Public Accounts Committee

Meeting Venue:
Committee Room 3 – Senedd

Meeting date:
28 January 2013

Meeting time:
14:00

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

For further information please contact:

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Agenda

(Informal meeting 13:50 – 14:00)

1. Introductions, apologies and substitutions

2. Public Audit (Wales) Bill: Stage 2 – Consideration of Amendments (14.05 – 16.00)

In accordance with Standing Order 26.21, the Committee will dispose of amendments to the Bill in the following order:

Sections 1–37
Schedules 1–4

Supporting documents:
Marshalled list of amendments
Groupings of amendments

Jane Hutt AM, Minister for Finance and Leader of the House

3. Papers to note (Pages 1 – 20)

4. Motion under Standing Order 17.42 to resolve to exclude the public from the meeting for the following business:

Items 5 and 6.

5. Consideration of draft Committee report on Maternity Services in

Wales (16:00 – 16:30) (Pages 21 – 60)

6. Consideration of draft report on Health Finances (16:30 – 17:00)

(Pages 61 – 113)

Jane Hutt AC / AM
Y Gweinidog Cyllid ac Arweinydd y Ty
Minister for Finance and Leader of the House

Llywodraeth Cymru
Welsh Government

Eich cyf/Your ref
Ein cyf/Our ref LF/JH/0033/13

Public Accounts Committee
Members

18th January 2013

Dear Members,

You may be interested to see a copy of the information that I have sent to a number of individual AM's in response to their correspondence.

Throughout the passage of the Public Audit (Wales) Bill I have been clear that it has always been the Welsh Government's intention to ensure that provisions in the Bill protect the interests of staff who will transfer from the employment of the Auditor General to the employment of the Wales Audit Office. To that end I have very carefully considered the representations made by Assembly Members and others, relating to the transfer and have discussed the matter with the Chair of the Assembly's Public Accounts Committee.

I am pleased to advise you that yesterday I tabled an amendment to the Bill which will provide protection against unfair dismissal of an employee that is wholly or mainly by reason of the transfer or a reason connected with the transfer. Furthermore, I have asked my officials to consider how, at Stage 3 of the Bill, further Welsh Government amendments can address and meet the concerns of the AGW's staff, their trades unions and the PAC relating to variations in employment contracts, trades union recognition and preserving collective agreements.

Your Sincerely,

Jane Hutt

Jane Hutt AC / AM
Y Gweinidog Cyllid ac Arweinydd y Ty
Minister for Finance and Leader of the House

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Date: 22 January 2013
Our ref: HVT/ 1799/fgb
Page: 1 of 3

Mr Darren Millar AM
Chair, Public Accounts Committee
National Assembly for Wales
Cardiff Bay
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Dear Darren,

PUBLIC AUDIT (WALES) BILL: COMPOSITION OF THE WAO BOARD

I have seen that Mohammad Asghar AM has tabled a new amendment (number 46) and withdrawn amendment 39 so that two employee members will be elected and only one nominated by the Auditor General. Having reflected on this, I feel that I owe it to my office as AGW to put on public record that I do not think that having two elected employee members would be a development conducive to the good governance and smooth running of the WAO.

The reasons for my concerns at having two elected employee members are as follows:

i. It leaves the Board very light in terms of senior managers responsible for implementing decisions.

ii. As there are two trade unions with substantial memberships in the WAO, it may create a situation where, by default, each elected member effectively represents a particular union. This might well lead to dissatisfaction amongst WAO staff who are not a members of one of the two main unions. They may feel that their interests are not represented, and this may lead to pressure for a third member to be elected.

iii. Whilst such an arrangement should be workable in the case of a supervisory board, the Bill creates an executive board (ie a board to run the organisation). I am not aware of another UK body with a board that runs the organisation that has as many members specifically intended to present the staff experience as it has as senior management members. Such a composition is novel, and the dynamics (including managing conflicts of interest) may well be problematic, particularly as the staff experience members are to have exactly the same full range of executive functions as all of the other board members, including collective responsibility for all board decisions. Whilst it might be sensible to explore such an arrangement on a pilot basis through co-option, introducing it untested through primary legislation does not seem to be an example of well-managed risk-taking.

