few moments. I will bring Julie in in a second. I would like to check something with you, Allison. I think that you referred to the strategy document itself being a very welcome catalyst for improvement in your own health board. Of course, that strategy document was delayed somewhat, was it not? It was not published until September 2011, despite the Government giving a commitment that it would be available by December 2010. Did that delay improvement in your own board?

[202] **Ms Williams:** No, what happens whenever we receive any national or local audit reports is that the recommendations are always driven forward as a matter of urgency in terms of improvement within the health board. What the strategy did is that it brought together a number of strands that helped us to focus on the consistent delivery of that, because in the absence of a strategy, you are focusing very much locally on the local issues that are relevant to you. What the strategy enabled us to do was to take a more whole-system approach. The strategy itself is not the key. The key is how we then consistently implement that strategy. Having the implementation board and our own representatives from health boards around that table has been very instrumental in getting that consistent approach across Wales.

[203] **Darren Millar:** Thank you for that. Julie you wanted to come in.

[204] **Julie Morgan:** Yes. I think, Allison, you said that user involvement has been very significant. Could you give us any examples of the way that the strategy or your policies have been changed by user involvement?

[205] **Ms Williams:** I think that this is not unique to maternity services. This is the journey that the NHS has been on. It may sound almost like stating the obvious, but getting user involvement and using the user experience to drive and implement improvement and change is so significant and is becoming a much more integral part of the way that we are working as health boards. Certainly, our own local liaison committees have been very significant in giving us feedback to help us improve services. If I could give you a very local example, we were looking at changes to a midwifery-led unit in Cwm Taf and the staff and the users were extremely instrumental in helping us to identify what the priorities were, what we needed to do and the pace of change that we needed to deliver that. They are also part of the evaluation of the changes that we make. It is not just about how we trigger change, but how we evaluate what we have done, and we use their experience on a continuous basis. That has been very instrumental to us.

[206] **Jocelyn Davies:** So, your boards produced the local delivery plans in line with the March 2012 timetable set out in the strategy. Perhaps I was not very good at searching, but I

could not find them on your website when I had a look today. I could not find them individually. Can you tell us what the key features of those plans are, and outline how you have worked together with others? You have mentioned co-operating with other local health boards several times. Could you explain how that works in south-east Wales?

[207] **Ms Williams:** I will start and perhaps Kath may also wish to contribute.

[208] The local delivery plans have been very much about targeting local interventions for local improvement, in relation to things like our breastfeeding rates, compliance with the national standards for breastfeeding initiatives, caesarean section rates, user involvement and other significant indicators. The reference that I made to service reconfiguration does not feature specifically within the delivery plans, because that is a piece of work that we have been doing across south Wales with the health boards working together. Particularly, medical manpower planning for the future is something that we are doing together. However, nurse and midwifery staffing levels for neonates and midwives are an integral part of our local delivery plan. There are two levels to that. We would be very happy to make our plans available to you if that would be helpful.

[209] **Jocelyn Davies:** When I went on to your websites, I tried all the key things and could not find them. Do you have anything to add?

[210] **Ms McGrath:** With regard to a co-ordinated approach across Wales, we are in an ideal position with regard to maternity services. The heads of midwifery advisory group, which brings together heads of midwifery from across Wales along with the Royal College of Nursing and the local supervising authority, has been very powerful in the past with regard to developing an all-Wales maternity record, which minimises risk to women as they move around Wales. That group is key to the implementation of the actions from the strategy. I went to a recent heads of midwifery advisory group, and that was a key part of its agenda. It is about taking these issues forward on an all-Wales basis, not just in the local delivery plans.

[211] With regard to our local delivery plan, one of the key areas for us is going to be caesarean section rates, as we have a high rate. With regard to breastfeeding rates, we have full accreditation for both our hospital sites and we are soon to be assessed for full accreditation for a community baby-friendly initiative. For us, the key areas will be those that are out of line with other areas in Wales. The main one will be the caesarean section rates, although they all have detailed action plans.

[212] **Jocelyn Davies:** Are both of you completely happy with your midwifery staffing levels?

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

[214] **Ms McGrath:** Yes.

[215] **Jocelyn Davies:** I do not know whether you heard earlier, but, when I was trying to look for the delivery plans, I came across a freedom of information request about the percentage of women who have their first antenatal assessment in the first 12 weeks of pregnancy. I thought that the figure was rather low. Between 2009 and 2010, it was 36.9%; in 2010-11, it was 29.2% in your area; and, between April and December last year, it was 55.8%. It seems very low when you say that your staffing levels, in terms of women having access to services, are adequate.

[216] **Ms McGrath:** This is around the multi-professional approach. We measure midwives' point of contact at their booking visit. In a lot of areas in our locality, general practitioners are still the first point of contact because they still want to be involved in

maternity services. So, we are working with GPs to make that point of contact as fluid as we can, so that women get to see a midwife very early on, as well as a GP.

