Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Cofnod y Trafodion
The Record of Proceedings

Y Pwyllgor Plant, Pobl Ifanc ac Addysg

The Children, Young People and Education Committee

12/07/2017

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Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Michelle Brown	UKIP Cymru
Bywgraffiad|Biography	UKIP Wales
Hefin David	Llafur
Bywgraffiad|Biography	Labour
John Griffiths	Llafur
Bywgraffiad|Biography	Labour
Llyr Gruffydd	Plaid Cymru
Bywgraffiad|Biography	The Party of Wales
Darren Millar	Ceidwadwyr Cymreig
Bywgraffiad|Biography	Welsh Conservatives
Julie Morgan	Llafur
Bywgraffiad|Biography	Labour
Lynne Neagle	Llafur (Cadeirydd y Pwyllgor)
Bywgraffiad|Biography	Labour (Committee Chair)
Mark Reckless	Ceidwadwyr Cymreig
Bywgraffiad|Biography	Welsh Conservatives

Eraill yn bresennol
Others in attendance

Vaughan Gething	Aelod Cynulliad, Llafur (Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon) Assembly Member, Labour (The Cabinet Secretary for Health, Well-being and Sport)
Bywgraffiad|Biography	
Karen Jewell	Swyddog Nyrsio Mamolaeth a Blynyddoedd Cynnar Nursing Officer for Maternity and Early Years
Joanna Jordan	Cyfarwyddwr Iechyd Meddwl, Llywodraethu'r GIG a Gwasanaethau Corfforaethol Director of Mental Health, NHS Governance and Corporate Services

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

Llinos Madeley	Clerc Clerk
Sarah Bartlett	Dirprwy Glerc Deputy Clerk

Rebekah James Y Gwasanaeth Ymchwil
Research Service

Dechreuodd y cyfarfod am 09:30.
The meeting began at 09:30.

Cyflwyniad, Ymddiheuriadau, Dirprwyon a Datgan Buddiannau
Introductions, Apologies, Substitutions and Declarations of Interest

[1] **Lynne Neagle**: Good morning, everyone. Welcome to this morning's meeting of the Children, Young People and Education Committee. We've received no apologies. Are there any declarations of interest? No. Okay, thank you.

Ymchwiliad i Iechyd Meddwl Amenedigol: Sesiwn Dystiolaeth 11
Inquiry into Perinatal Mental Health: Evidence Session 11

[2] **Lynne Neagle**: Item 2 this morning is an evidence session with the Cabinet Secretary for health on our perinatal mental health inquiry. I'm very pleased to welcome the Cabinet Secretary. Thank you for attending and for the paper that you provided. Would you mind introducing your officials for the record, please?

[3] **The Cabinet Secretary for Health, Well-being and Sport (Vaughan Gething)**: Yes, I have Joanna Jordan and Karen Jewell with me today.

[4] **Lynne Neagle**: Thank you. We've got lots of questions, so, if you're happy, we'll go straight into questions.

[5] **Vaughan Gething**: I'm delighted to go into questions, Chair.

[6] **Lynne Neagle**: Thank you. Michelle.

[7] **Michelle Brown**: Good morning, everyone. The 'Together for Mental Health' delivery plan stated that all the perinatal mental health services should be in place by now. I understand that, for Betsi Cadwaladr, that isn't quite the case yet. Can you explain to us why that is, please?

[8] **Vaughan Gething**: Well, Betsi decided—. The fact is the services are in place. Betsi took a considered approach. It's actually about recruitment and

making sure they got all of their right people into their team. I should have explained in the introduction that Joanna Jordan is a director, and so can deal with governance issues, and Karen Jewell has joined our midwifery team, having been a consultant midwife at Cardiff and Vale. So, it might be helpful—Karen, do you want to explain the situation?

[9] **Ms Jewell**: Yes. Betsi, because there were no services in place prior to the introduction of the moneys, actually decided to take a scoping approach to actually look at what services and what need was within the area before they actually decided on what the composition of the perinatal team would look like. So, that perinatal team scoping has now been done and the team is actually ready to start taking referrals, and has started taking them this month. So, it's already on board.