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iv. I appreciate that the specific procedures supporting the appointment of the elected employee members will be a matter for the WAO Board. However I do not see how the rules could address the problem of insufficient senior management representation without the rules themselves becoming a source of dispute and challenge.

In this context, I think it is particularly helpful to consider again both the evidence from my Trade Unions and that of the Comptroller & Auditor General on the subject of board composition, as both sets of evidence make clear that there are significant drawbacks to staff (as opposed to management) representation on a board that has executive responsibility for running the organisation:

Extract from transcript of session of 16 October 2012 —

[142] **Mr Robertson:** ...Our view is that an employee representative would be best placed on a supervisory or advisory board, acting in that capacity. There might be problems on an executive board if an employee representative were called upon to make decisions in its capacity as an employer. That might compromise their role as a staff representative, so it is probably best avoided. If they were an observer on an executive committee, that would be fine, but we would have reservations about their being a full member of an executive board. If there is to be an executive board, there need to be senior managers on that board who are able to bring management knowledge and experience to the decision-making functions.

Extract from transcript of session of 16 October 2012 —

[152] **Julie James:** ... Evidence has also been put forward by a witness stating that the employee member should be chosen by the workforce. What are your views on that?

[153] **Mr Morse:** It depends on what you think the board is for. If someone is chosen by the workforce, that is another randomising factor because do they speak for management or not? No, they do not, really. If you have a lot of access to the workforce, you do not necessarily have to have a workforce representative on the board. You can do it, but it is just a different way of looking at it. For me, the advantage of having a reasonable number of people who are leading the organisation available and talking to their own brief, so to speak, is that you get a pretty good assessment, as a non-exec, of how they are running the organisation. You can then reach down into the organisation and check whether what they are telling you at the board table fits with what you find when you talk to other people. So, I think that that works and that it is a reasonable model.

[154] The problem with having an employee on the board is the question of who are they speaking for? Are they speaking about employment conditions? If so, you would get something from them. However, you could equally do that by inviting someone to do it occasionally, rather than have them sitting through every board meeting, because I suspect that you are not going to be talking about that every time. To be absolutely honest, it sounds a little clunky to me, in getting good, continuous debate. However, I understand that the intention is good, but I probably would not make that a permanent feature, personally.
[155] **Julie Morgan:** So you are not against it, but you are doubtful of it.
[156] **Mr Morse:** It would not be what I would do, no. I would not have a permanent employee on the board. You are making it a lot more difficult to understand what the management is thinking and where it is trying to take the organisation if, all the time, this is now becoming a way of discussing with employees. Hopefully, the management should have other ways of doing that, so I am not sure that the board needs to be the way of doing it.

Can I stress that, as I have previously indicated in my evidence to the Committee, I am not opposed to having an elected employee member of the Board. I do see that there is merit in bringing staff perspective to the Board. But that objective is met by having one elected employee member, and there seems to be no additional objective that is met by having a second such member.

In conclusion, whilst not ideal, because it does not increase senior management input, I consider that the Government amendment providing for a board with one employee elected and one nominated by the Auditor General, would be preferable to the two-elected member proposition, albeit not as good a model as a board with one employee elected and two senior managers nominated by the Auditor General

I am, of course, happy to discuss further.

HUW VAUGHAN THOMAS
AUDITOR GENERAL FOR WALES

Lesley Griffiths AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Eich cyf/Your ref
Ein cyf/Our ref: SF/LG/0040/13

Chair
Public Accounts Committee

January 2013

Thank you for your request for an update on progress following the Public Accounts Committee on 12th November 2012. Document 1 sets out information in relation to the specific issues identified.