[217] **Jocelyn Davies:** I do not know whether it was for midwifes; it just said 'first antenatal assessment'. This was a request that was put in by somebody else that I just came across.

[218] **Ms McGrath:** We capture the midwives' first point of contact—the booking visit—rather than the first appointment with a professional.

[219] **Ms Williams:** People can still go directly through primary care to their midwife as the first point of contact. We still have parts of our community where the GP is used as that first point of contact. That would not be captured within those data, so it could be that a significant proportion of those women not included within that had already had that first point of contact—

3.30 p.m.

[220] **Darren Millar:** Why are you not able to capture that, because it is a pretty important indicator, is it not, as we just heard a few moments ago from the Welsh Government?

[221] **Ms Williams:** It depends on the question that we ask. That specific question is about the first point of contact at antenatal, where we would measure the midwife contact. We could produce those data, but we would be asking a different question, about the first health professional—

[222] **Darren Millar:** What is your current rate then, if that is not the accurate rate?

[223] **Ms Williams:** I could not tell you the absolute rate as I sit here, but I can get those data for you if that would be helpful.

[224] **Darren Millar:** That would be very helpful.

[225] **Darren Millar:** What about your situation?

[226] **Mr Roberts:** We have an implementation plan as well, which covers five headings. My apologies that it is not on the website. We can go back and have a look at that.

[227] **Jocelyn Davies:** It might just be that I am rubbish at searching the website.

[228] **Mr Roberts:** They are not always the easiest to navigate, I agree.

[229] **Jocelyn Davies:** However, I am sure that a member of the public would have the same difficulty.

[230] **Mr Roberts:** That is a fair comment.

[231] **Jocelyn Davies:** Mind you, do not ask us about our website, because finding any information on that is even harder.

[232] **Mr Roberts:** I will just quickly run through the headings but, as Allison said, it is mainly focused on the local issues. The national implementation group is looking at the national issues, and we have people involved in that. The local issues, particularly for midwifery, are getting a unified leadership structure for the board, because we have brought two/three services together. I mentioned earlier co-ordinating information systems, and we

have now achieved that. On obstetrician availability on the labour ward, we are not there in Swansea yet. We have a business case that we will be looking at for our services in readiness for next year's business plan, because that is quite a costly investment to make. However, it is clearly an area involving the standards that the Welsh Risk Pool and the Royal College of Obstetricians look for. On inconsistency in community midwifery services, we now have a lead right across the patch, and she has developed a group that is looking at standards in community midwifery, but also at workload levels across the community. It is quite early days on that, so I cannot point to any outcomes.

[233] The last area is the development of perinatal mental health services, and we have developed a group to assess our current service in that area. We have made limited progress on that, but we recognise it as a priority, and it also fits in well with our implementation of the Mental Health (Wales) Measure 2010.

[234] **Jenny Rathbone:** Going back to the early referral to midwives, is it that GPs are resistant to ensuring that the patient gets immediate access to a midwife, or is it that community midwives are not aligned with health practices and GP practices?

[235] **Ms McGrath:** Midwives are aligned with health practices. There are some GP practices that still want to be very much in tune with maternity services, and there are others that are happy to hand that over to the midwife. We have to get the right balance there, because the GP holds a wealth of information about the family and the individual, and we need to capture that as well. There is a bit of a fine balance there, as we do not want to turn GPs off because they have the wealth of knowledge, but we need to get women in to see the midwives for their full antenatal assessment as soon as possible. That is work that we need to do with the individual practices, and not one specific issue.

[236] **Jenny Rathbone:** My main question was about how well placed you are to develop the hub and spoke model, which is where the majority of women having normal deliveries are being looked after by the experts, who are the midwives, with back-up and referral where things start to go wrong and they may need the input of a consultant.

[237] **Ms McGrath:** We would certainly be looking for as many low-risk women as possible to be cared for in their community rather than in the centres. They may choose to give birth in those centres, but the lion's share of their care should be given in the community service with their midwife and general practitioner.

[238] **Jenny Rathbone:** How well developed is this hub and spoke model in both areas? You are the outlier as far as caesarean sections are concerned. It is good to see that your rate has gone down slightly, but you are still way the highest in Wales.

[239] **Ms Williams:** Perhaps I could start on that. It is one thing that exercises us, and is a considerable issue for debate, as you might imagine. There is no magic figure that is necessarily applicable across the board. We are also very conscious that, particularly in our community, there is a correlation between caesarean section rates and deprivation and health inequalities. We have the highest levels of obesity and the highest levels of deprivation within our community, and these are health inequalities that we must tackle, and are tackling, working with colleagues in the Welsh Government, as well as locally. That is often about pre-pregnancy: by the time someone is pregnant, it is already too late to be tackling some of these issues. So, it is a bigger public health issue that we are working on. However, we are also constantly scrutinising caesarean section rates, and we are looking at the outcomes following caesarean sections. Interestingly, we are a community that has the highest level of low birth-weight babies, but the lowest perinatal mortality rate. So, we are tackling some of the health inequalities issues, and grappling with those, but that is not necessarily bearing fruit in respect of the adverse outcomes for babies and the mothers. Our surgical site infection rates are lower

than the Welsh average, but there is no complacency there, and we are constantly working with our clinicians, and the communities to manage expectations about caesarean sections and the normalisation of normal birth, as opposed to caesarean sections.

