National Assembly for Wales
Health, Wellbeing and Local Government Committee

Report on Inquiry into Neonatal Care in Wales

July 2010
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National Assembly for Wales
Health, Wellbeing and Local Government Committee

Report on Inquiry into Neonatal Care in Wales

July 2010
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The Health, Wellbeing and Local Government Committee is appointed by the National Assembly for Wales to consider and report on issues affecting health, local government and public service delivery in Wales. In particular, as set out in Standing Order 12, the Committee may examine the expenditure, administration and policy of the Welsh government and associated public bodies.

Powers

The Committee was established on 26 June 2007 as one of the Assembly’s scrutiny committees. Its powers are set out in the National Assembly for Wales’ Standing Orders, particularly SO 12. These are available at www.assemblywales.org

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Chair’s Foreword

The birth of a child is a magical, miraculous event, but if a baby is born too early, it can be an extremely difficult, emotional and stressful time for a family. All babies deserve the best possible start in life, and the care that premature babies receive can have a profound effect on the rest of their lives.

Given the rising birth rate in Wales and the increase in the number of low-birth-weight babies being born, pressure on neonatal services is set to increase. In 2008, the Minister for Health and Social Services announced new funding for neonatal care but, as Members, we are still receiving representations from constituents and special interest groups voicing significant concerns about these services. Given these concerns, the Committee decided to undertake an inquiry to determine whether improvements have been made since the announcement of this additional investment in neonatal services.

During the course of the inquiry, we received evidence of the high-quality care provided to special care babies and their families against the backdrop of a severe funding shortfall. We also heard of a lack of specialist staff providing neonatal care and problems in recruiting neonatal doctors and nurses.

The recommendations in our report cover funding and staffing as well as areas such as neonatal unit occupancy levels, transport services, and the implementation of the All Wales Neonatal Standards produced by an expert group established by the Minister. As a Committee, we trust that our recommendations will lead to improved services for our most vulnerable babies and their families.

On behalf of the Committee, I would like to express my gratitude to all those who contributed to this inquiry, and I commend it to the Minister for Health and Social Services and to the National Assembly.

Chair, Health, Wellbeing and Local Government Committee
June 2010
The Committee’s Recommendations

Recommendation 1. We recommend that the Welsh Government should ensure that a review of capacity be undertaken by the All Wales Neonatal Network, to include current staffing and activity levels. (Page 21)

Recommendation 2. We recommend that the Welsh Government, in assessing future requirements of the service, should pay particular attention to the increasing birth rate in Wales. (Page 21)

Recommendation 3. We recommend that the Welsh Government should ensure that there is capacity across all services to meet future demand. (Page 21)

Recommendation 4. We recommend that the Welsh Government should ensure that staffing ratio guidelines, in compliance with BAPM 2001 minimum standards and as set out in the All Wales Neonatal Standards, are met, but not through a reduction in cot numbers. (Page 21)

Recommendation 5. We recommend that the Welsh Government should put in place measures to ensure that neonatal units achieve occupancy levels that are capable of meeting the fluctuations in demand. (Page 21)

Recommendation 6. We recommend that the Welsh Government should require the All Wales Neonatal Network to develop a plan to deliver the All Wales Neonatal Standards within a clear set of timescales, and to make public the action it will take to ensure the standards are met. (Page 24)

Recommendation 7. We recommend that the Welsh Government should ensure that rigorous procedures are in place to monitor the implementation of the All Wales Neonatal Standards. (Page 24)

Recommendation 8. We recommend that the Welsh Government should establish a Cot Locator system, to ensure that cots are allocated on an efficient basis and to reduce unnecessary transfers between units. The system should be compatible with systems in England. (Page 31)
Recommendation 9. We recommend that the Welsh Government should ensure that the clinical network and database is working effectively as soon as possible. (Page 31)

Recommendation 10. We recommend that the Welsh Government should ensure that the 12-hour transport service is in place and operational as soon as possible. (Page 31)

Recommendation 11. We recommend that the Welsh Government should keep under review the effectiveness of the 12-hour transport service, in particular in relation to meeting demands on the service and patients' needs. Further to this, we recommend that, at an appropriate time, consideration should be given to whether a 24-hour transport service would better meet patients' needs. (Page 31)

Recommendation 12. We recommend that the Welsh Government should ensure that the All Wales Neonatal Network regularly reviews arrangements for cross-border transfers of patients, to ensure that they are effective. (Page 31)

Recommendation 13. We recommend that the Welsh Government, in conjunction with the Health Boards, puts in place measures, as a matter of urgency, to address the shortfall in medical and nursing staff to ensure services are safe. (Page 38)

Recommendation 14. We recommend that the Welsh Government should ensure that procedures are put in place to ensure that neonatal nurses can access education and training. (Page 38)

Recommendation 15. We recommend that the Welsh Government should explore with relevant professional bodies, including the Royal College of Nursing and Royal College of Midwives, the development of a neonatology specialty. (Page 38)

Recommendation 16. We recommend that the Government should ensure better integration of, and joint working between, neonatal and maternity services. (Page 44)
Recommendation 17. We recommend that the Welsh Government should ensure that Health Boards review their current arrangements for supporting parents of special care babies, to address in particular: practical guidance for health professionals on identifying parents’ needs; helping parents to be involved in their baby’s care; and providing support to parents as they gradually become the main carers.  

Recommendation 18. We recommend that the Welsh Government should ensure that sufficient accommodation is provided for parents, particularly in the lead centres. As part of this, we recommend that the use of transitional care units should be considered.  

Where appropriate, we expect the Welsh Government to report on progress in implementing the Committee’s recommendations within 12 months of their initial response to this report.
1. **Introduction**

1. We agreed to conduct an inquiry into Neonatal Care in Wales as a result of concerns that constituents and special interest groups had raised with Members.

**Terms of reference**

2. We agreed the terms of reference at the Committee meeting held on 11 February, 2010. The terms of reference for the Inquiry were:

An inquiry into the progress in implementing the recommendations of the expert group on Neonatal Services and delivery of the All Wales Neonatal Standards; including:

- arrangements for monitoring the implementation of the All Wales Neonatal Standards, in line with the British Association of Perinatal Medicine’s staffing standards and the Health Commission Wales review;
- the Welsh Government’s long term strategy for improving neonatal care and whether it is seen as an integrated part of maternity services;
- consideration of how the Welsh Government plans to increase the number of neonatal nurses, midwives and neonatal consultants;
- funding arrangements for the development of round-the-clock access to dedicated neonatal transport services available to all units in Wales;
- increased support for parents;
- the impact of NHS reforms on neonatal services in Wales;
- screening for hearing loss.

**Methods**

3. We took oral evidence for the inquiry throughout March, and the call for written evidence was issued on 12 February. Twelve written submissions were received, 11 of which were from healthcare professionals, healthcare organisations, and special interest groups, and one of which was from a parent. A link is provided [here](http://www.assemblywales.org/bus-home/bus-committees/bus-committees-scrutiny-committees/bus-committees-third-hwlq-home/business-hwlq-inquiries/hwlq3_lscb.htm) to the inquiry web pages, where the written submissions can be accessed.
4. Eight sets of witnesses were invited to give oral evidence over three Committee meetings. Details of the witnesses who appeared, written papers provided to the Committee, and consultation responses are provided in Annexes A, B and C respectively.

5. Agendas, papers and transcripts for each meeting are available in full on the Committee’s pages on the National Assembly for Wales’ website, which can be accessed here.²

² http://www.assemblywales.org/bus-home/bus-committees/bus-committees-scrutiny-committees/bus-committees-third-hwlq-home.htm
2. Background

6. Neonatal services provide care to babies born prematurely or with an illness or condition requiring specialist care. There are three levels of progressively more complex specialist care facilities: local special care baby units; high-dependency units; and highly specialised neonatal intensive-care departments. A baby needing neonatal care can move between these three levels of care as his or her condition changes. Of the 33,000 babies born in Wales each year, it is estimated that approximately 3,800 are admitted to the 13 neonatal units in Wales.3

7. The overall birth rate in Wales has been rising since 2001, as has the number of low-birth-weight babies being born. There has also been a rise in the incidence of risk factors associated with prematurity, such as: maternal obesity; deprivation; assisted conception; and high and low maternal age. Therefore, the number of babies admitted to neonatal units looks set to increase year upon year.4

8. In 2005, Health Commission Wales undertook a review of neonatal services in Wales,5 which suggested a number of recommendations for improving care and access to neonatal services in Wales. However, the review was never published for consultation.