Much progress has been made in further improving maternity services in Wales. Each Local Health Board (LHB) has produced an action plan in response to the Maternity Strategy and the Chief Nursing Officer is in the process of setting up a Maternity Board to monitor Health Board progress on a six monthly basis, starting in April 2013.

I can assure you Maternity Services are a priority and that continuous improvement will be made throughout the coming year.

Lesley Griffiths AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

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WELSH GOVERNMENT'S RESPONSE TO THE ACTION POINTS FOLLOWING THE PUBLIC ACCOUNTS COMMITTEE HELD ON 12.11.12

1. Further information on how a measurement of 'confident and knowledgeable parents' would be made, following appropriate discussions.

A meeting is being held on 23rd January 2013, to finalise and standardise how to measure confident and knowledgeable parents.

The 7 Maternity Service Liaison Committee chairs have been invited to attend, along with the lead midwives for user involvement at each Health Board.

Those attending have been asked to consider:

a. What specific questions need to be asked to identify what we want to know?
b. Who needs to be asked? (mother and partner)
c. When is the best time to ask?
d. How will we ask (by phone, questionnaire, social media)
e. How will responses be collated?
f. How will the public be informed of the responses?

Once agreement has been reached Health Boards will be informed and required to implement by April 2013. Compliance will be monitored twice a year by the Maternity Board, set up to monitor the performance of maternity services in Wales.

2. Data highlighting the number of practitioners needing to move to the RCOG/RCM training tool method;

All midwives and obstetricians across all 7 Health Boards will be expected to move to the new training and assessment tool.

Whilst all Health Boards currently use the training package 'K2', as recommended by Welsh Risk Pool, three are also informally testing the use of the new RCOG/RCM package.

All Health Boards will be expected to move to the new RCOG/RCM package by January 1st 2014 once their current contracts for the 'K2' training has expired.

3. **Further information on the recruitment of neonatologists in Wales including details on how the trend in the reduction of neonatologists is being addressed;**

All Health Boards undertake workforce planning to ensure units are staffed to a safe standard to comply with British Association of Perinatal Medicine standards (BAPM). Meeting BAPM staffing standards is a key element in shaping the Health Boards' decisions on how neonatal services will be configured. Much progress has been made in implementing the recommendations of the neonatal capacity review. Each Local Health Board (LHB) has produced an action plan in response to the report and the Neonatal Network is monitoring progress on a six monthly basis.

The next report, representing progress one year on, is due to be considered by the Neonatal Network in February 2013. I will ensure the Committee receives a copy of this report.

4. **A link to research conducted by Public Health Wales on the relationship between BMI, pregnancy and caesarean rates;**

Obesity in pregnancy has been recognised as a significant risk factor for both the mother and the child. The Confidential Enquiry into Maternal and Child Health (CEMACH) state that "The magnitude of risk means that obesity represents one of the greatest and growing overall threats to the childbearing population of the UK" (Centre for Maternal and Child Enquiries 2007).

Increased rates of obesity in pregnancy are reflected in increased social and financial costs: (Galtier-Dereure et al 2000)

- On average obese women spend 4.43 more days in hospital;
- Antenatal care costs are increased five fold due to the increased levels of complications obese women experience during pregnancy and labour;

Babies born to obese mothers are at increased risk (3.5 fold increase) of requiring admission to Neonatal Intensive Care Unit (NICU).

References:

Centre for Maternal and Child Enquiries (CMACE) 2007. Confidential enquiry into maternal and child health: Saving mothers lives reviewing maternal deaths to make motherhood safer 2003-2005. The seventh report of confidential enquires into maternal deaths in the United Kingdom. CMACE: London. Available at www.cmace.org.uk [accessed 27.07.10]

Centre for Maternal and Child Enquires / Royal College of Obstetrics and Gynaecology (CMACE/RCOG) 2010. CMACE/RCOG joint guideline: Management of women with Obesity in pregnancy. CMACE: London. Available at http://www.cmace.org.uk/getdoc/1812417f-de48-4291-a58c-e85b87bc95fc/CMACE--RCOG-Joint-Guideline_Management-of-Women-wi.aspx [accessed 29.07.10]

Galtier-Dereure F. Boegner C. Bring J, 2000. Obesity and pregnancy: complication and cost. American Journal of Clinical Nutrition Vol 71, No 5, 12425-1248.