[240] **Jenny Rathbone:** Given the profile of your population, how does that impact on your hub and spoke delivery model? You clearly have a high percentage of high-risk women, from what you say.

[241] **Ms Williams:** Yes. In the antenatal care, it should not make any difference at all. The issue is with those 24 to 48 hours around delivery. Our home delivery rates are lower than average. However, through our maternity services liaison committee, we have worked with our service users and with our staff, particularly in the north of Cwm Taf, where we have some of the highest levels of deprivation, to undertake a trial of co-locating our low-risk delivery units on the same site as the full consultant and obstetrics service, to increase the uptake of lower-intensity deliveries. We are six months into that programme, and we are just about completing the evaluation. What we are finding is that that is enabling us to have a higher uptake of the lower-intensity-type delivery, because we are able to manage the women who may have a greater degree of risk, because the services are co-located. So, it is horses for courses, depending on the community. That is why it is so important to work with staff and service users, to ensure that we are meeting their needs.

[242] **Jenny Rathbone:** That sounds very interesting. I am sure that we would like to hear more about that when you have had time to evaluate it. What is the situation in Abertawe Bro Morgannwg University Local Health Board?

[243] **Mr Roberts:** I will give a brief summary first. I think that the board has a good track record on this. We have both models working in the board. We have an alongside midwifery-led unit, as well as a standalone midwifery-led unit, and both units have a good track record. As we know, the research programme on birthplace, although it is being conducted in England, tells us that that is a decent system to have in place, and that its outcomes are pretty reasonable. Therefore, for normalising birth, that is a good system to have in place. So, we have an alongside midwifery-led unit in Swansea, and in Neath Port Talbot, as I am sure you know, we have a standalone midwifery-led unit. We also have reasonably high home birth rates, too. So, it feels to me that, in practice, the normalisation of birth works well in the health board. One could always go further, of course, and as we further pursue looking at the shape of maternity services in the future, we probably would want to push that further, because we could go further, but it is a good track record now. C-section rates for us are really picking up. As Allison said, you can almost trace the direct relationship with deprivation rates, although I suspect that, having brought several services together, there are some historical and some cultural issues that come through with c-section rates as well. Our overall rate is about 25%, but we have a higher rate at Singleton Hospital.

[244] **Jenny Rathbone:** The rates have gone up.

[245] **Mr Roberts:** Our rates have come down.

[246] **Jenny Rathbone:** In the latest figures in the paper presented by David Sissling and co, they had gone up, which obviously is of concern.

[247] **Darren Millar:** Just to correct, we also have, from the auditor general, figures from March 2007 as compared with March 2011.

[248] **Mr Roberts:** Those are the figures that I am looking at.

[249] **Darren Millar:** They have come down: from 30% at Singleton to 27%, and from

22% at the Princess of Wales to 21%. However, there is a big gap between the two hospitals. You were talking earlier about the need for consistency. Just talk a little more about that.

[250] **Mr Roberts:** I said earlier that it is in our action plan going ahead. You could certainly argue that both those rates are too high. It depends on the circumstances.

[251] **Jenny Rathbone:** I would say that they are too high.

[252] **Mr Roberts:** Indeed, many people would, although many would debate it. It is fair to say that, even with bringing the rate down to 27%, that is still a high rate. Work is ongoing in the Swansea units to bring those rates down further. As Allison was saying, some of it is to do with people's attitude and nervousness about some of the comorbidities and public health factors that we have within the board, but some of it is still clinical culture. We have to tackle this on both fronts. It is definitely on our agenda, and we definitely see it as a priority to address.

[253] **Aled Roberts:** You explained the reasons for the higher rate within boards and also the difference down to the culture and approach within certain units and between units. Have you carried out any assessment at a Welsh level of whether approaches to antenatal care et cetera and established practice may lead to higher rates here than in other countries? I am thinking of Europe in particular, where there appears to be a different approach to antenatal care. We seem to be focusing on the traditional NHS model.

[254] **Ms Williams:** I am not aware of an all-Wales specific study looking at models of antenatal care in the way that you describe. Locally, we have looked at a number of factors to get underneath and have a better understanding of why the caesarean rates are high and why there is variability between clinicians and between hospital sites. For example, we collect the data down to the level of community midwifery teams. We monitor trends so that we can identify whether there is any one particular team in the community that seems to have a higher rate than another, which might indicate that the counselling at antenatal stage is different from that in another team. We use all that to help us to focus our interventions with staff. If you recall, when the National Institute for Health and Clinical Excellence guidance came out about choice in caesarean section, there was anxiety that that might result in an increase in the number of caesarean sections. Arguably, if the antenatal counselling is robust and if women are very clear about the risks and benefits, the choice should always be the right choice, based on clinical need as opposed to just an uninformed personal preference. There has not been a specific piece of work on an all-Wales basis that I am aware of, unless I have missed something.