9. In 2008, the review was revisited by an expert group, led by Dr Jean Matthes, Consultant Neonatologist at Abertawe Bro Morgannwg University Health Board. The expert group produced the All Wales Neonatal Standards, key recommendations that include establishing a neonatal managed clinical network and a neonatal transport system.

10. In October 2008, the Minister for Health and Social Services, Edwina Hart AM, announced £4 million new funding for neonatal services over two years.6 There has been a subsequent commitment to sustain this level of funding at £2 million each year.7

3 Baby steps to better care (Wales briefing) Bliss Baby Report 2008: Neonatal care in Wales
5 Health Commission Wales, Neonatology Review, July 2005
6 Welsh Government press release, Health Minister to outline two-year spending plan, 15 October 2008
7 Welsh Government press release, Expert report outlines improvements in neonatal care, 8 December 2009,
Neonatal Business Case

11. A clinical advisory group (expert group), which included Bliss, were involved in the development of a neonatal business case setting out how the neonatal service should be delivered, and these recommendations were accepted by the Minister for Health and Social Services in December 2009. The business case recommended:

- introducing a neonatal transport service with two different methods of delivery: one in the south and one in the north of Wales, to operate 12 hours a day;
- specialist neonatal services to be concentrated in three centres in the south and one in the north;
- recruitment to begin for additional neonatal consultants and neonatal nurses;
- a single neonatal database enabling the standardised collection of data across Wales; and
- the establishment of a managed clinical network.

Remaining Concerns

12. Bliss, the Royal College of Nursing and the expert group that produced the All Wales Neonatal Standards have published information highlighting their concerns about a shortage of neonatal nurses and middle-grade doctors with relevant experience. There are also concerns that many neonatal units across Wales could be operating outside the minimum nursing standards set by the British Association of Perinatal Medicine (BAPM).

13. Experts recommend that neonatal units should aim to work at 70 per cent occupancy. According to a survey of neonatal units carried out by Bliss, 38 per cent of neonatal units in Wales said they exceeded 100 per cent capacity at some point in 2007.

14. Bliss has stated its concerns that the All Wales Neonatal Standards cannot be achieved within current levels of funding.

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8 Baby steps to better care (Wales briefing) Bliss Baby Report 2008: Neonatal care in Wales
3. Demand for Neonatal Services

Introduction

15. We heard that demand for neonatal care in Wales has risen year on year, and this is set to continue with a growing birth rate and medical advances in the treatment of, and survival rates for, premature babies. This will put increasing pressure on neonatal service capacity. The need to base capacity and staffing requirement on the increasing birth rate was suggested in the evidence.

16. Dr Dawson, Fellow of the Royal College of Obstetricians and Gynaecologists and Chair of the National Specialist Advisory Group on Obstetrics and Gynaecology said,

“…we have seen a huge difference in the technical ability of our neonatal colleagues… we are now transferring babies at much earlier gestational ages than we used to. When I started in my career, the idea that a 28-week-old baby could survive was almost miraculous, and we have now reached the point where we are transferring babies to level 3 units at 22 and 23 weeks on the grounds that they might survive. So, the expectations that we have of our colleagues in neonatology are absolutely enormous.

“…we are also now delivering babies in cases where at one time mothers perhaps would have had a termination of pregnancy as a result of abnormality because of conditions such as gastroschisis, diaphragmatic hernia and a variety of other conditions”.

Funding

17. Much of the evidence to the inquiry highlighted that neonatal services in Wales have been under-resourced for many years and do not adequately meet the needs of newborn infants or their families. For example, the Health Commission Wales review of neonatal services in Wales, undertaken in 2005, estimated the cost of improving neonatal care to be around £10.4 million. This estimate was based on 2001 data.

9 Oral evidence, 18.3.10
10 Baby steps to better care (Wales briefing) Bliss Baby Report 2008: Neonatal care in Wales
18. Dr Mark Drayton, of the Expert Group on Neonatal Services, said, “there is, underlying all of this, a big resource issue... the Health Commission Wales report on the review into neonatal services commissioned right at the beginning of this decade...sat on desks for a long time and I think that it was eventually finalised in 2005 but never published. That review at that time, relating back to the study in 2001-03, identified revenue under-resourcing of approaching £10 million. I think that the reason it was never published and never went anywhere was fear in relation to the size of that number.

“What has happened since is that the birth rate in Wales has increased. Up until that point in time it had been decreasing for a few years. It has been increasing by more than 3 per cent a year since 2002, which is a total increase, since that report, of about 20 per cent, and there has been no significant input of extra resource. There are little bits of dribble here and there, and always a little dribble in response to acute pressures, but no overall planning goes on.”

Capacity

19. Experts recommend that neonatal units should aim to work at 70 per cent occupancy in order to maintain a manageable workload and to cope with sudden peaks in demand. High occupancy rates could have major implications for patient safety due to, for example, the increased risk of infection and/or inadequate staffing levels. It emerged from the evidence that the majority of Welsh neonatal units work above this level; the occupancy rates in some neonatal units can be as high as 130 to 140 per cent.

20. On being asked whether there is sufficient capacity for units to work at 70 per cent occupancy, as recommended by experts, Dr James Moorcraft of the Expert Group on Neonatal Services said:

“No, there is not...There is good evidence to show that many of the units have been working at 130 per cent or 140 per cent occupancy...Clearly, this is absolutely unacceptable. It puts undue pressure on the staff, who then feel unable to perform

[1] Oral evidence, 11.3.10
their duties in a family-friendly way...the staff are simply addressing the immediate clinical needs of the patients."\textsuperscript{12}

21. The clinicians highlighted the complex exchange of infants that frequently takes place to try to address the lack of staffed capacity in Wales and the delicate risk-balancing decisions that have to be made around the urgent needs of a new referral and a unit’s duty of care to existing babies and in-patient mothers with high-risk deliveries. There was considerable evidence of multiple negotiations to move babies or mothers around the system, which are invariably time-consuming. Other witnesses explained that babies from multiple pregnancies can be spread across more than one unit.

22. The Welsh NHS Confederation told us in written evidence that:

“The neonatal services in Wales are under pressure, especially in intensive care and high dependency care. The three large centres in South Wales – UHW, Swansea and Newport are frequently unable to accept intra-uterine transfers of high risk deliveries because they have no available staffed cots. These centres sometimes also have to transfer out their own local population to other units.”\textsuperscript{13}

23. Further, there was considerable evidence of inconsistency in reporting the number of available neonatal cots across Wales. Some figures relate to the number of equipped spaces and some relate to the number of nurse-staffed cots, and there is no consistency between units regarding the number of nurses that represent a staffed cot at each of the recognised dependency levels. Without consistency in the reporting of cots, occupancy figures are similarly inconsistent.

**High-dependency and Intensive Care**

24. Care in neonatal units is underpinned by guidelines from the British Association of Perinatal Medicine (BAPM), the professional body providing clinical leadership. The BAPM recommends a nurse-to-baby ratio of 1:1 for babies requiring intensive care, 1:2 for babies requiring high-dependency care, and 1:4 for special care babies. The Welsh Government endorses these staffing guidelines, which are also set out in the All Wales Neonatal Standards. However, the evidence suggests that these staffing standards are not being met.

\textsuperscript{12} Oral evidence, 11.3.10
\textsuperscript{13} Consultation response, HWLG(3)-NNC009-Welsh NHS Confederation
25. Specifically, there was evidence that level 3 (intensive care) units currently do not meet the recommended staffing standard.

26. It emerged from the evidence that demand at the more critical end has increased, specifically for neonatal surgery (which is only provided within Wales in Cardiff). Neonatal surgical cases require relatively short periods of intensive care, but extended periods of high-dependency care, which compounds the high-dependency capacity problems.

27. Dr Mark Drayton of the Expert Group on Neonatal Services said:

“One of the reasons why we have difficulty in accepting babies with surgical conditions from hospitals like James’s or from west Wales is not necessarily that we are using all our intensive care beds with intensive care patients, but we have high-dependency care babies that we cannot move anywhere else. So, clearly there needs to be an investment in that critical care capacity for south Wales in the three designated units.”\(^{14}\)

28. We also received evidence that because neonatal surgery in Wales is only provided in Cardiff, women are sometimes moved to units outside their local area.