5. Further information on the number of agency staff used in midwifery;

Aneurin Bevan has not used any agency midwives in the past 5 years

ABMU has not used any agency midwives in the past 5 years

Betsi Cadwaladr has not used any agency midwives in the past 5 years

Cardiff & Vale has not used any agency midwives in the past 5 years

Cwm Taf LHB has not used any agency midwives since the formation of the Health Board in October 2009

Between April 2007 and May 2008 a total of 468.10 hours were worked by agency Midwives on the Prince Charles Hospital site, Merthyr Tydfil.

Hywel Dda The only County in Hywel Dda that has used midwifery agency staff over the specified period of time is Ceredigion (Bronglais General Hospital). The following table with the breakdown of WTE and costs.

	Amount	Approx WTE	Month
	£639.01	0.26	Dec-09
	£2,900.00	1.17	Jun-10
	£2,012.46	0.81	Jul-10
	£7,943.87	3.21	Aug-10
	£1,875.16	0.76	Sep-10
	£1,312.00	0.53	Nov-10
	£732.80	0.30	Dec-10
	£1,375.08	0.56	Feb-11
	£88.70	0.04	Aug-11
Total	**£18,879.08**	**7.64**	

Powys has not used any agency midwives in the past 5 years.

6. A timescale for the rollout of electronic foetal heart rate monitoring for different Local Health Boards.

An all Wales group of midwives and obstetricians have been working together during 2012 to agree a standardised approach to training and assessment of staff in interpreting electronic foetal heart rate monitoring.

All Health Boards already have training programmes in place for midwives and obstetricians. The difference between what they use now and the new RCOG / RCM programme is that the new programme includes individual assessment of staff. This requires agreement on how tests are carried out, what the pass mark is and how to manage staffs that do not achieve the required standard.

Implementation will require that Health Boards:

a. Provide on-line access to all staff;
b. Provide facilities for staff to do the assessment at work of through access to the system through their personal computers;
c. Terminate their contract with the training system they use now – some may be contracted for another 3 years.

All Health Boards have agreed to implement the new training and assessment process. At the final all Wales meeting in February 2013, Health Boards will be asked to provide a timescale for implementing the new system.

Health Boards will all implement at different times, depending on what they need to put in place to achieve roll-out. However, all Health Boards will be expected to have implemented this by September 2013.

7. Further information on the progress made by Local Health Boards in implementing the Caesarean toolkit.

All Health Boards reported their progress in implementing the Caesarean Section toolkit in September 2012. (doc. 2).

All Health Board are required to:

a. Report their Caesarean Section rates to the Chief Nursing Officer monthly as part of the routine performance monitoring, commencing January 2013;

b. Present a six monthly analysis for the reasons why any maternity unit's rates are above 25%, commencing January 2013.

c. From April 2013 a Maternity Board, chaired by the Chief Nursing Officer will meet with relevant staff from the Health Board twice a year to monitor the performance in implementing the 5 outcome indicators and performance measures set by Welsh Government This will include actions plans for reducing rates that are 25% or above.

HEALTH BOARD PROGRESS IN IMPLEMENTING THE CAESAREAN SECTION TOOLKIT

Abertawe Bro Morgannwg University Health Board

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1. Rates over the last 5 years

Statistics as a Health Board have only been collected over past 4 years
There continues to be a big difference between the two obstetric unit rates. The Caesarean Section rates and the Normal Birth rates are displayed monthly in all the units.