[255] **Mr Roberts:** No.

[256] **Ms McGrath:** No, not that I know of.

[257] **Aled Roberts:** David Sissling or Jean White mentioned that there were, as you indicated, projects in specific health boards, but that is dependent on the configuration of your staffing within the health board. For example, it was mentioned that consultant midwives are not in place through Wales. How is best practice shared?

3.45 p.m.

[258] **Ms Williams:** We have the opportunity, through the professional networks, to share best practice. Consultant midwives is a very positive initiative, but we should not be reliant on individuals in such posts to be driving these sorts of quality improvements. These quality improvements are everybody's business; this is about every interface between a woman and her midwife and between a woman, her partner and the consultant obstetrician, if necessary.

So, those factors should not influence things such as the caesarean section rate directly, because those are decisions that are either made in an emergency in a medical situation, or on their maternity journey. It is about that continuity of care between the midwife and the woman in making the right choices about the place and the mode of delivery.

[259] **Aled Roberts:** I have a brief question on the data. What is your understanding regarding the Welsh Government's expectation on delivery of baseline data from health boards? Given that one of the outcomes that the Government is moving to is the percentage of women who have had an initial assessment within those 10 weeks—not by whom they have had it—is the informatics group aware of problems regarding the compilation of data?

[260] **Ms McGrath:** At the most recent heads of midwifery meeting that I attended, there was concern around measuring apples and pears on the outcome indicators. It was decided that more prescriptive and detailed outcome measures would be circulated, so that we were all measuring the same information. Some outcome measures were on the confidence and competence of parents—how do we measure that? Some health boards might capture that through a community midwife providing a questionnaire to women, but would they have a different response if they did an online questionnaire? When there is a health professional there, it can be very different. So, it is about how we capture those data so that they can be easily measured across the board. Online questionnaires, with the ability to complete them elsewhere if the individual does not have online access, would probably be best, so that we get a true measure across Wales. However, there is some confusion at the moment around the detail—the devil is always in the detail.

[261] **Ms Williams:** In terms of the output of the informatics group, where there are clear objective measures that have been cascaded and recommended, the next step is being sure about the reliability of the data capture and the informatics systems to enable us to do that. Speaking for Cwm Taf LHB, we have spent many years developing a local solution, which gives us quite a lot of very high quality, robust data. Some of that may need to be tweaked in order to answer the questions. Coming back to the question that you asked about the first point of contact: can we add the GP data information into that to get a more robust answer? The answer to that is 'yes'. The advantage of now having a national implementation vehicle is that we can share that across Wales, so that we are not reinventing the wheel and, where necessary, we can make local systems that work in one place available to others.

[262] **Aled Roberts:** When do you expect to be able to provide those baseline data, as health boards?

[263] **Ms Williams:** We understand that those have to be produced by the end of this financial year. We are all in slightly different positions, depending on your local data capture. That is something that we have been testing locally, within our health board and we are pretty much there in being able to answer the questions that have been put forward now. We have to go back to test that the right questions are being asked to get the right answer: the point in question is the first one that was asked today about the first point of contact in antenatal care.

[264] **Darren Millar:** Obviously, a very important part of these baseline data is going to be your caesarean section rates. The last information that we have available to us is dated March 2011. You are not going to make much progress on that if it takes a long time for that information to be produced, so how regularly do you publish that information?

[265] **Ms McGrath:** We publish ours on a monthly basis.

[266] **Darren Millar:** Every month. So, what is your current rate?

[267] **Ms McGrath:** Each delivery goes in, as it occurs.

[268] **Darren Millar:** Yes. So, what is your current rate?

[269] **Ms McGrath:** Our current rate varies, month on month. I looked at the figures for March of this year and our rate was 24% across the health board. However, I also looked at the overall figure from April up to now, which is 30%, so there are variations month to month in the caesarean section rate.

[270] **Darren Millar:** However, you have cumulative figures on a monthly basis that you are able to report.

[271] **Ms McGrath:** Yes.

[272] **Darren Millar:** It would be really useful if we were able to see those data. So you report those monthly to the Welsh Government—

[273] **Ms Williams:** No.

[274] **Darren Millar:** You do not. How often are you required to publish those?

[275] **Mr Roberts:** At the moment, when we are asked for them. However, as we know, there is going to be this system to gather the data more regularly, which is a good advance.

[276] **Darren Millar:** On the informatics, Kath, is your understanding that this will be required monthly in order to get a grip on this?

[277] **Ms McGrath:** My understanding is not that it will be required on a monthly basis. At the moment, we are looking at a baseline dataset. I do not have an indication of how frequently that will need to be updated.

