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Llywodraeth Cymru
Welsh Government

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Chair of the Children and Young People Committee
Ty Hywel
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31st October 2011

Dear Christine

Thank you for your letter of 29 September 2011, following the Committee inquiry into child health, in which you list a number of questions which the Committee did not reach during the meeting.

I will address the questions in the order of your letter.

1. To what extent is the current *Sexual Health and Wellbeing Action Plan* focused on unintentional teenage pregnancies and how effective has it been so far at decreasing rates of unplanned teenage pregnancy?

The Sexual Health and Wellbeing Action Plan for Wales, 2010-2015, has a number of strands to tackle unintentional teenage pregnancies. These include the continued approach to improve the universal provision of sex and relationship education, improved sexual health services alongside targeted intervention for those most vulnerable to teenage pregnancy and the promotion of the long acting reversible contraception (LARC) to teenagers who present to services already pregnant, following delivery or termination of pregnancy.

Phase 1 of the project, being led by Public Health Wales will target under 17s who present to services already pregnant. It is estimated if 50% of this cohort received contraception, particularly LARC, pre-discharge from termination services or delivery units, teenage pregnancies would be reduced by 10%. Phase 2 of the project will target vulnerable young women, particularly those in care in areas where teenage

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conception rates are high. In line with NICE recommendations, they will be offered one-to-one interventions and access to LARC.

The rates of teenage conception have reduced and in 2009 provisional figures were 40.1 per 1000 women aged 15-17 compared with 38.2 in England. Rates were highest in Merthyr at 67.8 and lowest in Monmouthshire at 28.2.

2. How much of the £450k being invested in preventing teenage pregnancy is targeted at reducing second pregnancies among teenage girls?

The £450k being invested in preventing teenage pregnancy is over a three year period. The funding will be used to provide evidence based interventions amongst those most vulnerable to teenage pregnancy, and strengthen the capacity of existing services to tackle young people's sexual health. In 2011/12, Public Health Wales is concentrating on the 2,500 pregnant teenagers who present in our maternity and termination of pregnancy services to try and prevent a repeat pregnancy.

3. According to figures produced by RNIB Cymru, around 43 per cent of children have never had an eye examination. General Ophthalmic Services (GOS) data shows that the uptake of sight tests for children varies across the Local Health Boards. What action does the Welsh Government intend to take on this issue?

One reason only a small percentage of children have eye tests at opticians is that vision screening is offered at the start of the school year for 4 – 5year olds. This screening is carried out by school nurses. Welsh Government officials will look at children's vision screening during 2012/13 including the role of optometrists in pre-school testing.

The provision of all health services, including children's eye screening, remains the responsibility of the Local Health Board (LHB). It must work with the Local Authority (LA), voluntary sector and others to assess the needs of the local population and to plan and prioritise their healthcare provision within the resources available.

Each LHB and LA in Wales undertakes a joint needs assessment for their area. This will subsequently inform the development of their local health, social care and well-being strategies, which will indicate how the health and well-being needs of the local population would be met.

The Welsh Government leads the way in the UK in its provision of primary eye care services. We should do everything we can to prevent avoidable sight loss and increasing public awareness is one of the things we can look at. Making eye services quicker and more accessible will also contribute to preventing sight loss. We aim for more services to be provided at local opticians across Wales closer to where people live.

4. According to Asthma UK, the cost of an emergency admission to A&E for people with asthma is three times more than the cost of treating somebody in primary care. Are Local Health Boards asked to monitor asthma among children and young people in their community and is this reported to the Welsh Government?

In Wales, 260,000 people are treated annually for asthma. One of my top priorities is for LHBs to manage chronic conditions more effectively and reduce hospital admissions for conditions such as asthma. The Welsh Government has published the All Wales Standards for Respiratory Services for Children and Young People and these Standards underpin LHB service planning and delivery. One of the Key Actions within the All Wales Standards requires that all children and young people with asthma are monitored regularly and have an action plan which is reviewed at least every 6 months. These action plans are about supporting children and young people to manage their asthma and stay out of hospital. LHBs are not required to report on these action plans to the Welsh Government,

5. In his Annual Report, the Children's Commissioner for Wales raises concerns about a lack of NHS provision for children with ADHD. Are you satisfied that the provision of services, including support groups and therapies as well as medication for children with ADHD is sufficient?

The Welsh Government's policy on ADHD is based on guidance issued by the National Institute for Health and Clinical Excellence (NICE). It is the responsibility of individual LHBs to make sure these recommendations are met and I expect LHBs to take account of the guidance and work towards it.

We recognise there is some variation in specialist medical provision across Wales, due to the ongoing problems of recruiting to both Child and Adolescent Mental Health Services (CAMHS) and community paediatric consultant posts. However, all areas are looking at provision of integrated neuro-developmental services (covering ASD and ADHD) to maximise existing resources and ensure that CAMHS services are robust and equitable.