[10] **Michelle Brown**: Are you happy that that team's going to have access to the relevant consultants that it needs to operate safely and provide a full service?

[11] **Vaughan Gething**: I think there's a difference here about what service we're talking about, because we're talking about a community-based team to try and deal with and support women and their families as locally and possible. That was the point of the investment that was made and announced in July 2015—to get us to the point where we weren't simply making a choice between a consultant service and sending women potentially a long way away from their homes or our ability to support people effectively in communities. That's why the money that we provided was about starting the service. So, that's what the £1.5 million was for.

[12] So, it is understanding how we better meet people's needs. Because even if people are assessed as potentially benefiting from a service in an acute setting, lots of families will opt not to do that, because, actually, whether it's 50 or 100 miles, actually, for a lot of people at that point in time, travelling even 10 miles away from their home can seem like a long distance away. It's about how far away they are from support, and what's most effective for the mother, the child, and the wider family, to make sure that support is provided.

[13] This is about enabling that to happen, making sure that we have more staff with the right sort of skills as part of the whole service. So, it's about the extra staff, but it's also about the wider generic service and the recognition and the support that should be provided as well.

[14] **Michelle Brown:** Thank you. So, what do you consider to be the core components of a community-based perinatal health service?

[15] **Vaughan Gething:** Do you want to run through what the team looks like in each area?

[16] **Ms Jewell:** Yes. The teams do vary, and that depends on local need. The core could be made up of perinatal psychiatrists, community psychiatric nurses, nursery nurses that would go and provide support within the house on a weekly or daily basis, perinatal specialist midwives, and psychologists as well. So, there could be lots of different components. Each team has looked locally at what's already available and then looked at what they require within that perinatal team to actually fit the need of the service and the demographics.

[17] **Michelle Brown:** Are you happy that those components—that needs are going to be met in each health board, given the plans you've seen?

[18] **Vaughan Gething:** Yes, and there's an understanding that one of my challenges about the service in all aspects is about: where is variation really about meeting local need and local circumstance, and you could and should have a different approach, and where is it simply that you want to do something locally that isn't necessarily really about demonstrating there's an evidence base that that's what's best to do for that local population? But I think, as I say, you're going to see a slightly different service; a slightly different configuration of staff. I know you've heard from Powys, for example. Powys is different in lots of ways. If you live in an area where you know that a district general hospital is actually quite a long way away, it changes the mindset of both the population and also healthcare professionals as well about how they provide a community-based service. I actually think that in many aspects we could learn lots from Powys about how to provide community-based services. That's why I also think the evaluation stream that we'll have will be really important for understanding how that staff mix has been drawn together, how effective that is—in not just the number of referrals but the experience of people who have gone through the service and providing it—and to give a sense and lessons, hopefully, about learning lessons around Wales from each other. Because I certainly think that health boards in south Wales, who may say they have relatively similar populations, will have a lot to learn from each other, as well as from Powys, Hywel Dda and north Wales as well.

[19] **Michelle Brown**: Coming to Powys health board specifically, they've boosted their generic service offering, as opposed to creating a dedicated perinatal mental health team. What's your assessment of that? Do you think that's going to meet the need? What's your assessment?

[20] **Vaughan Gething**: Well, I know you've heard directly from Powys on this point as well, but if you just think about the geography of Powys, if you had a team in Powys, it couldn't possibly meet the needs of people all across the county. Actually, they've got to think about a model that actually meets the needs of their population and is the best fit for that group of people and provides a proper service. I think if you just had one flying team going around, you could easily be stretched within different parts of the county. That doesn't make sense, so I think that's the logic and the rationale behind their model of actually improving their generic service. You will understand why that makes sense. The challenge always is about the understanding of how you equip the generic service to be able to do that. And within this field, we're not just talking about having a specialist team to do all of this as well. There is a point about how that wider generic service understands and is able to identify challenges and problems in getting people to the right place for the right support and, again, thinking about women in their context. So, not just assuming that for everyone the right answer is to send them off to a different service many miles away, because, as I said earlier, lots of people just don't want that, and that could exacerbate a problem that exists, rather than actually being helpful.

