Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Cyfrifon Cyhoeddus
The Public Accounts Committee

Dydd Mawrth, 12 Mehefin 2012
Tuesday, 12 June 2012

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Cofnodir y trafodion hyn yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir cyfieithiad Saesneg o gyfraniadau yn y Gymraeg.

These proceedings are reported in the language in which they were spoken in the committee. In addition, an English translation of Welsh speeches is included.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Mohammad Asghar	Ceidwadwyr Cymreig Welsh Conservatives
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

Tracey Davies	Rheoli Perfformiad, Swyddfa Archwilio Cymru Performance Management, Wales Audit Office
Dave Thomas	Cyfarwyddwr Iechyd a Gofal Cymdeithasol, Swyddfa Archwilio Cymru Director of Health and Social Care, Wales Audit Office
Huw Vaughan Thomas	Archwilydd Cyffredinol Cymru Auditor General for Wales

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 9.08 a.m.
The meeting began at 9.08 a.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **Darren Millar:** Good morning, everybody, and welcome to today's meeting of the Public Accounts Committee. I note that we have received apologies from Lindsay Whittle AM. I remind everybody that the National Assembly for Wales is a bilingual institution, and we welcome contributions during this meeting in Welsh or English, as people see fit. Translation facilities are available to Members and members of the public—channel 1 of the headsets for translation, and channel 0 for amplification. I ask everybody to turn off their mobile phones, BlackBerrys and pagers, as these can interfere with the broadcasting equipment.

9.09 a.m.

Cyngor gan Archwilydd Cyffredinol Cymru ar Ohebiaeth ynghylch Gwasanaethau Mamolaeth yng Nghymru
Advice from the Auditor General for Wales on Correspondence on Maternity Services in Wales

[2] **Darren Millar:** The auditor general has kindly produced an update for us further to our previous meeting. Auditor general, do you want to talk us through this? This picks up on information from the report that the Wales Audit Office produced in June 2009, does it not?

[3] **Mr H. Thomas:** That is right, Chair. We produced a report on maternity services in Wales in June 2009, and the then PAC took evidence from the Welsh Government in November 2009, producing an interim report in February 2010. There was then further evidence in terms of looking at progress in February 2011, from the Welsh Government. That was supplemented by some written evidence, but the PAC at the time did not have a chance to consider that before the end of the third Assembly. So, in a sense, this is a continued business. We had already identified the need to follow up the 2009 report with local audit work, which we did last year. We have reported our findings to each health board, but we have summarised them in the form of the briefing paper that you have. It provides an opportunity to gauge progress against the key issues identified in the previous work and in the subsequent evidence sessions with the Welsh Government. In preparing the briefing, we have liaised particularly closely with the Welsh risk pool, which also looked at maternity services in the intervening period. The briefing that I prepared draws on the relevant findings from its work as well.

[4] Basically, to summarise, our overall conclusion is that there has been some progress in all areas covered by the previous audit recommendations, but this does need to be accelerated, particularly to address the challenges that still exist in relation to reducing caesarean section rates. In Wales, we have one of the highest rates in Europe. The World Health Organization set a guideline a few years back of about 15%, and you will see from the figures that the rate in Wales is considerably higher than that. We need still to enhance the capacity of neonatal services and to implement a better, more robust performance monitoring and management framework. I will ask Tracey to take you through some of the more detailed issues in the report, but I think we ought to be looking for further evidence from the Welsh Government of how it is addressing the findings that we have continued to report on.

[5] **Darren Millar:** It was remiss of me not to welcome you, Tracey, as the performance audit manager for this piece of work, and Dave as director of health and social care at the Wales Audit Office.

[6] **Ms Davies:** The report focuses on four key areas. Part 1 focuses on strategy, planning and performance management. We found a clearer strategic framework for maternity services and better information on which to plan those services, although it was not yet clear to what extent those developments had led to service improvements. At a national level, the Welsh Government produced and published a maternity services strategy in September 2011, but it is too early to say how it is affecting delivery at a local level. The Welsh Government has also established an all-Wales services implementation group to drive forward, support and oversee the health board's efforts to transform maternity services. Notably, we found a greater focus on outcomes and improving the quality of maternity services.