Year	Total Health Board Rates	Princess of Wales	Singleton
2008	23.06%		
2009	24.18%	20%	29%
2010	23.74%	21%	26%
2011	25.68%	20%	27%

2. What are you goals? What are you doing to get there?

An analysis has been undertaken to understand where we are in relation to Vaginal Birth After Caesarean (VBAC) and keeping the first birth normal. This has helped to identify the short, medium and long term goals and influence the job plan for the consultant midwives.

3. What did you achieve through the Caesarean Section Toolkit?

Multidisciplinary meetings to discuss way's forward. Focusing on an action plan to improve VBAC rates and keeping the first birth normal for women

i What project did you take on?

First Birth Normal

- Latent Phase Care Bundle
- Health board wide group that focuses on achieving more normal births
- Maternal position in labour audit in line with the normal birth campaign from the Royal College of Midwives
- Increasing the Home Birth rate from 2% to 4%
- Home birth rate in the Bridgend and Neath areas has remained at 8%
- Increasing the number of women giving birth in the free standing Birth Centre
- At this present time 42% of women having their first baby in the free standing birth centre

VBAC

- Consultant Midwives Clinic – VBAC in all three areas
- Updated information leaflet.
- Letter given to women at the time of the first Caesarean section discussing the mode of birth in the next pregnancy
- Monitoring and display of VBAC rates.
- Debrief service via the Consultant midwives for women experiencing a traumatic birth

- Increasing the number of women who consent to an external cephalic version when a breech presentation is identified

ii How are you doing?

VBAC
Differences in two obstetric units re VBAC rates. Prior to the tool kit VBAC rate was 41%

Singleton 48.8% women attempt VBAC
56.9% achieve vaginal birth
43.1% unplanned Caesarean section
POW 49.2% women attempt VBAC
68.2% achieved vaginal birth
31.2% unplanned Caesarean section

Set up a Consultant Midwife Clinic data 2011. At the time 41% of women attempted VBAC. For women attending the consultant midwives clinic 79% achieved a vaginal birth

Keeping First Birth Normal
Normal Birth Rates

Year	POW	Singleton
2009	70%	62%
2010	71%	61%
2011	71%	64%

Home Birth Rate has increased in the Swansea area from 2 to 4% and remains 8% in the Bridgend and Neath areas.
42% of women having their first baby in free standing Birth Centre
Influenced the review of the All Wales Clinical Pathway for normal labour to include the principles of the latent phase on part 2

iii What is stopping you achieving more?
- NICE Caesarean Section Guidelines 2011
- Conflicting advice from professionals to women on the benefits of a VBAC
- Lack of identification of women with medium risk complications, who during the intrapartum period could have midwife led care

Aneurin Bevan Health Board

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1. Rates over the last 5 years.

Year	
2007	25%
2008	25%
2009	24.00%
2010	23.00%
2011	23.73%

2. What are your goals? What are you doing to get there?

Goals

- Improve outcomes for mothers and babies
- To improve the VBAC service operated within ABHB
- Reduce Cs rate to 23% and continue to reduce annually or at minimum maintain rate not increase
- Monitor and audit through the maternity dashboard

How are you doing?

NHH Consultant obstetricians need to be geographically based to improve multi-agency working and continuity of care. Work is ongoing to develop this in the south of ABHB. All elective CS should be booked with the authorisation of the consultant.

3. What did you achieve through the caesarean section tool kit?

i What project did you take on?

- We under took the project t of the Vaginal Birth After Caesarean (VBAC)
- The development and Provision of leaflets and information on VBAC for women following debriefing by consultant obstetricians.

ii How are you doing?

- We currently operate a community VBAC service. This is supported by the community midwifery service within RGH to promote VBAC.
- We achieved the reduction of LSCS rate from 25% to 23 % over 2 years.

iii What is stopping you achieve more?

- Lack of engagement by women to attend VBAC clinic.
- Engagement with the CS tool kit from a multi agency team
- New NICE guidance
- Induction of labour rates, particularly maternal requests
- Lack of a public education campaign on all Wales basis

Betsi Cadwaladr Health Board

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1. Rates over the last 5 years.