29. Dr Andrew Dawson of the Royal College of Obstetricians and Gynaecologists and Chair of the National Specialist Advisory Group on Obstetrics and Gynaecology stated,

“we are also now delivering babies in cases where at one time mothers perhaps would have had a termination of pregnancy as a result of abnormality because of...a variety of...conditions that require immediate surgery at delivery, which in Wales—certainly in the most southern parts of Wales—will only be in Cardiff. We have a situation, not infrequently, where mothers who are booked to deliver in Cardiff at the last minute cannot be accepted there because there are insufficient intensive-care cots and, therefore, we end up with a mother being transferred to England to a unit that she does not know, which does not know her, and where no preparations have been made at all. That has a huge effect not only on the woman but on her family and on the unit that she is being transferred to.”\(^{15}\)

\(^{14}\) Oral evidence, 11.3.10
\(^{15}\) Oral evidence, 18.3.10
30. Dr Mark Drayton stated:

“We end up having to transfer out mothers who may live just outside the Heath hospital in Gabalfa or Birchgrove or wherever. We try, insofar as we can, not to transfer out babies who have surgical conditions. We try to accept them in, because there is nowhere else in Wales that those babies with surgical conditions can go and we know that if we say ‘no’, Bristol is very often full and so they may then have to go to Birmingham or London, and so may have to travel very long distances. So, we bend over backwards, but, of course, the other side of that is we do not do well by our local population. So, the population of Cardiff gets transferred and that has a knock-on effect on our obstetric and midwifery colleagues. You are well aware that the midwifery service is under considerable pressure due to staffing issues, but, of course, if you have to transfer a mother out in early pre-term labour you are on the road for two or three hours. It needs a midwife and it takes another midwife away from the service. So, the problem is just compounded.”16

31. The BAPM told us that, invariably, intensive-care units are operating very close to full capacity with a log jam of high-dependency babies backing up to the intensive-care cots, making it difficult to accept new babies. In other words, problems with the lack of high-dependency and intensive-care capacity in Wales frequently mean that seriously ill babies requiring the highest level of care are transferred away from local units, sometimes to units that are far away and/or outside of Wales – to Bristol, Birmingham and beyond. The Royal College of Obstetricians and Gynaecologists told us that the lack of available level 3 capacity and a reliable transport system frequently means that some units have to struggle on to provide care beyond their staffed capacity and beyond their experience and competence.

32. Dr Mark Drayton stated:

“There is clearly a need for more critical care capacity…the biggest problem relates to the high-dependency capacity because we have babies who are receiving high-dependency

16 Oral evidence, 11.3.10
care who back up, if you like, into our intensive care capacity.”17

33. Dr Jean Matthes, of the British Association of Perinatal Medicine and Chair of the Expert Group on Neonatal Service said,

“we do not have enough staffed cots in the units in Wales, particularly in the lead centres and particularly in the high-dependency sector. Intensive care is perhaps also a problem, although to a slightly lesser degree than is the case with the high-dependency sector. The pressure on the high-dependency sector has increased over the past five to 10 years because of changes in the way that neonatal care is delivered. We have more pre-term babies surviving and we have had changes to the way that we care for babies, which means that we deliver much more high-dependency care.

“I have discussed this with colleagues in England and the rest of the UK, and it is mirrored throughout the whole of the UK. So, we find that we have pressure on the cots in the lead centres, which means that sometimes the lead centres are closed or they cannot accept women in threatened preterm labour from further afield, or even that they have to transfer women in threatened preterm labour from their own labour wards out to other units. It is a significant problem.”18

34. Pressures on capacity can also lead to the closure of critical care cots in the lead centres and the re-designation of units. Bliss told us that, too often, there are unnecessary transfers due to understaffing, and the Royal College of Midwifery told us that some units have been closed to new admissions up to 100 times in the last 2 years.

35. Dr Jean Matthes also gave examples of this,

“in my own unit in Swansea, in February of this year we were shut 18 days out of 28. In March, so far, we have been shut three days...We were operating a 36-week model, which meant that our labour ward could only deliver at 36 weeks and above because we only had one flat space for an unexpected flat delivery, that is, a baby who is born and who unexpectedly needs care...Capacity is not adequate. We try to staff the cots

17 Oral evidence, 11.3.10
18 Oral evidence, 18.3.10
safely and within the funded levels, but the capacity is in no way adequate…

“In February, when we were shut, we had one extremely preterm baby brought to our unit because there was nowhere else for that baby to go. We did not have a cot, and we ended up admitting that baby and then having immediately to take another baby, who was in better health, to another unit...we...wanted to transfer the mother to be with the baby. We thought that the ambulance would be able to transfer her, and then the ambulance could not transfer her. So there was this awful anguish, with the mother and the baby being separated, which I feel is totally unacceptable. It is just an example of the pressures that the units are under. Everybody tries to do their best but we do not have enough cots.”

36. Dr Jean Matthes suggested that 24 intensive-care cots – an additional six or seven on current provision - are needed in south Wales to achieve medical standards and that they should be in the lead centres, where standards for medical care are met, where there is most pressure and where high cot occupancy is found. She also stated that, according to 2008 figures, the Welsh Neonatal Committee calculated that there is a shortfall of 12 high-dependency cots in South Wales (30 high-dependency cots are funded at present). She stated that there is also pressure in high-dependency neonatal care in Glan Clwyd, where another one or two high-dependency cots are required.

37. However, when asked whether the high-dependency or intensive-care cots were the priority, Dr Jean Matthes stated:

“We need both, but what we can achieve with the amount of money there is I do not know. If I had to choose I would go for high-dependency cots. In an ideal world, yes, let us have it all.”

Minister’s View

38. In 2008, the Minister announced that she would make £2 million available each year for neonatal services.

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19 Oral evidence, 18.3.10
20 Oral evidence, 18.3.10
39. Simon Dean, Director of Strategy and Planning in the Health and Social Services Directorate General, stated:

“The Minister made available £2 million through Health Commission Wales…I believe that I am correct in saying that the Gwent authorities invested an additional £1 million last year in neonatal care and there have been additional investments in neonatal services from other health boards including, if I recall correctly, the former Abertawe Bro Morgannwg health board. So, the £2 million is not the sum total of additional investment in neonatal care since 2005. That was a specific sum announced by the Minister about a year ago, but there have been additional investments on top of that. So, the gap is not quite as stark as it might appear.”

40. In her evidence, the Minister confirmed that the lack of available information on the costs associated with neonatal transfers is being addressed:

“There are some available data but they are not collected on a consistent basis, which is why we have introduced the clinical information system, which will enable us to collect the data on neonatal transfers between Wales and England. The network will drive consistency in the data collection process, which will allow us to answer some of these questions in the future.

“I have to say that data are sometimes collected on the basis of bed days or episodes, so there is no consistent approach and, therefore, no clarity in the system. That is why one of the priorities of the clinical network was to introduce the clinical information system”.

Committee’s View

41. It is the Committee’s view that consistency is needed in the number of nurses that represent a staffed cot at each of the recognised dependency levels and in reporting the number of available neonatal cots across Wales.

21 Oral evidence, 25.3.10
22 Oral evidence, 25.3.10
42. Given the likely increase in demand for neonatal services and the historical underfunding of them, the Welsh Government should fund an increase in cot capacity, particularly for high-dependency care.

43. It is unacceptable that the BAPM guidelines are not being met and that units are sometimes operating at double the capacity recommended by experts.

Recommendation 1 - We recommend that the Welsh Government should ensure that a review of capacity be undertaken by the All Wales Neonatal Network, to include current staffing and activity levels.

Recommendation 2 - We recommend that the Welsh Government, in assessing future requirements of the service, should pay particular attention to the increasing birth rate in Wales.

Recommendation 3 - We recommend that the Welsh Government should ensure that there is capacity across all services to meet future demand.

Recommendation 4 - We recommend that the Welsh Government should ensure that staffing ratio guidelines, in compliance with BAPM 2001 minimum standards and as set out in the All Wales Neonatal Standards, are met, but not through a reduction in cot numbers.

Recommendation 5 - We recommend that the Welsh Government should put in place measures to ensure that neonatal units achieve occupancy levels that are capable of meeting the fluctuations in demand.
4. All Wales Neonatal Standards

Introduction

44. The All Wales Neonatal Standards were published by the Welsh Government in December 2008. They present a vision for services for special care babies and their families, to be achieved over a ten-year period. The neonatal standards were welcomed by the Health Boards and clinicians working in neonatal services.