To this extent Children and Young People Plans should promote effective partnership arrangements to deliver local interventions such as parenting support and school support programmes. Officials and key stakeholders are also meeting in November 2011 to explore the mapping of workforce skills to maximise the experience available within the CAMHS workforce; how it interacts with the deliverers of frontline services; and how this compliments the setting of intelligent targets for services. The aim is to ensure that children and young people get early mental health support at a community level.

The CAMHS service mapping and monitoring process currently monitors audits of eating disorders, early onset psychosis, ASD and depression, and introduction of ADHD NICE guidelines into this is under discussion.

6. What are your views on over diagnosis of, and over prescription for, ADHD?

The diagnosis and treatment of ADHD is guided by NICE guidelines. As with all NICE guidelines the responsibility for delivery lies with the LHBs, who offer a range of multidisciplinary paediatric and CAMHS expertise throughout Wales, including audit against these standards. The guidelines recommend that medication along with behavioural intervention is the treatment of choice for the majority of cases. Evidence from the Durham mapping exercise carried out over 3 years on Welsh CAMHS indicate that the number of cases being treated are appropriate for the expected numbers in the population given national figures. We are currently discussing intelligent performance targets for CAMHS in the forthcoming year that will look to ensure local services are auditing themselves against national standards.

I also agreed to provide additional information on the following:

7. Contradictory comments made by the Royal College of Midwives about midwife numbers in Wales.

The Royal College of Midwives (RCM) referred to the number of midwives employed in Wales over the last three years. My official met with Helen Rogers, Director of the RCM, to discuss the discrepancy in midwifery staffing numbers. Whilst the RCM was correct in stating that midwife numbers were reduced in 2009/10, it cannot be assumed this means there is a shortage of midwives. NHS organisations are responsible for ensuring they have the appropriate number of staff to meet a fluctuating demand. Midwives have a crucial role in caring for mothers and their babies. They are assisted by midwifery support workers who play a vital role in ensuring that our maternity services are of a high, safe standard. In terms of midwife numbers, since 1999 there has been an 11% increase in the number of midwives in Wales.

Based on the workforce planning tool 'Birth Rate Plus' (the workforce planning tool used in Wales as recommended by the RCM, an indictor of the consistency of numbers of midwives to match changing birth rates), we are training the appropriate number of midwives. All LHBs are required to meet the midwife numbers as identified by Birth Rate Plus. It has been agreed that, in future, when discussing midwife numbers, the figure the RCM and Welsh Government use will be LHB compliance against Birth Rate Plus recommended staffing levels.

There will obviously be year on year fluctuations which influence education commissioning numbers so they are responsive to service change, and to ensure that all students in training have employment once qualified. The number of midwives trained in Wales each year depends on the needs of the service. The number of midwives trained is based on what the NHS determines it will require to meet future demand through its workforce plans. The number of nursing, midwifery and health visiting staff has increased from 27,806.4 whole time equivalent (WTE) in 2008 to 28,168.4 (WTE) in 2010 - an increase of 362, or 1.3%.

LHBs in Wales are reviewing maternity, gynaecology, neonatal and child health services as they work to continually improve services and maintain patient safety and care. As noted above, Midwives will continue to have a crucial role within these services .

Despite the cuts to the overall Welsh budget by the UK Government, we are maintaining our investment in the health service in Wales. We are also continuing to invest in the next generation of healthcare professionals, including midwives, by funding over 2,000 new training places from September 2011. This brings the total number of non-medical healthcare students in training in Wales to 6,462 - a 41% increase on 1999. This is a clear demonstration of our commitment to the NHS.

8. Where do recruitment problems in neonatal services exist?

General recruitment problems have been reported for medical staff in paediatrics which includes neonates in many Health Boards, with an 18% vacancy rate in recruitment to Wales training posts currently reported by the Wales Postgraduate Deanery. Some of these are filled by locum and temporary staff but this leads to a more expensive and less well trained workforce than if training posts were filled substantively, and inevitably impacts on rota staffing in all parts of Wales. Work is being undertaken by the Postgraduate Deanery along with LHBs and Trusts to manage the impact of vacancies to ensure safe service delivery to patients.

9. The number of mother and baby beds available to women suffering with post-natal depression.

In line with NICE guidance, all pregnant women in Wales are now asked about any past history of mental health problems so that those with an increased risk can be indentified and referred for support, advice and care planning to minimise the development of postnatal depression.

There are three designated beds at the University Hospital of Wales in Cardiff as a Wales wide provision, bed usage during the year standing at 64%. North Wales commissions beds as required in England, as locally and as practical as possible for women suffering from post-natal depression. All teams in Wales provide care via Community Mental Health Teams as locally as possible with support and advice from the specialist service in South Wales. The main aim would be to return mother and baby home as soon as possible with a comprehensive package of care.