[278] **Ms Williams:** Just to be clear, for our own purposes and our own governance within the organisation, this is something that we look at very regularly. There are two levels of scrutiny. There is, obviously, the organisational scrutiny and we look at it by site. In fact, as part of revalidation for medical staffing, which is coming in, we will be expecting consultant-level data to be scrutinised for consultants and their teams. So, that level of scrutiny takes place. What we are not clear about yet is how frequently we will need to report that as part of any dashboard performance reporting to the centre. However, in some ways, from our point of view, that is the lesser issue. For us, it is more important that we are looking at it and taking action in response.

[279] **Darren Millar:** Yes, but you will appreciate that, from the committee's point of view, it is important that the Welsh Government has a grip on this and that it is asking for this information regularly in order that it can scrutinise the performance of local health boards.

[280] **Ms Williams:** Indeed.

[281] **Darren Millar:** So, at present, you are asked for this information infrequently, on an as-and-when basis, but you expect that there may be a change in that coming forward.

[282] **Ms Williams:** I think that we are quite clear that, as part of the implementation of the outcome of the implementation board's work, the regular reporting of a suite of indicators will form part of a dashboard that we would be expected to put in the public domain as part of our performance management. We would expect that to be made available to the Welsh Government to scrutinise as part of our ongoing performance measures. What we are not clear about at this point is the frequency of that, but I am sure that it will be part of the next phase

of the work of the implementation board.

[283] **Darren Millar:** However, you have those data on a monthly basis.

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

[285] **Darren Millar:** So, are they in your own local dashboard, as it were, at the moment?

[286] **Ms Williams:** Yes, they are.

[287] **Darren Millar:** From when will that information be shared regularly with the Government?

[288] **Ms Williams:** We are able to share that information now.

[289] **Darren Millar:** Okay, but it is not necessarily asking for it on a regular basis. I want to check one other thing. Obviously, there has been a downward trend in your local health board, Mr Roberts, with regard to the caesarean section rates, which is clearly very welcome. However, the downward trend has still kept this huge gap in caesarean section rates between Singleton and the Princess of Wales hospitals. Would you say that that is as a result of clinical attitudes on the part of clinicians rather than an absolute need for caesarean sections? I am trying to query the extent to which it is deprivation-led and the extent to which it comes down to clinical attitudes.

[290] **Mr Roberts:** I do not think that I can give a definitive answer, because it is multifactorial. However, with Singleton, we have to remember that it is also the hospital with the intensive care neonatal unit, so it takes the higher risk deliveries, not only from Swansea but from a wider area. From the literature, we know that clinical culture and attitude are part of the reason why caesarean section rates are high, so I would not rule that out. Our view is that the reason is multifactorial.

[291] **Jenny Rathbone:** Before we leap off into medical issues, I want to focus on your strategies for driving up breastfeeding rates. You both mentioned that obesity is very high in your populations, so how are we going to help people bring their weight down as well as improve their babies' health through breastfeeding?

[292] **Ms Williams:** With regard to midwifery, as I said earlier, this is not just about maternity services. This is almost a crusade—a public health crusade—that we are having to work on. One thing that we are working on in Cwm Taf with the Welsh Government at the moment is looking at how we really drive the work on health inequalities issues. Obesity, smoking, teenage pregnancy and alcohol consumption have been the focus.

[293] In smoking and teenage pregnancy, we have seen some real successes in the last two years, with both rates coming down. That has been the initial focus. We are now switching our attention to obesity management, and not just in pregnancy. We are using the interface between the midwife and the pregnant woman for advice on nutrition and dietary management and the encouragement of breastfeeding. We are hitting a 50% initiation rate overall across the health board, but that has to be higher. We have the accreditation, and we have all of the systems in place, which is something that we must continue to push. The community-based accreditation programme that Kath related to earlier is also instrumental in driving that forward.

[294] **Mr Roberts:** I guess that we are taking a similar approach. We have a public health framework and I think that we are seeing this as being driven through that. One thing that we are focusing on at the moment is smoking in pregnancy, which our public health team would

regard as the biggest public health risk. It is developing a smoking cessation pathway that is specifically designed for pregnant women. Equally, work has been done on obesity as well. Breastfeeding initiation rates are not quite as good as the ones that Allison is talking about; but, again, if you look at the pattern within my health board, you will see a very different breastfeeding initiation rate between different parts of the patch. Again, I think that that can be explained partly by history and culture, but it is also partly related to deprivation factors, which, as we know, also have a big impact. Obviously, we have the UNICEF baby-friendly accreditation, and the teams are working hard to get the breastfeeding initiation improved.

[295] **Darren Millar:** Did you want to start the ball rolling on staffing issues, Jenny?

[296] **Jenny Rathbone:** Are you talking about question 5?

[297] **Darren Millar:** Yes, the question on ratios.

[298] **Jenny Rathbone:** Where are we on the ratios of qualified to unqualified staff? Staff like maternity support workers can obviously have a huge impact in terms of the public health issues that you have been talking about.

[299] **Ms Williams:** Our primary focus, over the past couple of years, has been on securing the achievement of the Birthrate Plus rates. The maternity support worker initiative is alive and well within our community. I do not know whether Kath wants to give some details around that.