45. The standards set out that care should be provided in a co-ordinated managed clinical network of neonatal units and that a dedicated transport service with specially trained staff should be in place at all times, in all areas of Wales. Other key actions in the standards document include making improvements to the staffing of neonatal services and ensuring that appropriately trained doctors are available to all units at all times; ensuring that there are appropriate cots and equipment for babies who need high-dependency and intensive care; and providing improved care of the baby and the family.

46. A common concern raised through the evidence was that co-ordinated health planning and new investment was necessary if the All Wales Neonatal Standards are to be met. Most witnesses agreed that it is unlikely that all the Neonatal Standards will be met within the timescales proposed. Bliss also pointed out that, in many respects, neonatal services in Wales do not match up to those in other parts of the UK.

Funding

47. The evidence we received supported the All Wales Neonatal Standards, and most witnesses believed that they are necessary to improve the quality of neonatal care in Wales. However, many were concerned that insufficient funding and pressure on resources has meant that there has been little improvement in neonatal care to date.

48. Dr Mark Drayton, of the Expert Group on Neonatal Services, said:

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“No-one in Wales, to the best of my knowledge, meets those standards. We are a considerable way away from those standards. If we were to say, ‘Tomorrow we will meet the standards’, there would be a massive reduction in capacity and we would not be able to cope with that. England would not be able to take the slack, it would be hopeless for families and parents, and that would not improve the matter. So, we manage below the standards.”

49. Funding is needed to employ the staff required to deliver the All Wales Neonatal Standards. Health Commission Wales estimated in 2005 that £10.4 million was required to realise the All Wales Neonatal Standards. However, those figures were based on the falling birth rate at the time.

**Monitoring Implementation**

50. It emerged from the evidence that approaches to monitoring the implementation of the standards varies between Health Boards. The Welsh NHS Confederation stated in its evidence that a number of Health Boards have undertaken comprehensive reviews of their units against the standards, while others have undertaken informal reviews.

**Minister’s View**

51. The Minister told the Committee that the assessing of neonatal services against the All Wales Neonatal Standards will be a priority and that one of the key roles of the neonatal managed clinical network will be to co-ordinate regular reviews of progress in complying with the standards:

“It is the responsibility of LHBs to develop plans to improve service standards and to meet the standards, and the networks will be assessing the position now against the standards as a priority in their work. I expect the networks then to advise the LHBs through, of course, the new commissioning bodies that we will be utilising, on the next priorities for development. That is the key area there.”

52. Simon Dean, Director of Strategy and Planning in the Health and Social Services Directorate General, added:

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24 Oral evidence, 11.3.10
25 Oral evidence, 25.3.10
“I will add two other components of that. One is the performance management system that we have in place, whereby we assess the performance of individual NHS bodies, and, in this case, we will be looking at the performance through the Welsh Health Specialised Services Committee.”

**Committee’s View**

53. The Committee accepts the evidence from witnesses that an increase in investment is required if the All Wales Neonatal Standards are to be met and capacity maintained.

54. The Committee believes that variation in the monitoring of the implementation of the standards between Health Boards needs to be addressed.

**Recommendation 6** - We recommend that the Welsh Government should require the All Wales Neonatal Network to develop a plan to deliver the All Wales Neonatal Standards within a clear set of timescales, and to make public the action it will take to ensure the standards are met.

**Recommendation 7** - We recommend that the Welsh Government should ensure that rigorous procedures are in place to monitor the implementation of the All Wales Neonatal Standards.

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26 Oral evidence, 25.3.10
5. A Neonatal Network and Transfer Service for Wales

Neonatal Managed Clinical network

55. The issue of neonatal capacity is complex, and a common concern raised through the evidence was the lack of strategic management of existing capacity. Clinicians stated in their evidence that staff spend a great deal of time searching for available capacity elsewhere. There was considerable evidence of the impact of this on the ability to provide safe care for babies in neonatal units and those needing to be transferred to and from other units. In some instances, the lack of capacity has led to babies being transferred long distances to receive appropriate care. Further, professional time is lost due to the need for neonatal or midwifery ambulance escorts during transfer for sick babies or women in early labour.

56. Dr Mark Drayton of the Expert Group on Neonatal Services told us about the work involved in managing these transfers in individual units and hospitals,

“quite a large proportion of my service week is taken up with managing the capacity. That takes my time away from doing what I ought to be doing, which is providing hands-on care for the babies...Almost invariably, I have either no critical care capacity whatsoever or one cot and one, two, three or four mothers...all of whom have high-risk pregnancies and who may need to deliver their babies in the next 24 hours. Then I receive a telephone call from one of my colleagues somewhere in south Wales or England requesting that I take another baby. So, all the time I am doing this balancing act and considering how far I can push my team, the risks that I am running...We end up doing some really convoluted things sometimes, such as multi-way transfers. If I can get a certain baby back to a certain place then we can do a three-way transfer. Then we end up wanting a three-way ambulance transfer to take the baby from us to a certain place, pick a baby up from there and move it elsewhere, and then get the critical care baby back in.”

27 Oral evidence, 11.3.10
57. Dr James Moorcraft of the Expert Group on Neonatal Services stated:

“Quite often we can be on the phone for four or five hours trying every hospital in the south-west of England, and all along the M4 corridor.”

58. Whilst witnesses recognised that transfers are part of ensuring that mothers and babies receive the level of care that they need, the evidence suggests that, too often, there are unnecessary transfers caused by closer units that are appropriate to their care being closed due to understaffing. There was some discussion in the evidence about the difficulties in having the right staff in the right place at the right time. Some witnesses felt that more work was needed to better manage capacity and demand if the All Wales Neonatal Standards are to be met consistently, ensuring a safe, high-quality service to mothers and babies at all times.

59. Dr Mark Drayton of the Expert Group on Neonatal Services stated,

“there is not…any overarching mechanism that manages that process…we…feel frustrated that we have no control over those processes and that there has been no planning in the processes…we just have to react to manage the clinical risk as best we can. What we need is a planning process, and we see the development of a formal network as being key to that.”

60. There was considerable evidence of strong support for neonatal services to be delivered through such a network, which was seen to be important in improving communication and co-ordination between units. Witnesses felt that the network would help to optimise efficient and effective use of existing capacity, helping to reduce the number of times babies have to be transferred long distances to obtain the necessary level of care. However, there was widespread frustration that this network, which was supposed to be operational from February 2010, is still not yet up and running.

61. The Welsh NHS Confederation told us in written evidence that:

“There is strong support for the development of the formal managed neonatal network. The establishment of the network

28 Oral evidence, 11.3.10
29 Oral evidence, 11.3.10
will be key to maintenance and monitoring of the standards across the network, ensuring a high quality service is available to all."\textsuperscript{30}

62. The evidence submitted by the Health Boards suggested that once the neonatal managed clinical network is in place, it will be possible to monitor the transfers that are happening within Wales from different Health Boards. There is currently limited information available on the commissioning and financial management of neonatal services and no method for tracking the costs associated with neonatal transfers.

63. The witnesses agreed that the establishment of the neonatal managed clinical network and the three specialist neonatal intensive care centres will help to make the best use of existing resource and capacity, but it was felt that a major staffing shortfall will remain without further investment.

**Neonatal Transport Service**

64. The Welsh Ambulance Service currently provides emergency transportation for neonates on an ad hoc basis. Witnesses told us that Wales does not yet have an appropriately staffed and equipped transport system.

65. In accepting the neonatal business case, the Minister announced that she would be providing funding for a 12-hour service in the first instance, with planned progress towards a 24-hour service in the future, as recommended in the All Wales Standards.

66. However, we heard that the dedicated 12-hour service, which should have been operational from spring 2010, has not been established. Dr Mark Drayton of the Expert Group on Neonatology Services emphasised the importance of the 12-hour transport service. He stated:

   “The only way to use...resource effectively is to apply a degree of concentration of the services, to have good transport services to allow those babies to get to those centres, to have the capacity in those centres to deliver the care, and then, equally, to focus very strongly on getting babies back to their local units to recover when the critical episode has passed.”\textsuperscript{31}

\textsuperscript{30} Consultation response, HWLG(3)-NNC009-Welsh NHS Confederation

\textsuperscript{31} Oral evidence, 11.3.10
67. There was some discussion in the evidence about the need for a 24-hour neonatal transport service. The All Wales Neonatal Standards recommend that:

“A transport service, staffed by trained personnel is in place 24/7 for all areas of Wales, to provide rapid and timely transport of neonates to and from appropriate services across the network and country boundaries.”