[21] **Lynne Neagle**: Linked to that, do you think it's realistic to expect the community perinatal teams to provide care and treatment for women with moderate to severe perinatal mental health problems, while also having this focus on early intervention and prevention?

[22] **Vaughan Gething**: Well, there's some interesting stuff around the recent conference event and actually about the learning about how better to meet people's needs, and about how, actually, some people who previously, you would have thought, actually, their care needs to be provided in an acute setting, it's been possible to do that more locally. But there is something about understanding where that balance is and, again, that being an individual assessment with that person and with their healthcare professionals about making a choice about what that could and should be. That gets us into not just a barrier between the community service and hospital-based service, but then how we have an appropriate configuration

of the hospital service as and where it is. Because, at the moment, as you know, we commission that service from outside Wales, and that's the ongoing debate that I'm sure we'll get into, about what that could and should look like, and how it links to the community service, because it wasn't that long ago that we didn't have this specialist community service. So, this is definitely a service improvement and a step forward. The investment we've made has delivered more staff, delivering a service, now, in every health board. We need to understand what that looks like, how that helps and better supports people, and what that then means about what we still will have to do about providing a hospital-based service for those families that need it and where it's appropriate.

[23] **Lynne Neagle**: Okay, thank you. Mark.

[24] **Mark Reckless**: On that note, Cabinet Secretary, how confident are you that the health boards have sufficient staff and resources to deliver an effective and appropriate perinatal mental health service?

[25] **Vaughan Gething**: Well, I'm positive about the fact that I think there are over 27 whole-time equivalents who've been recruited. Obviously, there are part-time staff within that as well. There are a handful of vacancies, but recruitment is ongoing, and I think it's really important not just to see this as, 'Is the £1.5 million delivering the whole service?', because this is about pump priming a service that did not exist in the same way beforehand, but about being part of how you plan your service for your whole community. So, it's part of a wider team. That's why I made the comments that I made earlier—and I appreciate they were partly through questioning—about the service needing to think about how to skill those staff as well to be part of the whole service. It isn't simply to say, 'This is nothing to do with me; go into the specialist team.' You've still got responsibilities for the people you provide healthcare for. It's also about remembering that this isn't a service that just relies on £1.5 million, because the whole budget is nearly £7 billion, and so, actually, we need to think about how the whole service is deployed and not just this one part of it, albeit we recognise that there was a gap and that's what the money and the commitment is helping to deliver on.

[26] **Mark Reckless**: Given that that £1.5 million was spread proportionally, according to the number of births, across each health board, hasn't that left a situation where you had some health boards that did actually provide at least their bones of the service before, whereas others perhaps didn't have provision in this area and that adding that incrementally to existing provision

has left some health boards with significantly better services than others?

[27] **Vaughan Gething:** I think you need to remember that £1.5 million, compared to about £7 billion, is a really significant difference and this is about how you start the service and make clear there is a need to start the service. What I'd also say is that there is never a perfect answer, because if we had said, 'We have assessed each of the teams that exist in each health board and because health board A has a better provision than health board B regarding the number of births, we will give health board B more money', you would understandably have those people saying, 'Well, treat me fairly. Why is it that, if this health board has a better base to start from, it's then disadvantaged when money's allocated?' I think it was a fair way to allocate money: to look at the number of births, thinking about the relative need moving forward and how we help that service across the country. But, as I say, there was always going to be an alternative and not unreasonable view about how we could allocate moneys. But I don't want to get the Chair into encouraging me to talk about health board formula allocation.

[28] **Mark Reckless:** I'm probing that alternative rather than criticising the decision.

[29] **Vaughan Gething:** I appreciate that.

[30] **Mark Reckless:** What I would like to ask, though, is: we had, I think, some quite compelling evidence last week from people in the voluntary sector. In particular, two charities, and at least one with a very clear focus on the postpartum psychosis, suffered by, I understand, perhaps one to two women per 1,000. Essentially, they didn't have funding, yet they appeared to be stepping in to provide what one would have expected to be a statutory service—for instance, referring some ladies to the existence of a specialist professor in Cardiff, where people who should have been doing the referring weren't aware of that: a number of training sessions, but also, I think the committee felt, impressive support to women who might be suffering from this portpartum psychosis from those who had experienced it themselves. I just wondered whether some of the £1.5 million, or indeed some of the £7 billion that you referred to—even a very small amount of that money, through sharing that to support that non-statutory third sector provision, which was particularly skilled and brought something to the table—might actually improve the delivery in that area.