[300] **Ms McGrath:** We have certainly trained a number of maternity care assistants. However, we need to train some more. Obviously, it is a matter of train and test and then move forward. We are looking to train another three individuals this year, in order to get our skill mix right. At present, we have a heavy skill mix towards midwifery rather than maternity care assistants. Some of that, again, is due to the history of midwives not actually using maternity care assistants previously. So, it is about developing their confidence in delegating some duties to other individuals.

[301] **Jenny Rathbone:** So, it is work in progress. What about peer-to-peer support?

[302] **Ms McGrath:** We have trained a number of individuals, particularly around breastfeeding rates. We have three or four peer support groups working across our community to support individuals who are breastfeeding.

[303] **Mr Roberts:** I am sorry, but I do not know the detail on the maternity care assistants. However, as Allison has said, our focus has been on making sure that we achieve Birthrate Plus compliance, which we do.

[304] **Mohammad Asghar:** How much do you rely on locum doctors to maintain adequate levels of medical staffing? Are you confident that the measures that you have in place for assessing locum competence are working effectively?

[305] **Ms Williams:** Perhaps I could start. In terms of obstetric services, our reliance on locum doctors is very limited. We have a number of very experienced SAS doctors who are non-training grade doctors who provide a very effective backbone of middle-grade cover within obstetrics.

4.00 p.m.

[306] **Darren Millar:** What do you mean by ‘SAS’? Is it a hit squad that rolls in? [*Laughter*.]

[307] **Jocelyn Davies:** That sounds a bit worrying. [*Laughter.*]

[308] **Ms Williams:** They are non-career grade or middle-grade doctors who are no longer in training and who have not gone on to a consultant post; they provide that level of cover. This is a specialty that has, historically, offered a successful career path for people who do not want to go on to be consultants. We have not had any difficulties in recruiting consultant obstetricians. We occasionally have to use locums for sickness absences, but it is an occasional usage. We either use locums from people who we know or, if required, from agencies when we are satisfied that a rigorous assessment of competency to meet our needs has been carried out.

[309] The area where we have had more challenges historically, and which is one of the underpinning reasons for the reconfiguration within the south-Wales programme, is around baby doctors—paediatricians to provide generic paediatric support for obstetric care and also for neonatology, which you will be aware that we discussed at some length in the Children and Young People Committee when we were discussing neonatology. So, our reliance on locums in obstetric services is minimal and we are confident, in terms of competency, that we have the scrutiny mechanisms in place. It is probably a similar case across the board.

[310] **Mr Roberts:** I do not have that much to add, because our situation is the same. We are partly looking at those specialties where there are shortages, so the picture is pretty much identical in ABMU to what has just been described.

[311] **Jocelyn Davies:** You will know, Ms Williams and Ms McGrath, that the Welsh Risk Pool findings in 2011 stated that you did not have effective arrangements in this area for the mandatory training of medical and midwifery staff. Do you have any evidence to show that you are moving in the right direction?

[312] **Ms McGrath:** At that time, there was a difficulty in relation to our mergers as health boards. With regard to training, we have a central database that is maintained and which means that we are able to monitor regularly. The Welsh Risk Pool assesses us against its standards in relation to cardiotocography training, neonatal life support, maternal life support et cetera.

[313] **Jocelyn Davies:** Mr Roberts, the Welsh Risk Pool found that you did have effective arrangements for monitoring mandatory training. Could you briefly describe how you go about that?

[314] **Mr Roberts:** I have to admit that, while I am aware of our compliance rates, I do not know the detail of how we go about the mandatory and statutory training.

[315] **Jocelyn Davies:** You could send us a note on that, if you would like.

[316] **Mr Roberts:** I am aware of our compliance rates, and I have taken my briefing note further, but I am happy to send a note on that.

[317] **Darren Millar:** I have one question for you, Allison: if Mr Roberts's health board was able to meet this requirement in 2011, why was yours not, given that it had gone through the same reorganisation process as you?

[318] **Ms Williams:** The issue here was data capture. It was not that the mandatory training was not being undertaken; it was about whether we had a central repository containing all of the data, which meant that, at any one point in time, we could run a report to identify compliance. We could not do that at that point, and so that is one of the things that we put

right. So, we now can ensure that, through one central database, we can capture and report that information.

[319] **Darren Millar:** From a management point of view, it would appear that you did not have that information for quite a long time. Were you on the ball as a health board chief executive and as a health board in being able to monitor these things? It does not appear to me that you were.

[320] **Ms Williams:** What we were not able to do was to get a single-point-in-time snapshot of entire compliance with the training. I accept entirely that that was not good enough and we were able to put that right. We have been through the process of the roll-out of the electronic staff record and, as a health board, we have been in the vanguard of that roll-out. One of the challenges for us at the time was whether we were inputting the data into the ESR, or were we inputting the data into the maternity information system. Ideally, we want all of this information to be in the single electronic staff record, so that, at any point in time, we can run that report for any staff group. What we have done, because of the long lead-in period around that roll-out, is reinstate the local maternity capture system. It is not desperately efficient in the short term, but it means that we have the ability to capture that while the ESR roll-out continues. However, that is the gold standard and, as a chief executive, that is what I want to be able to do, having everything in one place.