68. In their written evidence to Committee, Bliss stated:

“We urge the Welsh Assembly Government to provide the leadership and funding necessary to develop the workforce and run a 24-hour service as soon possible. This is the standard for transport services in Scotland and England. Special care babies in Wales deserve no less.”

69. However, the Welsh NHS Confederation told us in written evidence:

Whilst there is a longer term proposal that it should be extended to a 24 hour service, a review of the 12 hour service needs to be made before such a decision is made. Only small numbers of transfers will be required out of hours.

70. Dr Mark Drayton also stated that the 12-hour service was the priority:

“The neonatal standards...state that a 24-hour transport service should be provided but, clearly, running a 24-hour service requires more resource than has been made available to us. On the positive side, I expect it... [12-hour service]... to be possible to manage 85 per cent or so of transports within the hours that are available. In other words, you get the most benefit per pound spent in those hours. There will still be demands out of hours for babies who need urgent transfer and who cannot wait the few hours until the transport service is available... and for the time being we will have to fall back on what happens now.”

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33 Written evidence, HWLG(3)-05-10 Paper 1
34 Consultation response, HWLG(3)-NNC009-Welsh NHS Confederation
35 Oral evidence, 11.3.10
71. Dr Iolo Doull, Consultant Respiratory Paediatrician, Welsh Paediatric Society President and Royal College of Paediatrics and Child Health Officer for Wales also strongly supported having a 12-hour transport service:

“I think that having the 12-hour service in place will change things dramatically. I think that it will allow babies to be cared for in the right position hopefully. Once the 12-hour service is up and running, we will have a clearer idea as to how much more provision is needed and whether babies are being cared for in the right places, not just in the level 3 units. The problem is that level 3 units get blocked by high-dependency children.”36

72. However, when questioned as to whether he would like to see a 24-hour service being implemented immediately, he stated:

“I think that, as a college, we would feel that it should be a case of waiting and seeing. If you look at the rest of the UK, there is not unanimity on the best model of transport for neonatal care... So, as a college, I suppose that we would say that 12 hours is vital and we really welcome that. I think that once the 12 hours is running, if there was funding available would we say that for a very large sum of money we want 24 hours or would we be better off investing in the high dependency and intensive care cots?”37

73. Helen Kirrane of Bliss pointed out the special problems that affect the transport and transfer of patients in north Wales:

“there are unique issues that the service in north Wales faces and there needs to be unique solutions. Additional support is needed, perhaps, to overcome some of the rurality and population issues. So, because the population is not as dense, there really needs to be that excellent transfer service to take babies and mothers to where they need to go to get the care that they need.”38

**Minister’s View**

74. The Minister for Health and Social Services has announced the allocation of £2 million for the establishment of a managed clinical

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36 Oral evidence, 25.3.10  
37 Oral evidence, 25.3.10  
38 Oral evidence, 11.3.10
network, neonatal transport service and IT database for use across all the neonatal care providers in Wales.

75. We were told that the Minister had received advice from her clinical advisory group (the expert group) on a model for how the managed clinical network would operate. In his evidence to Committee, Simon Dean stated:

“The Minister established a clinical advisory group to advise her on the priority developments. It provided that advice in November, and the Minister agreed all the recommendations in December. Included in that advice was a model for how the network would operate. Since December, the clinical advisory group has been working on the detailed plans and as part of that it wanted to look at some of the details of its proposed model, particularly how the clinical lead worked. So, it provided further advice to the Minister, which she signed off.”

76. The Minister told us that the network is in the process of being established and that there will be a national network lead clinician,

“we are now appointing the lead clinician, which will be quite important, and the network manager.”

77. The Minister has approved funding for a 12-hour dedicated neonatal transport service to ensure rapid and safe transport to specialist centres. She said:

“I understand that the first appointments are due to be made in April or early May. Consultant appointments will take slightly longer, but that process is also under way...

“Transport services should be fully operational by the autumn—that is what I understand from officials.”

78. The Minister confirmed in her evidence that she will be considering the case for a 24-hour service once the 12-hour service is up and running, but that it would be for the Health Boards to fund it:

“To be frank with you, my entire budget is currently allocated for next year to the LHBs, but I do expect them to look at all
these issues to deliver a sustainable service across the piece. I think that once the 12 hours is set, we will then have to have discussions on the 24 hours because that is an issue that has probably been raised across the piece.”

Committee’s View

79. The Committee accepts the view that a 12-hour transport service should be established in the first instance, and that a 24-hour service should be considered in the light of experience. The Committee shares the frustration that witnesses felt in relation to the delay in establishing the 12-hour service but accepts the Minister’s confirmation that progress is being made and that the service will be fully operational by autumn 2010.

Recommendation 8 - We recommend that the Welsh Government should establish a Cot Locator system, to ensure that cots are allocated on an efficient basis and to reduce unnecessary transfers between units. The system should be compatible with systems in England.

Recommendation 9 - We recommend that the Welsh Government should ensure that the clinical network and database is working effectively as soon as possible.

Recommendation 10 - We recommend that the Welsh Government should ensure that the 12-hour transport service is in place and operational as soon as possible.

Recommendation 11 - We recommend that the Welsh Government should keep under review the effectiveness of the 12-hour transport service, in particular in relation to meeting demands on the service and patients' needs. Further to this, we recommend that, at an appropriate time, consideration should be given to whether a 24-hour transport service would better meet patients' needs.

Recommendation 12 - We recommend that the Welsh Government should ensure that the All Wales Neonatal Network regularly reviews arrangements for cross-border transfers of patients, to ensure that they are effective.

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42 Oral evidence, 25.3.10
6. Recruitment, Retention and Training of Staff

Introduction

80. There was considerable evidence that problems in recruiting, retaining and training the staff required to deliver the service remain a major challenge.

Recruitment

81. There are serious shortages in the numbers of neonatal nurses in Wales. Figures provided by the Welsh NHS Confederation show that each unit has had, on average, two vacancies for nurses qualified in neonatal care.

82. There are more vacancies in the specialist centres than in the local neonatal units. University Hospital Wales, which provides the most intensive care, has the highest number of vacancies.

83. Bliss set out the extent of the shortfall in meeting the British Association for Perinatal Medicine minimum nursing guidelines:

   “In 2008 we did a survey of neonatal units in Wales, which found that 382 neonatal nurses were working across Wales. Using the staffing standard set out by the British Association of Perinatal Medicine, there needs to be 500 nurses. There is a shortfall of 120, according to those figures, across the 13 units in Wales, so it is a significant level of understaffing.”

84. It emerged from the evidence that changes to recruitment processes at a national level have led to additional shortages of medical staff, resulting in considerable clinical risk and cot closures on the neonatal unit. A common concern raised through the evidence was the number of Welsh neonatal units that could be operating outside BAPM minimum staffing standards.

85. Dr Mark Drayton stated:

   “The staff problems, as I mentioned a moment ago, are both medical and nursing. If we go back to the standards that we have had in Wales since 2008 based on the BAPM standards, no

43 Oral evidence, 11.3.10
unit in Wales meets those standards in terms of nursing provision in relationship to the cots that are on the ground. That has enormous impacts on how well we are able to develop and deliver our services.”

86. In answer to a question about the extent to which staff shortages put special care babies at risk, Dr Mark Drayton said:

“It is difficult to measure that risk, but anybody with common sense can understand that, if you cannot put the doctors and nurses on the ground in the number that is needed, you are going to stretch the resource and there will be risk. It is partly about managing that risk down to levels that we do not feel are acceptable, but that we can live with for a while. We have had to close, temporarily...four cots, despite the impact that that is having on the public and on our mothers and babies.”

87. The European Working Time Directive has also placed increased pressure on neonatal units, many of which report a shortage of junior doctors and problems with middle-grade rotas. The implementation of the European Working Time Directive means that there is a 48-hour maximum working week for medical staff.

88. There was some discussion in the evidence around the need for dedicated neonatal consultants. Neonatal consultants are employed by Abertawe Bro Morgannwg University Health Board, Aneurin Bevan Health Board and Cardiff and Vale University Health Board. The remaining Health Boards staff their neonatal units with paediatricians with an interest in neonatology.