[7] At a local level, we found significant improvements in terms of a greater corporate priority for maternity services than we found previously. Most health boards had a clear strategic vision for maternity services and, where that vision was not in place, work was well under way to develop one. Nationally, work to identify the common data sets is due to complete by 2012. In its absence, health boards, with the exception of Powys, use a maternity

dashboard to inform and strengthen their performance management and monitoring. However, we continued to find technological limitations, and most health boards were continuing to use resource-intensive manual processes, which are inevitably costly. At both a national and local level good progress had been made in engaging with users to inform and plan services.

[8] In part 2, we focused on staffing levels and training, and concluded that, while health boards reported that they are able to cope with demand, some are still not meeting recommended staffing levels, and most could not provide the evidence that staff had received the necessary mandated training. In our previous report, we identified significant midwifery staffing shortfalls in most health boards, and they did not meet the recommended Birthrate Plus staffing levels. Our follow-up review found significant progress had been made, but there were four health boards that still had small midwifery deficits, although they were seeking to address those shortfalls in various ways. Of note, the heads of midwifery advisory group expressed concerns about sustaining safe staffing levels in the current financial climate, and they felt that it needed close attention. During 2011, the Welsh risk pool annual assessment of maternity services found that, with the exception of two, most health boards met the safer childbirth minimum standards for obstetrics staffing levels for delivery of care.

9.15 a.m.

[9] In February 2011, the then PAC expressed concerns about the costs and safety of using locum medical staff to help health boards meet the required staffing levels. For this recent review, all health boards confirmed that they had appropriate measures in place to assess locum competence. However, it was not possible to assess locum expenditure, as many health boards were unable to disaggregate medical staffing costs between maternity and gynaecology services.

[10] Since our previous review, all health boards have established mandatory training programmes for midwives. With the exception of one health board, the Welsh risk pool assessments could not find evidence that all relevant staff had undertaken mandatory training. We previously identified that incidences of harm to the unborn were often contributed to by the failure to correctly use foetal monitoring equipment and to interpret results. Following a pilot scheme to assess competence, a multidisciplinary group led by the chief nursing officer for Wales is being taken forward to strengthen the assessment of competence in processes.

[11] Part 3 focuses on neonatal services. We concluded that despite previous reports highlighting problems, neonatal services in Wales are still failing to meet relevant standards. Despite additional Welsh Government investment, problems remain. In January 2012, the neonatal network produced a capacity review which repeated the messages from earlier reports. They refer to systematic dysfunctionality and mismatch between demand for, and the availability of, cots, with variability in clinical practice and resource utilisation. Given these findings, we consider that urgent action is needed by the Welsh Government to develop an all-Wales strategic approach to the delivery of neonatal services to provide sustainable solutions to the challenges that exist.

[12] The Health and Social Care Committee and the Children and Young People Committee are currently examining the progress that the Welsh Government has made in implementing the recommendations of the previous Health, Wellbeing and Local Government Committee inquiry into neonatal care in Wales. As a result, we have copied this letter and annex to the Chairs of these committees. It may be helpful for this committee to consider what further action it might wish to take in dialogue with these other two committees.

[13] The last part, part 4, focuses on key aspects of maternity care. We concluded that while key aspects of service provision such as antenatal services have improved, caesarean

section rates remain high. Since our previous report, we found that aspects of antenatal provision have improved, particularly the promotion and enhancement of access to midwives, and the strengthening of antenatal education and access to antenatal classes. All health boards have now developed and complied with maintaining equipment inventories, but there is no comprehensive and up-to-date picture of whether units are meeting guidelines for creating a supportive birth environment for mothers.

[14] Our 2009 report drew attention to high caesarean section rates. At the time, the Welsh Government had invested £50,000 to help implement a toolkit to help maternity units achieve lower caesarean section rates and maintain safe outcomes for mothers and babies. Training on the use of the toolkit was completed in June 2010. By March 2011, we found that while some health boards had achieved notable reductions, overall caesarean section rates remained high and that some health boards' performance had deteriorated.

[15] Breastfeeding support has improved markedly in all health boards, with a variety of initiatives and some indications of increasing breastfeeding rates in Wales.

[16] In summary, while our work pointed to some progress and improvements in maternity services, it has shown that a number of challenges still exist.