[321] **Darren Millar:** Do you have any further questions on that, Jocelyn?

[322] **Jocelyn Davies:** No.

[323] **Darren Millar:** Over to you, Mike.

[324] **Mike Hedges:** What progress have you made on training on the electronic foetal heart rate monitoring?

[325] **Ms McGrath:** Again, an all-Wales piece of work has been done with regard to what is the most effective process for training on cardiotocography interpretation. Lots of the health boards have had K2 training in place for some considerable time. That can provide a roll-off and an update on all midwives and staff of all grades trained in that. However, there was no significant change in the incidence associated with interpretation of CTGs. So, the all-Wales group has reviewed that and is now looking to implement the Royal College of Obstetricians and Gynaecologists CTG interpretation module. Alongside that, in our organisation, we have put in place what we call a ‘fresh eyes’ approach, which means that CTG interpretation is not down to an individual any more, but, on an hourly basis, it is reviewed by another professional, whether they are medical or midwifery. For example, a midwife may be in a room with an individual with electronic monitoring for six hours, which is a long period of time, and it becomes overwhelming and you go along with the trace, whereas a fresh pair of eyes every hour comes in with a different approach to review that CTG interpretation. Our concern was that, even when you have evidence of robust training, there still seem to be incidences with regard to CTG interpretation.

[326] **Jenny Rathbone:** Are you saying that the woman is linked up to the electronic foetal monitor for six hours?

[327] **Ms McGrath:** No, again, that is dependent on the level of risk for that individual woman. There will be women who will be monitored throughout the course of their labour, but there will be other women who will not go on a CTG at all, and they will have 15-minutely intermittent auscultation of the foetal heart.

[328] **Jenny Rathbone:** This is, presumably, one of the things that you look at in terms of

analysing your caesarean rates, is it not, namely whether you interpreted the data inaccurately?

[329] **Ms McGrath:** Absolutely.

[330] **Julie Morgan:** On neonatal care, to which you have referred, what progress are you making in developing plans that would deliver all-Wales neonatal standards, particularly related to medical and nurse staffing levels?

[331] **Ms Williams:** If I may start, the medical staff levels around neonates are very much linked to the work that we are doing across health boards around the configuration of services in the longer term. So, there has been a significant amount of modelling, and when we come to our consultation in the new year, after our period of engagement, we will make some recommendations, I am sure, about the change of configuration that will help us to deal with some of the challenges around medical manpower. On nursing, if I may speak for myself, in our health board, we are extremely fortunate in our nurse staffing levels—we have had a history of training and retaining our own in Cwm Taf, so we do not have significant challenges around nurse staffing numbers in our organisation.

[332] **Mr Roberts:** Again, I gave evidence not that long ago about this in terms of our staffing situation, which is that we are compliant, but we have the same issues around the paediatric rotas for the staffing of neonatal high dependency units, because that is a problem across the UK and in Wales too. So, we support HDU-level neonatal services, as you know, in Bridgend. You may recall that we had a discussion at that time about intensive care. We now do not have intensive care neonatal services in Bridgend, and that was always the plan. They are now provided in ABMU only on the Singleton site, which is clearly better in terms of staffing, which is, frankly, quite fragile. We are able to staff it, but it is not a sustainable staffing situation in Bridgend, and that is why we need to get together to make sure that the system set up in the future is robust and sustainable, whatever that involves in terms of the change programme, and that the Swansea staffing levels are appropriate.

[333] **Julie Morgan:** So, essentially, you are all working together.

[334] **Mr Roberts:** Yes, and that is the only way that we will be able to solve this problem.

[335] **Aled Roberts:** Regarding the process that has been adopted this year because of the auditor general's report and the consideration by the Children and Young People Committee, I think David Sissling mentioned that neonatal is now in the premier league as far as attention to detail is concerned. The Minister required that local delivery plans were put in by, I think, May, but I am just anxious because of the timetabling as far as reconfiguration is concerned. Was it the position that the local delivery plan dealt with services as they are currently configured? Was there any expectation in the case of Betsi Cadwaladr and Hywel Dda LHBs, for example, which will be coming on board very shortly, that the local delivery plan also had to deal with how to meet BAPM guidance under any reconfigured service?

[336] **Ms Williams:** In terms of the south Wales position, as part of our engagement process we have been very open about the sustainability of the number of rotas that we can support in the long term. We know that the number of cots is one issue. We also know that there is a requirement over time to increase the number of cots in Wales to meet demand, and there is also a big challenge for us in terms of having the right baby in the right cot at the right time, which is balancing the challenge of moving babies and their families around the system and keeping care as local as we can. There is a multitude of factors here, but certainly in terms of the reconfiguration, we have been very clear about what is sustainable locally and what needs to happen in terms of some of the choices that we might have to face around the number of units that continue to provide consultant-led paediatrics and obstetrics longer term.