89. The Royal College of Paediatrics and Child Health in Wales told us that the current model of neonatal and paediatric care based on middle-grade doctors is not sustainable and that Wales should move towards a consultant-delivered service. The RCPCH told us that doctors are not attracted into neonatal care because it is delivered at middle grade rather than consultant level:

“...There are plenty of posts; it is that they cannot be appointed to. If you look at the modelling for how you want a service to run, the bottom line is that, if you want to maintain it on middle grades, that is not sustainable. As a college, we would

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44 Oral evidence, 11.3.10
45 Oral evidence, 11.3.10
advocate that we should be moving towards more of a consultant-delivered model. There are good examples of that; Salisbury, Hereford and Dorchester are used as examples where, rather than having middle grades, you will have consultants delivering. You are moving then towards a consultant-delivered service. The current model of neonatal and paediatric care based on middle grades is not sustainable”.  

90. There was strong support in the evidence for an increased number of Advanced Neonatal Nurse Practitioners (ANNPs): trained neonatal nurses who take on an extra year of training, including training in skills that enable them to work in the place of doctors on junior on-call rotas. Abertawe Bro Morgannwg Health Board said that it has two ANNP s and would like more. It was felt that the ANNP s play a crucial role in developing a more flexible workforce.

91. Dr Jean Matthes expressed strong support for ANNP s:

“Advanced neonatal nurse practitioners are a very beneficial resource...They tend to be a permanent feature in the workforce as well, which gives a sense of continuity. They really are extremely valuable. In these days where we have uncertainties about medical staffing, in that we have already seen a middle-grade crisis in staffing, to develop ANNP s would really strengthen the service. It may be that we could use them on the first on-call rotas; it may be that we could use them later on, once they have become more expert, on the transport service; it may be that some of them will then be able to go on to the middle-grade rota. It takes time to develop, but certainly to have these people trained and working within the neonatal service in Wales would be a huge asset. We only have three or four in Wales at the moment. We certainly have a lot who are keen to train. If we can train more, then I think that would be very beneficial.”

North Wales and Rural Areas

92. Some of the Health Boards covering rural areas do not have neonatal units but commission these services from other Health Boards.

46 Oral evidence, 25.3.10
47 Oral evidence, 18.3.10
93. There are medical staff shortages across Wales and concern was expressed that there is no dedicated consultant neonatologist at any of the three units in North Wales. Dr Mark Drayton stated:

“I can say that...[North Wales] is some way behind us in organisational terms. There is a desperate need for additional neonatal input in north Wales and, in particular, for dedicated neonatal consultant staff to provide that focus and develop those services. I know that my north Wales colleagues would agree with me on those issues.”

94. Dr Jean Matthes stated the following when discussing neonatal care provision in North Wales:

“There are staffed intensive-care cots, from the nursing perspective anyhow, in the Glan Clywd and Wrexham units, and there are also high-dependency cots staffed in those units. I believe that we have paediatricians with an interest in neonatology who look after those patients. There is no dedicated middle grade rota or dedicated first-on rota for neonatology and, again, those aspects of the service are provided by paediatricians who have many other calls on their time. It is not the same standard as in the Welsh standards. It is not meeting those standards, and it is not the same standard as in south Wales.”

95. Evidence from the Neonatal Subgroup of the Children and Young People Clinical Programme Group in North Wales stated:

“There is a national shortage of both nurses and junior doctors and rural areas are frequently disadvantaged in the recruitment market.”

**Training**

96. Neonatal nursing is a post-registration specialty, requiring a specialist training course, and we heard that there are challenges in ensuring that nurses are properly trained and that their skills are up to date. We heard evidence that staff can find it difficult to find time to attend training, a problem exacerbated by existing staff shortages. For example, the Royal College of Nursing told us that nurses are not

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48 Oral evidence, 11.3.10
49 Oral evidence, 18.3.10
50 Consultation response, HWLG(3)-NCC012-Dr Michael Cronin
being released from their NHS work to be trained in neonatal care. The Royal College of Nursing (RCN) also told us that nurses frequently fund their own studies and/or study during their annual leave. Some Health Boards provide in-house training to deliver training in more flexible ways, although even in-house training is not protected, as we heard from Neonatal Sister, Claire Bateman-Jones:

“I have had three study days cancelled in the last year because there were no nurses to backfill. These courses were in-house training, but they still had to be cancelled.”

97. Lisa Turnbull of the Royal College of Nursing stated,

“the one thing I would urge the committee to consider is who has responsibility for doing the long-term planning to ensure access to education...The issue at the moment is that someone has to take that responsibility, and that does mean a protected budget, even if it was small or notional. At the moment, we have the situation where local health boards simply cut CPD. We know that there are local health boards out there where they have just said, ‘Right, that is it; even in the middle of courses, people are not going to be released’, and that is causing tremendous problems. I can understand that they are doing it because of financial pressures, but it is not really a sensible way forward in terms of planning for the future. So, perhaps that is something the network should explicitly have responsibility for.”

98. Lisa Turnbull also said,

“there is a perception among those at the local health board level that their problem is today and that it is an operational issue and not just a question of resourcing... If you look, for example, at Scotland, the Scottish Government has provided not just money to commission places for training, but also money to backfill places to ensure that nurses can be released to go on those courses. So, it has taken that extra responsibility to do that. One issue at the moment is that the Welsh Assembly Government can commission as many places
as it likes, but if LHBs refuse to release nurses, that has no impact on the service.”

Minister’s View

99. Simon Dean, Director of Strategy and Planning in the Health and Social Services Directorate General, told us that the Government has established a national clinical project to draft a strategy looking at the provision of sustainable maternity and neonatal services,

“we put in place a project...to ensure that progress is made on implementing the standards and to identify any key issues that need to be pursued, for example, around sustainability.”

100. The Minister also told us that investment had been made in staffing to provide additional consultants—including two in north Wales—and additional middle-grade doctors, neonatal nurses and advanced neonatal nurse practitioners:

“We have to look at the improvements from 2005. We have now gone up to 18 whole-time equivalents and I announced a further five consultants in December. There will be a further five middle-grade doctors within the system and an additional 11 nurses, together with four advanced neonatal nurse practitioners.”

101. In addition, the Minister’s written submission stated,

“midwifery training places have increased in each of the last three years.”

102. In her written submission, the Minister stated that one of her priorities was the,

“recruitment of additional midwives by LHBs to meet the staffing levels recommended by Birthrate Plus.”

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53 Oral evidence, 11.310
54 Oral evidence, 25.3.10
55 Oral evidence, 25.3.10
56 Health, Wellbeing and Local Government Committee 25.3.10, written submission from the Minister for Health and Social Service, HWLG(3)-07-10-p2
57 Health, Wellbeing and Local Government Committee 25.3.10, written submission from the Minister for Health and Social Service, HWLG(3)-07-10-p2
Committee's View

103. The Committee accepts the view that there is a shortage of consultant posts, middle-grade doctors and nurses in neonatal services, which, inevitably puts babies at risk.

104. Given that neonatal nursing is a post-registration specialty, the Committee believes that facilitating access to training is vital if the shortage in neonatal nurses is to be addressed, and that nurses should not have to fund their own training or take training time out of their annual leave.

Recommendation 13 - We recommend that the Welsh Government, in conjunction with the Health Boards, puts in place measures, as a matter of urgency, to address the shortfall in medical and nursing staff to ensure services are safe.

Recommendation 14 - We recommend that the Welsh Government should ensure that procedures are put in place to ensure that neonatal nurses can access education and training.

Recommendation 15 - We recommend that the Welsh Government should explore with relevant professional bodies, including the Royal College of Nursing and Royal College of Midwives, the development of a neonatology specialty.
7. Service Structure

Introduction

105. Until 1 April 2010, responsibility for commissioning neonatal services had been divided between Health Commission Wales and Local Health Boards. Health Commission Wales was responsible for commissioning neonatal intensive care and neonatal high-dependency care in units providing intensive care. Health Boards were responsible for all low-dependency care and high-dependency care in units not providing intensive care. Some witnesses felt that this division has hindered the planning and provision of joined-up care in relation to neonates.

106. Health Boards have been responsible for all neonatal services since 1 April 2010. Planning for neonatal intensive-care services will be through Welsh Health Specialised Services Committee (WHSSC), a joint committee of Health Boards. The Neonatal Clinical Network will be accountable to the Health Boards through WHSSC.