[17] **Darren Millar:** Thank you for that, Tracey. I will ask the first question and I will then invite other Members to come in. You mentioned that the caesarean section rate was particularly high; the auditor general mentioned the fact that it was one of the highest in Europe, which is quite alarming. Is that anything to do with health issues that are particular to Wales, such as obesity or the young age of some of our mums? What are the factors that lead to a caesarean section?

[18] **Ms Davies:** The health boards have indicated that there is an increasing rate of obesity in mothers, which increases the chances of the mother having a caesarean section, and there are other factors that mothers are experiencing. As far as I am aware, that is no different to other parts of the UK, where you would expect the rates to be within a similar range as the rate in Wales. We previously compared the rates with those of European countries, but we have not compared them this time. However, the rates continue to be high, and it is notable that they have increased in five health boards over the period that we were looking at.

[19] **Darren Millar:** It is incredible, is it not? On this issue of caesarean sections, in terms of the costs to the NHS and the costs to the individual patients of a caesarean section, I assume that patients are put at a higher risk with the longer recovery period, post birth.

[20] **Ms Davies:** There is a fine balance, because a caesarean section may be the safest route to take for some mothers. Obviously, this has to be on the basis of risk, but there is an increased cost and a longer stay.

[21] **Julie Morgan:** On that point, has the National Institute for Health and Clinical Excellence not produced some guidelines recently that almost encourage people to have caesareans, causing quite a lot of concern? Do you know anything about this?

[22] **Ms Davies:** Yes, I am aware of the guidelines. I am told that the guidelines are there to support clinicians to educate mothers so that they understand the reasons for caesarean sections. So, one would assume that a better-educated public would make the right decisions. I think that it is too early to make any judgment on the effectiveness and impact of that.

[23] **Julie Morgan:** It was very recent.

[24] **Ms Davies:** Yes.

[25] **Darren Millar:** It suggested that people would be able to demand caesarean sections, did it not?

[26] **Julie Morgan:** That was how it was interpreted, I think.

[27] **Darren Millar:** Is the reason for the high number of caesarean sections that Welsh mums are more demanding in accessing them? Is there any evidence of that?

[28] **Ms Davies:** We are told that there are instances of mothers requesting caesarean sections, but a lot of it is down to the guidance that they are given by the professionals—the midwives and the obstetricians—from when they become pregnant, talking about the risks and the need for normal births or a caesarean section.

[29] **Mike Hedges:** I am trying to get behind these figures. Are they all hospital births, or do they include home births as well?

[30] **Ms Davies:** Total births.

[31] **Mike Hedges:** Secondly, do we have figures from Scotland's health boards, Northern Ireland's health boards or England's health boards, so that we can compare the situation? I am most interested in Singleton Hospital, for obvious reasons, but are the figures there similar to those in Birmingham, for example? Do those sorts of figures exist?

[32] **Ms Davies:** We did not compare them for the review, but those data should be available for us to consider.

[33] **Mike Hedges:** How easily accessible are those data? If I wanted to get hold of them, would I be able to do so, or would I have to ask you to do so?

[34] **Mr H. Thomas:** We could provide them for you.

[35] **Jenny Rathbone:** My concern is about the time that it is taking to change things. The Welsh Government invested £50,000 in the 'Pathways to Success' toolkit for caesarean sections in 2009, yet your report indicates that this is only now beginning to be applied, which is the most obvious key to improving the financial situation—it costs at least twice as much to have a caesarean delivery as it does to have a normal birth. On the one hand, they are saying that they have problems with their midwife retention rates because of their financial situation, and on the other hand, they do not seem to be addressing this excessively high caesarean rate. There are high obesity levels in other parts of the world as well, but that is all the more reason to be driving down caesarean rates among those who do not have that problem.

[36] **Ms Davies:** It would be helpful to compare the English rates, because the toolkit came into effect much earlier in England. It would be helpful to examine whether that has now been more effective because, as you can see from the report, the training was not completed until June 2010, so there were about nine months following that. It would be helpful to look at the effectiveness in a year's time. That toolkit looks at the multidisciplinary approach to considering caesarean section rates, and there are cultural elements within that in terms of the practices of those practitioners.

[37] **Jenny Rathbone:** Why do we not have the March 2012 figures, given that it is now nearly July?

[38] **Ms Davies:** This was drawn from the report that we had written locally during last year. We would be able to access those figures.

[39] **Jenny Rathbone:** Okay. We need to know whether travel is still in the wrong direction in these five health boards.