That is part of the wide engagement that we are going through at the moment very openly with our staff and with communities, but, very positively, this is being driven clinically by our senior midwives, senior doctors and senior nurses, advising us about the best shape for those services for the future. The local delivery plans are interim because they are dealing with the here and now, but they also make clear reference to the work that we are doing across south Wales to get a long-term, sustainable solution.

[337] **Aled Roberts:** As far as the local delivery plans are concerned, you refer to them as being interim; there was no requirement on the local health board, if it was proposing reconfiguration, to ensure that it could actually meet BAPM guidance within a specific timetable, or that resources would be put forward to meet those.

[338] **Mr Roberts:** Maybe it would be helpful if I could comment. I came before the Health and Social Care Committee with representatives from Hywel Dda LHB, because obviously we have a particular link with the services in Hywel Dda LHB, and we were able to give evidence that we were aware of the detail of the Hywel Dda LHB plans and that, in fact, the delivery of our plans depended on Hywel Dda LHB's plans, because the successful delivery of HDU care in Hywel Dda LHB is something that is really important for the sustainability of the service in Swansea. We are working very closely with Hywel Dda LHB on that. It is also important to say, on the wider south Wales programme, that the deanery is part of the programme management for that. It has to look at training right across Wales, so it is having to make sure that it understands the staffing issues in north Wales and west Wales as well as in south Wales. We are obviously being, to some extent, guided by the deanery in the robustness of some of the staffing arrangements that we would propose, but clearly we would not have a sustainable plan if, at the end of this, we put a proposal forward where we were not able to fulfil the staffing requirements for neonatal services. So, it is one of our objectives to be able to do that, and that has to be done on a sustainable, robust basis. As I say, we are sustaining it now, just, but it is quite fragile.

[339] **Darren Millar:** So, what you are saying to us is that, at the moment, in terms of reaching that standard, everything is hung on the one peg of service reconfiguration. That is what you are saying, is it not?

[340] **Mr Roberts:** That is an interesting way of putting it. I am not sure that there is another way of achieving it. So, I do not think that it is a case of all the eggs being in one basket—there is only one basket. We have to ensure that we have the number of units required to meet the capacity requirements so that we can staff robustly and sustainably if we are to have safe services. That is the process that we have to go through.

4.15 p.m.

[341] **Darren Millar:** It is important that we get that message clearly. As a final question, because I think that we have covered all the areas that we wanted to cover, to what extent is the financial challenge that the NHS faces over the next few years a barrier to improvement in maternity and neonatal services, if at all?

[342] **Ms Williams:** We have made it very clear around our board table that a quality-driven NHS has to be the way that we drive forward change. We recognise the financial challenge, and it is a fiscal challenge that sits with it—it is the reality—but compromising quality as a consequence of any financial challenge is not something that our board will support. We have to be innovative. There are opportunities for us to be innovative in the way that we configure and staff our services. We have to move away from traditional models of delivery, and that is part of the engagement process that we are going through with our staff and our communities. It is a reality that we have to work within, but it is not a reality within which we would ever countenance compromising quality of care.

[343] **Mr Roberts:** Similarly, safety has to be the top priority for every health board. Particularly with regard to the service that we are talking about today, the costs of not having a safe service are absolutely huge. Clearly, the cost to families is the most important thing, but there is also a financial cost if we get these services wrong in terms of ongoing care, particularly for children and in support of families. We know that the costs of getting safety issues wrong in obstetrics and maternity services are absolutely huge. That is understood by the board and, therefore, that probably gives us an added impetus in these fiscally tight times to make sure that we really bolt down our governance arrangements and quality arrangements in the maternity service.

[344] **Darren Millar:** Thank you very much. If there are no further questions—I see that Jenny has one. Come on, then, but be quick.

[345] **Jenny Rathbone:** I just wondered whether we could ask Mr Roberts to provide some information about maternity support workers and any peer-to-peer initiatives.

[346] **Darren Millar:** Yes, I think that the clerks have taken a note of that, and also on the c-section rates.

[347] **Jenny Rathbone:** Also, details of maternity services liaison committees in both of your board areas would be really helpful.

[348] **Mr Roberts:** I am happy to do that.

[349] **Darren Millar:** Okay, that is along with the information on the c-section rates that we asked for earlier. Thank you very much indeed for that; we really appreciate the opportunity to take some oral evidence from you, and we look forward to receiving the other items that you promised to send us. You will be sent a copy of the transcript of today's meeting so that you can correct it if there is a factual error in the record. I am sure that you will be interested in the report once we have produced it. Thank you very much indeed. Diolch yn fawr iawn.

4.18 p.m.

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

[350] **Darren Millar:** I move that

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

[351] I see that there are no objections. Thank you.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 4.18 p.m.
The public part of the meeting ended at 4.18 p.m.