As is evident from the table, the c-section rate has been consistently higher in Central area for the past 4 years and it has been confirmed that demographics alone cannot account for this variance.

	East	Central	West	Total Average
2007	25.87%	25.45%	22%	24.4%
2008	26.39%	29.33%	24.4%	26.7%
2009	26.3%	29.64%	20%	25.3%
2010	22.53%	28.32%	24%	24.9%
2011	24.75%	29.66%	22.02%	25.47%

2. What are your goals? What are you doing to get there?

The agreed target is to reduce the c-section rate by 1% per annum, and review local rates in line with the National rate. The rate for each unit is monitored monthly on the Maternity Dashboard.

3. What did you achieve through the Caesarean Section Toolkit?

i What project did you take on?
Central and West initially implemented the 'Promoting Normality in First Pregnancy Pathway' East implemented the 'Vaginal Birth After Caesarean Section Pathway'.

ii How are you doing?
Areas of good practice are shared amongst the 3 units and these practices are rolled out across North Wales.

In an attempt to reduce the rate in Central, the Caesarean Section Toolkit has formed the basis of a more robust action plan, which includes several elements of the toolkit. This is in addition to a concerted effort to optimise normality by promoting the Alongside Midwifery Led Unit.

The Health Board is also currently undertaking an audit looking at all the elective and emergency Caesarean sections within a given period in Central to see if there are areas of clinical practices that need improving. The results are awaited and will be scrutinised at the Women's CPG Board and Quality and Safety Sub-Committee.

iii What is stopping you achieve more?
Buy in from all professional groups to ensure that every opportunity is taken to optimise normality

Cardiff and Vale University Health Board

1. Rates over the last 5 years

Year	
2007-2008	23.3%
2008-2009	23.67%
2009-2010	23.91%
2010-2011	21.25%
2011-2012	20.43%

2.

2. What are your goals? What are you doing to get there?
To maintain current rates of 20-22%

3. What did you achieve through the Caesarean Section Toolkit?

i What project did you take on?
VBAC

ii How are you doing?
VBAC clinic in place with some measureable outcomes.

iii What will help you achieve more?

Continue with existing measures to include:

- VBAC clinic
- Junior doctor training and Consultant support
- Information to women
- Directing women to the NCT website for information
- Consultant Midwife clinic
- Maintaining the Midwife Led Unit
- Further achievement - NICE guidelines and maternal request for LSCS

Cwm Taf Health Board

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1. Rates over the last 5 years

Caesarean Section (CS) rates within Cwm Taf Health Board have remained fairly static over the past five years, averaging at approximately 29% of all births. Overall, there has been a 0.6% reduction in CS births since the introduction of the 'Toolkit' in 2009.

Cwm Taf Health Board replaced two former NHS Trusts in 2008, with birth statistics collected in a consistent and reliable way since 2010, therefore figures presented prior to this date have been amalgamated from the previous organisations, for comparison purposes.

Year	
2007	28.8%
2008	28.4%
2009	30%
2010	29.8%
2011	29.2%

2. What are your goals? How are you going to get there?

Our goals were to:

Reduce the number of CS with no medical indication in both first-time mothers, and those women who had had a previous CS. This was a longer-term goal, which relied on the introduction of a robust VBAC Pathway for all women from 2009 onwards.

Ensure that women were booked and cared for by the appropriate professional according to their health needs.

3. What did you achieve through the Caesarean Section Toolkit?

i What project did you take on?

Vaginal Birth After Caesarean (VBAC) Pathway

ii How are you doing?