[31] **Ms Jordan:** Across the range of mental health provision, we do provide

grants to the voluntary sector. We run what we call a section 64 grant scheme. Any voluntary sector organisation that offers services on an all-Wales basis are able to bid into that funding pot, as long as the services they deliver are in line with the ambitions of 'Together for Mental Health', which clearly this would be. So, we've just had bids in for the current round. I haven't gone through them myself yet, so I don't know, but there are opportunities for organisations to bid directly to Welsh Government for funding the services, as well as, obviously, discussions with local health boards.

09:45

[32] **Vaughan Gething:** I think it's also worth mentioning, of course, that some of this is about different referral and support routes. It's entirely understandable that in every treatment area, there'll be an active third sector and there'll be a support that's provided that is appropriate. There are often peer groups that people are committed to attending, because of their own experiences. For lots of people, that's more useful and often earns an entry to get somewhere because they don't necessarily want to go and have that conversation in a more medical setting. So, those routes for support are really important. That's a recognition right across the service as well. It looks at every single service area, and, actually, the third sector are part of their conversation about the future. So, they're not kept outside; they're part of an active conversation on what the future service should look like.

[33] **Mark Reckless:** Just a final question from me: you mentioned a requirement to be offering a service on a national, pan-Wales basis. One charity we had last week I think had just received its charity number and was Cardiff focused, but certainly willing to expand beyond that. But I just wonder if you'll only consider people who are already in a position to provide pan-Wales before they get any support, and whether that would unnecessarily limit the providers you might use.

[34] **Ms Jordan:** In terms of the funding we provide directly, that is for an all-Wales service. We would then expect that to be built on by local health boards in contact with organisations that provide services on a very local basis. Those discussions should be happening in terms of when the generic NHS service is fully functioning, they will clearly need to look at signposting and providing other support from the voluntary sector, and we would expect that to be happening.

[35] **Vaughan Gething**: That is quite normal. That does happen, again, across a range of service areas where health boards actually have agreements with local organisations, whether it's a hospice to provide a service for a health board area, or individual third sector organisations supplying a very local service within that health board area as well.

[36] **Lynne Neagle**: Okay. We've gone into third sector, so I'm going to pick up the other Members on this now. I've got Llyr, and then Julie.

[37] **Llyr Gruffydd**: Just to ask, really, generally how effective you think the relationship is between the statutory and voluntary sector in Wales, because we can all point to good examples, but that may not necessarily be a common situation around the whole of the country.

[38] **Vaughan Gething**: Well, on a national level, if you think about the work and the review that's being done, the third sector are around the table and they're part of having the conversation about what the future of the service should look like. I think that's a good place to be. It provides a patient voice, it provides real challenge as well as support, because the third sector want us to succeed and they start from that point, and I think that's accepted at every level. As we get through the evaluation, and I'm sure we'll come on to it again, we'll then want to understand how effectively people are drawn in, and you don't often understand—being honest—what those relationships look like locally until you actually have that conversation with those local partners, or until notice is brought to you. But there is a conversation that takes place between Karen's office and the chief nurse's office—between each health board about what's happening and the report, when it comes back in and there's awareness, but I wouldn't try and pretend that the central guiding hand of Government in there on the back of every single local relationship. But on a national level, I think we're in a good place about having a genuine conversation where third sector partners are valued and feel that, and feel that they've got a real input into the choices we're making.

[39] **Llyr Gruffydd**: A lot of the stuff we've seen points to a number of successful projects involving the third sector—the Enjoy your Baby project, for example. Now, we know that, generally, the third sector gives you a much greater return on investment, and the value for money that you can extract from the voluntary sector very often goes much further than other sectors, shall we say. So, based on that, would you be minded to do more with the voluntary sector? I know 'money trees' and everything, but, clearly, if you're lauding the fact that they're exceeding targets and they're doing more than

you ask of them, well, surely it would make sense to invest a bit more in that sector.