[40] **Darren Millar:** I would be interested to know whether any refresher training in using the toolkit is taking place when new members of staff arrive on a ward. I assume that we should be able to see that from the delivery plans in each health board area.

[41] **Ms Davies:** One would assume that that would be a key part of the training for new staff.

[42] **Mohammad Asghar:** Thank you for your report; I read it carefully because it is a serious topic. We are all born once and it gives a family great pleasure when a child is born, and the mother should be the top priority of all the facilities. It is an eye-opening report. In the second paragraph, you say that the financial information was not generally well collected and well used and, in three main points, you clearly state that health boards are still not meeting the recommended staffing levels, that neonatal services in Wales are still failing and that caesarean section rates remain high. I understand everything very well, but my main question is on breastfeeding. The fact that only 50% or 55% of women breastfeed is not acceptable. Breast cancer is a very scary illness for young women and if they are encouraged to breastfeed, the general perception in certain parts of the world is that they are less likely to contract breast cancer. So, why do you not emphasise that to young women in order to increase the percentage of young mothers who breastfeed from 55% to 95%, for example? In certain parts of the world, breastfeeding is quite common and there is no breast cancer there, so that is the area that you should consider seriously.

[43] **Darren Millar:** You referred to breastfeeding rates in your opening remarks and they have been increasing.

[44] **Ms Davies:** Yes, they have. A lot of effort has gone into improving support for mothers, but there is still some way to go. However, there are discrepancies regarding some of the figures because they vary from 71% to 55%.. The Welsh Government is looking at the robustness of some of the child health community database figures. We need to understand what the exact figures are, but there has definitely been improvement. We could see that when we looked locally at what had been put into practice, and mothers were also telling us as much when we spoke to them.

[45] **Darren Millar:** So, there has been a significant improvement.

[46] **Ms Davies:** A definite improvement, but there is still some way to go.

[47] **Aled Roberts:** On the caesarean issue, has any analysis been made of the 2011 figures that vary between 21% and 30%? Is any analysis undertaken of when those caesareans take place? For example, are they concentrated on certain days? I ask because of my wife's experience, which goes back 12 years; she was unfortunate in that she started going into labour on a Friday night, which clearly was not part of the pattern expected within the NHS. My feeling was that a lot more caesareans were taking place at weekends, when women were left in labour for many hours. Is there any statistical evidence on whether caesareans are concentrated on weekends?

[48] Secondly, in paragraph 27 of the report, you talk about the fact that there are obstetric requirements for units where there are more than 6,000 births and you cite two examples from Swansea and Cardiff. I do not know where I have read these figures, but my understanding is that the north and west Wales units have around 3,500 to 4,000 births a year. So, they would not be subject to the 60 hours of obstetric cover per week. Are there obstetric cover

requirements for units where there is a lower number of births, and were any of those smaller units in breach of cover?

9.30 a.m.

[49] **Ms Davies:** For the Welsh risk pool assessment for 2011, the only ones that did not comply were Abertawe Bro Morgannwg and Cardiff and Vale health boards. The others complied with standards that they had to meet.

[50] **Aled Roberts:** What about my other point, on the pattern?

[51] **Ms Davies:** We have not gone into the detail; we have gone with the high-level figures. Health boards should be performance-managing their caesarean section rate; if they have a high rate, they should be undertaking further analysis to understand why those rates are high and looking at whether there is a pattern.

[52] **Aled Roberts:** I have a question on breastfeeding. What sort of management—we are talking about grants management again—is there of the Welsh Government's grants as far as breastfeeding co-ordinators are concerned? I know that specific grants were given to local health boards to appoint breastfeeding co-ordinators. I know that one was not appointed in north-east Wales, although I understand that the money was received. It may be that there was a delay in the appointment, but certainly there was a period of time when there was no breastfeeding co-ordinator in north-east Wales. Do you know whether that was reflected elsewhere?

[53] **Ms Davies:** We have not asked questions to that level of detail, but it is a good point.

[54] **Darren Millar:** I have two final questions and then we will move on. You noted in the correspondence that the Welsh Government has indicated that it does not intend to set targets for caesarean sections. Did it explain why it feels that setting targets would be unhelpful?

[55] **Ms Davies:** It is still considering the performance management framework and it did not articulate why it did not want to set those targets. It is a question that could possibly be asked of the Government when it comes to give evidence.