Following the toolkit workshops, work has been completed to ensure that:

- Consistent information is given to mothers who have just had caesarean birth, to include whether or not this mode of delivery would be appropriate for a subsequent pregnancy.
- Information about subsequent birth is given verbally before discharge home, and documented in the woman's hand-held record and hospital record.
- Verbal information is reinforced during the care of the community midwife.
- A VBAC information leaflet is given to women.
- Women booking for maternity care with a history of previous caesarean section also discuss VBAC with the community midwife, and women are given the VBAC leaflet.
- Women who request a caesarean section with no medical indication are referred to a counselling midwife, who discusses their request following NICE caesarean section guidelines.
- Referral to a second obstetrician is arranged if necessary.
- Guidelines have been developed to facilitate booking a majority of women under midwifery led care with support from obstetricians when appropriate.

iii What is stopping you achieve more?

Barriers to achievement include:

- The publication of the updated caesarean section guidelines by NICE in 2011, which has increased the request for CS with no medical intervention.
- Cultural attitudes already in existence towards repeat caesarean sections (this will change with use of the VBAC pathway).

Progress meetings need to continue, with the use of audit to provide appropriate information.

Although we expected things to change rapidly once our VBAC pathway was commenced, what we are finding is that women who have had a previous CS (a few years ago) had the expectation that they would automatically have a CS in their next pregnancy. Unfortunately, the new NICE guidance has also proved to be something of a hindrance to changing this, as women are now prepared to insist that they have a CS on request, rather than take a chance on trying for VBAC.

This is proving to be quite a challenge, but reinforces how important it is to have the pathway in place for those first-time mothers, so they do not have the automatic expectation of a CS in every pregnancy (this part of the cultural change is already in place).

1. Rates over the last 5 years

	Carmarthenshire	Ceredigion	Pembrokeshire
2007	26%	28%	23.3%
2008	24.9%	24%	22.4%
2009	27%	27%	26.4%
2010	29%	28%	24.3%
2011	26%	26%	25.88%

2. What are your goals? What are you doing to get there?

- A consistent reduction in rates
- Implementing VBAC

3. What did you achieve through the Caesarean Section Toolkit?
Agreement on a way forward

i What project did you take on?

Vaginal Birth after Caesarean Section (VBAC)

ii How are you doing?

Template letters etc have been implemented however there is an expectation that all of the caesarean sections are reviewed for appropriateness within 24hrs and I am not confident that this practice is consistent across the three counties and what action is being taken if unnecessary caesareans are being undertaken. The Quality & Safety Committees should also monitor the rates and hold consultants to account for their rates if we are going to be serious in reducing the rate

iii What is stopping you achieve more?

There are a number of other factor that influence C/S rates including culture. We need to target Induction of labour rates and External Cephalic Version(ECV) for breech presentation and have consistency across the HB in terms of practice and clinical decision making. Cardiff have reduced their rate to 19% but really does involve holding people to account and have audit of practice in place to fully understand the picture. They also have dedicated Consultant presence on the labour ward which must have an impact.

1. Rates over the last 5 years

Due to the nature of the service in Powys women who require an elective or emergency caesarean section are cared for outside of the Health Board. Prior to 2011 caesarean section information was available as a global Powys number.

Year	% rate
2007-2009	18
2008-2009	17
2009-10	19.9
2010-11	18.7
2011-12	22.4

Caesarean section rates vary widely across our provider units. However as we aim to send only high risk women to our provider units we would anticipate the caesarean section rates being higher than average. Since April 2011 we have monitored caesarean section rates for Powys women by the units they deliver in and have used this information to inform discussions with our service providers. We also monitor rates for women who commence labour in Powys but are transferred out to a DGH

2. What are your goals? What are you doing to get there*?*

Increasing normal birth by;

- Encouraging eligible women to birth within Powys midwife led birth centres or at home using the evidence from the Birthplace study (2011).
- Providing women and their partners, regardless of choice of place of birth, with skills and tips that may help facilitate a normal birth through active birth workshops.
- Collecting data that allows the description of our pregnant population and the identification of groups where caesarean section rates are higher than anticipated.
- Concentrating on midwifery skills that support normal birth, specifically looking at the numbers of births supported by a Powys midwife. (The Welsh Government defines a 'normal birth' as a spontaneous vaginal delivery of a live baby without the aid of augmentation, acceleration, or epidural, and with no significant tear or post-partum haemorrhage).