[40] **Vaughan Gething:** That's why the evaluation matters, doesn't it, and the understanding of how much money we've got, how effectively it's being used, and whether those are things you want to roll forward or not? For example, the Mind Cymru collaboration—there'll be an evaluation of that, because that comes towards an end at the end of this month, and we'll understand then what the evaluation tells, and that goes into the grant agreement and provision process. But I can't pretend that, because I think that there are areas of the service where we've had a good return on investment, we'll definitely invest in all of them, because there is the reality that money is finite. If we were talking about a different subject area, you may be asking me about why we're not investing more money in this area as well, and that's because there's a limited sum. So, in all of these we have to be honest with each other, and with the third sector and the public, about the fact that we make choices within our budget about how we provide the service.

[41] But, as I say, I'm comfortable and happy with the fact that the third sector are a proper part of our national conversation and on a local basis with health boards, and that's part of what we expect to be the case in the future. The challenge will always be making sure we're getting value with and from each other to make sure that, ultimately, it's the citizen at the centre of the service that we need to be focusing on.

[42] **Lynne Neagle:** Julie.

[43] **Julie Morgan:** That was along the lines I wanted to ask, really. I think some of the most powerful evidence we had was from the third sector, and in particular one project from my constituency, based in Gabalfa in the hub there, which the Cabinet Secretary has visited, I know.

[44] **Vaughan Gething:** I've met them, yes.

[45] **Julie Morgan:** There was very powerful evidence from them, and the other group that came in, with the first-hand experience of women who have experienced these difficulties. I think we were struck by the hand-to-mouth way that they were operating in terms of—I think it was packing carrier bags or something that was actually keeping them going. And I suppose, really, it's following up on the questions that have already been asked in terms of

how do those sorts of organisations make the step forward in order to receive some funding, because, obviously, I think the Cabinet Secretary is absolutely right that the third sector are respected and are part of the planning, and I know that those women are on groups and are heavily involved, but how do they move forward and take that to a wider group—that experience?

[46] **Lynne Neagle**: I think, to add to that, it was very striking that the group Julie referred to was having referrals from social services, Families First—statutory organisations—but not a penny of funding.

[47] **Vaughan Gething**: This goes back to part of the challenge, doesn't it? It's about when you have people with first-hand experience, who are often in a position to provide a level of understanding that people want, and people go into the room with confidence and they can trust them because they've been through a similar experience. There's real value in that. It's getting from when you think there's a good idea, and then it's the start of something, to how do you then sustain it, and that isn't always easy, particularly when organisations are relatively new.

[48] So, there's a challenge there about how health boards go about that partnership and what that looks like and all the other services as well. Because it isn't just a health issue, it does go further afield. In so much of this, you could say that it's big and it's complex—well, it is. But, ultimately, what it comes down to is how you make that local choice. Health boards have some discretion about how they do that. I know there's a challenge about not getting drawn into large-scale procurement issues, because otherwise you tend to exclude those smaller organisations within that.

[49] **Ms Jordan**: I think, also, for local health boards, as with all of us, it is sometimes quite difficult to fund an organisation that isn't formally established on a charity basis, because of governance issues and monitoring et cetera. So, it seems to me that that organisation is doing the right thing, actually, by formalising their arrangements, which I think will make it easier to engage with the statutory sector for funding. It's very difficult, with public money, to give money out to local organisations that don't necessarily have any formal basis to them, but are very well meaning.

[50] **Vaughan Gething**: With this particular organisation, did you have contact with them when you were still in Cardiff and Vale?

[51] **Ms Jewell**: I did. So, at that point, they were Recovery Mummy, but they've changed their name. And, yes, it's about—. From a health board perspective, it's quite often looking at what's out there and scoping what's out there in the local community. And then, yes, you can have service level agreements, where you actually then bring in their services so that you can work jointly together. But also, you would expect the perinatal mental health teams across the patches to actually scope what's out there so that they can link in with them, because it's that step up/step down. So, sometimes it's that long-term support that's needed, either before or after they actually have intensive therapy support. So, it's making sure that you know exactly what's on the ground, but health boards definitely should be looking at what's out there and whether they can join.