10. Information on Female Genital Mutilation.

Deinfibulation operations are performed in Cardiff through the gynaecological clinic, subject to the elective surgery waiting list. The patients are identified either during pregnancy, when they are offered the reversal operation by 20 weeks to allow time to heal before childbirth. Alternatively, women come forward through awareness raising sessions run by the Health Board.

More widely the Welsh Government is taking a range of action to tackle Female Genital Mutilation as part of the delivery of our "Right to Be Safe Strategy" and the details are set out below.

The CMO newsletter 51 issued in September 2011 and distributed to all Doctors and Dentists in Wales, contained information and advice for health professionals on how to deal with concerns about Female Genital Mutilation (FGM) and also forced marriage.

The Welsh Government Forced Marriage (FM) sub group held a strategic planning day on Monday 28 March 2011. The aim of the day was to bring together strategic stakeholders to develop a high quality integrated plan to prevent and provide services for women and children at risk of female genital mutilation in Wales and to widen the impact of the forced marriage forum by engaging key stakeholders in addressing FGM. The planning day was developed by the Black Association of Women Step Out (BAWSO) and Cardiff & Vale in conjunction with officials from Community Safety Division, Welsh Government.

The planning day was well attended by organisations across Wales, who identified some key areas for further work including research, service provision and information giving. These areas will be considered as part of the Welsh Government's commitment to preventing and raising awareness of violence against women and domestic abuse, as outlined in the Welsh Government's 'Right to be Safe' Strategy.

At the planning day, BAWSO launched their 'storyboard' which had been developed with funding provided by the Welsh Government. This storyboard is used by health professionals with pregnant women who have been identified as being at risk of carrying out FGM on their daughters.

During 2010-11, we also funded South Wales Police to provide 'training for trainers' on forced marriage and honour based violence – the course also included a module on FGM.

The implementation plan that accompanies the 'Right to Be Safe' contains an action to: 'Develop and publish a specialist leaflet on Female Genital Mutilation for professionals and frontline staff working in criminal justice, health, education and social services.' Drafts leaflets have been circulated for comment to stakeholders and officials are currently finalising the leaflet for its publication.

11. An evaluation of the effectiveness of the MEND programme in Wales.

The MEND programme has been in place since October 2008 as a grant funded pilot programme, and rolled out across Wales. In the period October 2008 - April 2011, 111 programmes were delivered and 795 children (average age 10.4 years) benefited directly from the programme. In addition their parents or carers and siblings who attended will also have benefited. Average programme attendance and drop-out rates were similar to the UK national average, of 80% and 10% respectively.
The following outcomes have been achieved with participants:

- On average the Body Mass Index (BMI) decreased from 27.7 kg/m2 pre-MEND to 26.8 post-MEND, leading to a mean 0.9 BMI unit reduction.
- Waist circumference, an indicator of abdominal fat, was reduced on average by 2.3 cm post-programme.

- There was on average an 8.7 beats per minute decrease in recovery heart rate following the 3-minute step test, demonstrating an increase in fitness levels.
- Post-programme levels of physical activity rose and children were doing moderate to vigorous activity for 1.4 additional days per week, whilst a 6.1-hour decrease in sedentary activities per week was also observed post-MEND 7-13, as television viewing and computer usage were reduced from 15.9 to 9.8 hours per week.
- The MEND Programme also had a positive impact on the mental wellbeing of the participants. The Strengths and Difficulties Questionnaire (SDQ) is a parent-rated measure of common psychological symptoms in childhood. The mean score on the SDQ was within the low needs range and it is encouraging to note that post-programme the average SDQ score was even lower. This suggests that participating in the MEND Programme is associated with improved psychological functioning.

Taken together, the results indicate that the MEND Programme is having positive healthy outcomes for the participating children.

All MEND participants and their families are encouraged to continue their physical activity after the programme ends through signposting to local authority led leisure activities, links to the 5x60 scheme and Dragon Sport scheme in schools, and other local clubs.

As with all community based referral programmes it is demand led and some areas have been more successful than others in recruiting families to the programme – this is not dependant on population or rural areas versus town areas, as Powys has been one of the most successful areas to recruit and deliver the programme. The programme becomes more cost effective when the maximum number of 15 on each programme is recruited.

40% of families come to the programme by self referral from a marketing leaflet given out to all relevant age children in school. About 20% are from GP or dietetic referral. Current mechanisms in place to improve recruitment include a 'Talking about Weight' training day for school nurses and community professionals that work with families. This aims to develop their skills in raising the issue sensitively and being able to talk to families about concerns for their child's weight. Evidence shows that many parents do not see that their child is overweight or obese and overweight is seen as normal.

Kind Regards

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cc: Gwenda Thomas AM, Deputy Minister for Children and Social Services