Reconfiguration

107. It emerged from the evidence that the number of local paediatric services could be reduced in the future as existing units cannot maintain safe staffing levels. The evidence from Powys Health Board suggests that, should there be a paediatric unit reconfiguration, a whole host of different arrangements would be required to support more local care and local assessment.

108. The Royal College of Midwifery expressed concerns that if units merge, patients might have to travel further to specialist neonatal units. However, Dr Iolo Doull of the Royal College of Paediatrics and Child Health expressed a preference for fewer units if it meant that they were consultant-led:

“We are trying to have safety, quality, sustainability and access, but I believe that quality and safety are more important than access. In moving towards a consultant-delivered model of care, there are huge advantages for patients and their families. That is not going to be resource-neutral, though it probably is not going to be as resource-terrible as you might imagine, because you could then decrease the number of middle grades
and trainees…Ease of access is important, but if you look at, say, the Princess of Wales and Royal Glamorgan hospitals, they are not that far apart and the travelling time is not that great.

“So, if it was a question of going to a unit where you would see a consultant rather than a junior doctor and would get very good, high-quality care, or seeing a junior doctor somewhere locally, I think that it is important to ask people the question.”

109. Witnesses highlighted that if there are fewer units in the future, it will be crucial that parents are provided with appropriate support and transportation.

**North Wales**

110. Evidence from the Neonatal Subgroup of the Children and Young People Clinical Programme Group in North Wales stated:

> “It has long been recognised that the current configuration of neonatal services is not sustainable…neonatal units in North Wales cannot achieve some standards particularly those specifying the numbers of healthcare workers (medical or nursing) that are required to provide suitable working rotas and ratios of staff to cot.”

111. It was stated that:

> “A partial solution to…the…problems has been an intended rationalisation of neonatal services with the aim to achieve more efficient use of staff and closer conformity to standards. There is broad agreement within the clinical profession as to how this reconfiguration should occur (centralisation of intensive care to one unit with high dependency provided by the 2 other units)...One major obstacle here is persistent lack of clarity and direction with respect to the long term makeup of secondary care in the region and the assumption that neonatal services will be reconfigured once there is agreement on the provision of unscheduled care and obstetric services...

> “Funding announced by the Welsh Assembly Government (WAG) to improve neonatal transport across Wales and acceptance by

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58 Oral evidence, 25.3.10
59 Consultation response, HWLG(3)-NNC012-Dr Michael Cronin
the NHS organisation in North Wales to move towards a single intensive care unit will provide impetus...

“The unresolved issues around the longer-term structure of secondary care in North Wales, especially maternity services, is an obvious obstacle to the redesign and modernisation of neonatal services...

“The single unitary organisation will allow restructuring and facilitate a broader outlook on both neonatal and antenatal services; this will hopefully lead to more flexible and efficient use of workforce...However, this will not be achieved easily without suitable support and investment...

112. It was also stated that:

“Progress to the establishment of a single intensive care unit in North Wales can be seen as a forward step, both in utilising existing workforce more efficiently and towards delivering neonatal care based on national standards. It is essential that rapid progress is made in achieving this reconfiguration and that the move is supported by BCUHB [Betsi Cadwaladr University Health Board] and national commissioners...

“The resolution of uncertainties regarding the structure and function of secondary care in North Wales, particularly maternity services, is imperative. Whilst this remains unclear the redesign and planning of services will remain difficult.”

113. However, Dr Iolo Doull expressed admiration for the unified child health strategy that exists in North Wales:

“One of the strengths of north Wales is that Betsi Cadwaladr University Local Health Board has a unified child health strategy across the three locations, so they can make decisions. I would compare that with west Wales, where the three units have been forced to act as silos, almost. So, I think that north Wales is more advanced and I am aware from the clinical director there that there are plans to take that forward for level 3 care.”

60 Consultation response, HWLG(3)-NNC012-Dr Michael Cronin
61 Oral evidence, 25.3.10
Cohesion of Neonatal and Maternity Services

114. It emerged that neonatal services and maternity services are not currently cohesive. There are tensions in the decision-making process due to a lack of integration and partnership working. The need for neonatal and maternity services to provide an integrated service that provides high-quality care and minimises the stress on parents was suggested in the evidence.

115. Abertawe Bro Morgannwg University Health Board told us that, in its area, the Head of Midwifery manages neonatal and midwifery services, and other witnesses suggested that neonatal services and maternity services should not be managed separately and that this could help to improve partnership arrangements.

116. There was strong support for the inclusion of neonatal services alongside paediatric and maternity services in an all-Wales review.

117. The Health Boards highlighted the importance of very close links between neonatal services and midwifery services in reducing the number of neonatal transfers through early risk assessment. They also explained that any pressure placed on the neonatal service is inevitably transferred to obstetricians and midwives, as moving mothers, either delivered or undelivered, from one hospital to another takes staff away from the labour ward and places additional demands on the receiving labour ward.

118. Dr Dawson of the Royal College of Obstetricians and Gynaecologists and Chair of the National Specialist Advisory Group on Obstetrics and Gynaecology stated:

“I feel very strongly that we need to see ourselves as a maternity service in which neonatology is absolutely a leading part…good midwifery care will underpin the quality of babies that end up under the care of Dr Matthes and her colleagues. If babies are spending time in an ambulance while the mothers are in labour then those women will not be getting good care and neither will their babies.

“We really need to make sure that whatever service we arrive at is one that is truly responsive and…fit for the purpose it is intended for.”

62 Oral evidence, 18.3.10
**Minister’s View**

119. In her written submission, the Minister stated that neonatal services are an integral part of maternity services and should not be seen in isolation:

> "Neonatal services, which provide care for very sick babies, are an integral part of the maternity services and cannot be seen in isolation."  

120. In her oral evidence to Committee, the Minister stated that she hopes to publish a maternity strategy to drive improvements in maternity, neonatal and paediatric services by December 2010. Simon Dean, Director of Strategy and Planning in the Health and Social Services Directorate General, stated,

> "we put in place a project that will be looking at a strategy for maternity services and a strategy for hospital-based paediatric services, and neonatal care will form a part of that project. So, that national piece of work will be going on alongside the network to ensure that progress is made on implementing the standards and to identify any key issues that need to be pursued".

121. The Minister stated in her evidence that her priority is to have safe, secure, sustainable and well-managed units, with the appropriate staffing in key centres:

> "Parents would like these matters to be dealt with closer to home, but I do not think that, even in an ideal world, we would have the level of expertise necessary to have everything where everybody would want it. I would be happier in my own mind knowing that we had safe, secure, well managed units with the appropriate staffing in Wales in key centres."

**Committee’s View**

122. We feel that if units are to merge, there will need to be a focus on local care, assessment and support and on transportation.

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63 Health, Wellbeing and Local Government Committee 25.3.10, written submission from the Minister for Health and Social Service, HWLG(3)-07-10-p2
64 Oral evidence, 25.3.10
65 Oral evidence, 25.3.10
123. The Committee believes that the establishment of a single intensive-care unit in North Wales would be a positive step in utilising the workforce more efficiently and in delivering care in accordance with the national standards.

124. The Committee believes that neonatal services and maternity services are not cohesive at present and that they need to be if high-quality care is to be delivered.

Recommendation 16 - We recommend that the Government should ensure better integration of, and joint working between, neonatal and maternity services.
8. Support for Parents

Introduction

125. Support for parents is unquestionably a vital component of an effective neonatal service. There was considerable evidence of the high-quality care given to special care babies and their families in Wales but there was also evidence that facilities and support for the parents of special care babies vary across the units. The evidence also suggests that there are issues with physical space and equipment in some units.

126. Witnesses advocated a family-centred approach to neonatal services, to ensure that the emotional and social needs of babies and their parents are not overlooked. It was felt that good communication from the staff on the neonatal unit was crucial so that parents can be involved in decision making and can be informed about choices. Periods of transition - movement between different units or different levels of care and leaving the unit to take the baby home - are particularly stressful times and it emerged from the evidence that some parents do not feel supported at these times. Bliss told us that parents can feel that nurses are too busy to involve them in the care and that clinical priorities can take precedence over supporting parents when the units are at capacity.