3. What did you achieve through the Caesarean Section Toolkit

i *What project did you take on?*

Powys concentrated specifically on first pregnancies, pathway through labour. Early labour home assessments were a key part of this as was reviewing the birth environments and asking for users views.

ii *How are you doing?*

Women booked for a Powys birth are routinely offered home assessments in early

labour. We are slowly increasing this service to include low risk women who have booked for a hospital birth, some of whom at assessment then choose to remain in Powys to give birth.

We are continuing with the principles regarding care environment through transforming care.

iii ***What is stopping you achieve more?***
Due to the nature of the service within Powys we will always be reliant upon the practices and culture around caesarean section within the provider units.

Response to action point – 8 Jan 2013

Action point for the Welsh Government from the private session on 8 January 2013:

- The Auditor General's report concluded that not all health boards are meeting recommended staffing levels for nursing and medical staff. Could you please clarify whether the data collected by health boards on their staffing levels includes staff who are suspended or are on long-term absence.

Response from the Welsh Government:

- 'NHS Wales has informed us that it would not be normal practice to exclude staff who are absent long-term or suspended from staff in post records.'

Public Accounts Committee

Meeting Venue:	**Committee Room 3 – Senedd**
Meeting date:	**Tuesday, 15 January 2013**
Meeting time:	**09:00 – 11:00**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

This meeting can be viewed on Senedd TV at:
http://www.senedd.tv/archiveplayer.jsf?v=en_400000_15_01_2013&t=0&l=en

Concise Minutes:

Assembly Members:	**Darren Millar (Chair)** **Mohammad Asghar (Oscar) AM** **Mike Hedges** **Julie Morgan** **Gwyn R Price** **Jenny Rathbone** **Aled Roberts** **Jocelyn Davies**
Witnesses:	**Huw Vaughan Thomas, Auditor General for Wales, Wales Audit Office** **Andy Phillips, Performance Specialist, Wales Audit Office** **John Weston, Wales Audit Office**
Committee Staff:	**Tom Jackson (Clerk)** **Daniel Collier (Deputy Clerk)** **Joanest Jackson (Legal Advisor)**

1. Introductions, apologies and substitutions

1.1 The Chair Welcomed Members and members of the public to the meeting.

2. Briefing from the Auditor General for Wales on the Wales Audit Office report 'Civil Emergencies in Wales'

2.1 The Chair Welcomed Huw Vaughan Thomas, Auditor General for Wales; Andy Phillips, Performance Audit Manager; and John Weston, Performance Specialists.

2.2 The Committee discussed the findings of the Auditor General for Wales' report 'Civil Emergencies in Wales'.

3. Papers to note

3.1 The Committee noted the correspondence from the Auditor General for Wales on his 2011-12 Annual Report and Accounts.

4. Motion under Standing Order 17.42 to resolve to exclude the public from the meeting for the following business:

Items 5 to 7

5. Consideration of options for handling Wales Audit Office report 'Civil Emergencies in Wales'

5.1 The Committee discussed the Wales Audit Office report 'Civil Emergencies in Wales' and agreed to conduct a short inquiry during the spring term 2013.

6. The Welsh Government's acquisition and action to dispose of the former River Lodge Hotel, Llangollen - Key themes and emerging issues

6.1 The Committee discussed the Key themes and emerging issues of its inquiry into the Welsh Government's acquisition and action to dispose of the former River Lodge Hotel, Llangollen.

6.2 The Committee agreed to consider its draft report on the Welsh Government's acquisition and action to dispose of the former River Lodge Hotel, Llangollen at a forthcoming meeting.

7. Consideration of correspondence from the Auditor General for Wales on Local government audit and inspection fee scales 2013-14

7.1 The Committee discussed the Auditor General for Wales' Local Government audit and inspection fee scales 2013-14.

By virtue of paragraph(s) vi of Standing Order 17.42

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