[56] **Darren Millar:** Secondly, I know that the Welsh Government's maternity strategy referred to the date of March 2012 for the local delivery plans to be in place across the country. However, as I understand it, some local health boards in Wales are currently reviewing their maternity and children's services arrangements. How has that impacted on the timetable for the delivery of those local plans?

[57] **Ms Davies:** When we spoke to the Welsh Government, it had made a decision not to request those local delivery plans. It is going to assess the performance of health boards through the Welsh maternity services implementation group, which is due to finalise its arrangements, I believe, in a couple of months. That should align with the strategic direction.

[58] **Jenny Rathbone:** You have noted that different health boards have different traffic light systems for when they think they are doing well on caesarean sections. I wondered why the all-Wales maternity services implementation group does not lay down absolutely clearly what is deemed to be a green, red or amber flag. It does not require changes in bodies on the ground.

[59] **Ms Davies:** If you look at paragraph 51, you will see that the green flag and the red flag vary in each of the health boards. So, it just demonstrates the point that there is

inconsistency across Wales.

[60] **Aled Roberts:** In paragraph 13, you raise the fact that the Government, in February 2011, did away with the local delivery plans and referred the matter to the all-Wales implementation group, which you say will not be finalising its position for a few months. We have a total reorganisation of maternity services in north Wales. We understand that we will be told what the proposals are at the end of this month, hopefully going to full implementation in October. That is for an area that is already in breach of the Birthrate Plus situation. You also mentioned, with regard to paragraph 30, that you felt that there was a need for the Welsh Government to take urgent action on an all-Wales approach for neonatal services. The Children and Young People Committee received evidence two to three weeks ago that standards that have been operating at a UK level since 2008, which dictate that there should be eight consultants in neonatal services in north Wales but, in 2008, there was one consultant and one full-time locum. This year, we are in the position of having one consultant and one part-time permanent position. Depending on how you look at it, either we have one and a half permanent or we have gone down by half. On the point that Jenny made, my problem is that there have been repeated reports to Assembly committees saying that the situation is not acceptable. We have no picture of the all-Wales situation and yet local health boards are taking decisions that, in north Wales's case, may very well include there being no intensive care cots in the region at all post October 2012.

[61] Where is the evidence available if there are no local delivery plans in place and if the all-Wales groups are not making observations on the proposals? We were told in the neonatal network that, in the case of Hywel Dda, for example, it has not even received the information from the health board. There is the position on caesarean sections. I think that Wales is in the fourth worst position in the western world as regards stillbirth figures. Where does the responsibility lie for improving those services?

[62] **Darren Millar:** Aled, I think that some of those questions, frankly, need to be asked of other people than the Wales Audit Office.

[63] **Aled Roberts:** The point that I am making—

[64] **Darren Millar:** Do you want to capture some of those issues on monitoring progress? Is there any indication of how the Welsh Government is monitoring progress on those matters? In responding to that—and this is a final question, I assure you, because we need to move on—is there any evidence that the timetable has slipped because some of these decisions are difficult, and the timetables clashed with things like elections?

[65] **Ms Davies:** I do not think that it is my place to say whether the timetables have slipped because of that, but there has been slippage and it is not clear what the reasons for the slippage are. When we spoke to the Welsh Government about maternity service plans and neonatal service plans, we were told that it was within the remit of the health boards to make the decisions on their strategies for those services, and it was not for the Welsh Government.

[66] **Darren Millar:** So, it is washing its hands of responsibility.

[67] **Aled Roberts:** Are the minutes of those groups available as a matter of public record? If there are no local delivery plans, how do we as politicians and, more importantly, the people out there know that the situation is being monitored?

[68] **Mr H. Thomas:** We have summarised some of those issues, on which the Members have asked questions, in paragraphs 34 to 39. That question must be posed to the Welsh Government.

[69] **Darren Millar:** Let us move briefly on to item 3.

9.38 a.m.

Papurau i'w Nodi
Papers to Note

[70] **Darren Millar:** There are minutes of the meeting on 29 May. I take it that they are noted. Let us move straight on to item 4.

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

[71] **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).

[72] I see that there are no objections, so let us clear the public gallery.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 9.38 a.m.
The public part of the meeting ended at 9.38 a.m.