127. Dr Mark Drayton of the Expert Group on Neonatal Services corroborated this,

> “when your nurse staffing is perhaps 50 or 30 per cent below the standards, the priorities are to deal with the medical problems that are in front of you. Inevitably, from time to time, communication is not as good as you would like.”

Accommodation

128. All of the hospitals providing neonatal care in Wales have accommodation facilities for parents, but they can be limited – most units have only one or two rooms.

129. Neonatal services have grown over the years and it was clear from the evidence that many of the units have not had the space or

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66 Oral evidence, 11.3.10
resource to develop the number and quality of facilities in line with that growth.

130. Dr Jean Matthes stated:

“It is interesting that the Department of Health published a report on 16 March called 'Maternity and Early Years—Making a good start to family life'. One of the promises in that document states that,

'we will aim within five years that parents with babies in neonatal care can be confident a bed will be provided for them so that both mothers and fathers can stay close to the baby.’

“So, that commitment has been made in England, and it would be fantastic if that could be replicated in Wales.”

131. However, she also stated,

“it is important that the parent accommodation is protected. It does need to be increased, but I would say that the priority should be to increase the cot numbers.”

132. Some neonatal units use their accommodation as part of pre-discharge arrangements, helping parents to develop the confidence to look after their newborn before they go home, and this can help with earlier discharge. This was viewed as good practice by many witnesses. Victoria Franklin, Director of Nursing for Abertawe Bro Morgannwg University Health Board, stated the importance of such an arrangement:

“We…do not have a transitional care model or unit…We know that for the mothers and the babies, before they go home, that bonding and support is important. I firmly believe that we need a transitional care unit.”

133. Accommodation provision was described by Bliss as being ad hoc. It is sometimes provided by voluntary organisations, but it was suggested that such an important aspect of the service should not be reliant on voluntary sector funding, as it plays an important part in the care and progress of neonates.

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67 Oral evidence, 18.3.10
68 Oral evidence, 18.3.10
69 Oral evidence, 18.3.10
The need for a systematic review of facilities for parents of babies receiving neonatal care in Wales was suggested in the evidence. Witnesses felt that this needed to be mindful of the need to ensure that mothers and families in rural areas can access support networks. The evidence suggests that this also needs to focus on provision and support for both parents.

**Breastfeeding**

The evidence suggests that breastfeeding is actively encouraged, with many Health Boards having baby-friendly status. However, the evidence submitted by Bliss suggests that parents are not always supported or encouraged to express milk or to be involved in giving the milk to the baby. Therefore, improvements to the practical guidance are needed, along with encouragement in caring for and feeding babies, including ongoing support for breastfeeding.

**Minister’s View**

In her evidence, the Minister stated that she is working with Bliss to identify priorities in the area of parental support. She also stated that the managed clinical network should review the facilities available to parents:

“We have had some involvement with Bliss, the charity, and we have discussed issues around shaping some priorities in this area of parental support. We are working with that charity to develop better information and a website to provide information for parents. I agree that the network will have to review the facilities that are available to parents as part of achieving the standards.”

In her written submission, the Minister identified a focus on improving breastfeeding as a priority area for development:

“In my recent response to the Public Accounts Committee report on Maternity Services...I described the progress which has already been made, and priority areas for development including...a focus on improving breastfeeding”

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20 Health, Wellbeing and Local Government Committee 25.3.10, written submission from the Minister for Health and Social Service, HWLG(3)-07-10-p2
**Committee’s View**

138. The Committee accepts that parental support and facilities vary across neonatal units and that providing that support and communication is not always a priority for hard-pressed staff.

139. Although most units provide parental accommodation, it is limited, with room for one parent only. The Committee believes that it is important that both parents can stay close to the baby in order to facilitate bonding.

140. The Committee believes that the provision of transitional care units for parents to care for their baby with support is good practice.

141. The Committee believes that the voluntary sector should not be relied upon to provide accommodation for parents, as it is very important in the overall care of the baby.

**Recommendation 17 -** We recommend that the Welsh Government should ensure that Health Boards review their current arrangements for supporting parents of special care babies, to address in particular: practical guidance for health professionals on identifying parents’ needs; helping parents to be involved in their baby’s care; and providing support to parents as they gradually become the main carers.

**Recommendation 18 -** We recommend that the Welsh Government should ensure that sufficient accommodation is provided for parents, particularly in the lead centres. As part of this, we recommend that the use of transitional care units should be considered.
9. Hearing screening

142. Newborn Hearing Screening was implemented across Wales in 2003. It emerged from the evidence that newborn screening for hearing loss is well established across the Health Boards. There was consistent evidence that screening for hearing loss has good coverage and that audits of high-risk babies show rates favourable with the published standards. The Welsh NHS Confederation, on behalf of all the Health Boards in Wales, told us that coverage is almost 100 per cent in Wales, with the majority of initial tests being undertaken within 7 days of birth, exceeding the target of 75 per cent. On this subject, Dr Mark Drayton stated:

“I can be extremely positive on that one…All babies on the neonatal unit get that screening… it is a very effective service and it is working very well on the ground.”

21 Oral evidence, 11.3.10
Annex A - Witnesses

The following witnesses provided oral evidence to the Committee on the dates noted below. Transcripts of all oral evidence sessions can be viewed in full at [http://www.assemblywales.org/bus-home/bus-committees/bus-committees-scrutiny-committees/bus-committees-third-hwlg-home/bus-committees-third-hwlg-agendas.htm](http://www.assemblywales.org/bus-home/bus-committees/bus-committees-scrutiny-committees/bus-committees-third-hwlg-home/bus-committees-third-hwlg-agendas.htm)

**Thursday 11 March 2010**

Helen Kirrane  Campaigns and Policy Manager, Bliss
Dr Mark Drayton  Member of Expert Group on Neonatal Services
Dr James Moorcraft  Member of Expert Group on Neonatal Services
Pam Boyd  Neonatal Nurses Association
Lisa Turnbull  Policy Adviser, Royal College of Nursing
Claire Bateman-Jones  Royal College of Nursing Member and Neonatal Sister

**Thursday 18 March 2010**

Victoria Franklin  Director of Nursing, Abertawe Bro Morgannwg University Health Board
Carol Shillabeer  Director of Nursing, Powys Teaching Local Health Board
Richard Lee  Regional Director, Central and West, Welsh Ambulance Service NHS Trust
Dr Jean Matthes  British Association of Perinatal Medicine
Dr Andrew Dawson  Fellow of the Royal College of Obstetricians and Gynaecologists and Chair of the National Specialist
Advisory Group on Obstetrics and Gynaecology

Thursday 25 March 2010

Dr Iolo Doull
Consultant Respiratory Paediatrician, Welsh Paediatric Society President and RCPCH Officer for Wales

Rebecca Robson
Office Manager, Royal College of Paediatrics and Child Health in Wales

Edwina Hart AM
Minister for Health and Social Services

Simon Dean
Director of Strategy and Planning

Rosemary Kennedy
Chief Nursing Officer
Annex B - Written evidence

The following people and organisations provided written evidence to the Committee in support of oral evidence. All written evidence can be viewed in full at [http://www.assemblywales.org/bus-home/bus-committees/bus-committees-scrutiny-committees/bus-committees-third-hwlg-home/business-hwlg-inquiries/hwlg_neonatal/hwlg-neonatal-papers.htm](http://www.assemblywales.org/bus-home/bus-committees/bus-committees-scrutiny-committees/bus-committees-third-hwlg-home/business-hwlg-inquiries/hwlg_neonatal/hwlg-neonatal-papers.htm)

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<td>Dr Jean Matthes</td>
<td>British Association of Perinatal Medicine</td>
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<td>Dr Iolo Doull, Consultant Respiratory Paediatrician, Welsh Paediatric</td>
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<td>Edwina Hart, Minister for Health and Social Services</td>
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Annex C - Consultation Responses

The following people and organisations provided written evidence to the Committee as part of its public consultation. All consultation responses can be viewed in full at: [http://www.assemblywales.org/bus-home/bus-committees/bus-committees-scrutiny-committees/bus-committees-third-hwlg-home/business-hwlg-inquiries/hwlg_neonatal/hwlq3-neonatal-consultationresponses.htm](http://www.assemblywales.org/bus-home/bus-committees/bus-committees-scrutiny-committees/bus-committees-third-hwlg-home/business-hwlg-inquiries/hwlg_neonatal/hwlq3-neonatal-consultationresponses.htm)

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