[52] **Julie Morgan**: And one last quick question—they do get a lot of support, I think they said, from Mind, and I know that project is actually ending, so that means there is more insecurity around. So, I don't know—when are the decisions going to be made about Mind continuing?

[53] **Vaughan Gething**: There is an evaluation coming for the Mind project, and that will allow us to make choices about money moving forward. There's always that challenge about how and when you have the evaluation, at what point it happens, and then making a choice about whether that's good value for money. Because the challenge in all of this, and in particular it's not just about the third sector, actually, but when there is something that looks and sounds like a good idea and it gets funding, it's really difficult, if you have an evaluation, to then step away from it and say, 'Actually, we've made a choice, based on an evaluation, to walk away.' But it's important that we have the space to be able to do that and to say, 'We've evaluated it and it's the right thing to do', to give us confidence about how we spend money or actually about how we make different choices.

[54] The choices that health boards make should be informed by an understanding of local need, working with their partners, and understanding the provision that already exists. Now, they won't have to fund all of those things, and not every third sector organisation will want to have a service level agreement with a health board, but, where they do, they'll need to have enough governance and structure to make sure they can provide the service, and the assurance on the quality of it as well.

[55] Now, it sounds to me like Perinatal Mental Health Cymru want to move down that route, but that's a conversation they could and should have with

the health board, and, obviously—I'm sure, not just because you're on this committee, but as a constituency Member—others have a direct interest because there is this point about what does a whole-service provision look like. If that works there, I'm sure others in other parts of Wales will be interested in, 'Well, if that's the sort of thing that works and is of real value, should we have that within our mix?' It gets back to some of the questions that Michelle was asking about the staff mix, as well. What sort of mix of service that you provide directly from the statutory sector should be there, and how does that make sense of all that exists outside that sector as well?

[56] **Lynne Neagle:** Okay, thank you. We're going to talk in more detail now about evaluation. John.

[57] **John Griffiths:** Yes, thank you, Chair. Obviously, it's important for you to know what the quality of provision, the level of provision, is at a health board level in terms of community perinatal mental health services, so, obviously, you can assess whether particular health boards need to make particular improvements or not. Could you tell the committee what the system of evaluation is on that level?

[58] **Vaughan Gething:** Well, there are two points I'd make. The first is that Public Health Wales have a system-wide responsibility to look at what's working and provide evidence on what they think works as well. There's that overall responsibility that would exist in this area, as in any other. But, on the specific evaluation point, again, this goes back to our third sector conversation, because the National Centre for Mental Health is working with the NSPCC and Mind Cymru to evaluate services, and that work's due to conclude in March next year. So, we'll have a formal evaluation of the set-up of services and what it's delivering then, not just delivered by something that we're funding through Health and Care Research Wales, with a £3 million grant for three years of activity, but done alongside people from the third sector who have a direct and obvious interest as well. I think that should give us encouragement about not just the value of the third sector as partners, but then having an evaluation where people should be brought into the basis on which the evaluation was done. That will be very important for us in the decisions that we make, moving forward, in our conversations with health boards about the standards we expect and if there's going to be any advice or guidance on what 'good' and 'better' look like. So, I think that's quite important for us, and I expect the committee will be interested in that evaluation when it's available next spring.

[59] **John Griffiths**: So, are you satisfied, then, that that evaluation will give you a full and accurate enough picture in terms of the health boards and their particular responsibilities for community perinatal mental health services?

[60] **Vaughan Gething**: I think I'm as satisfied as I could be. Some of this is always—you need to see the evaluation and what you then see. If you say in advance, 'This will be brilliant'—. You need to look at the evaluation as well. There's always a caveat, not just because I used to be a lawyer, but to see what actually comes from that, but also to understand—and not just with that evaluation—and look at the data and the evidence that comes from that as well. Because we'll have lots of process measures to come through, and outputs. We'll then want to build on that a framework to deliver outcomes against that, too. But understanding what comes from the evaluation will be important, I think, to inform that work as well. So, it'll be important—not just about looking backwards about how the service has been set up and at what point we are at that point in time, but also about what we then positively want from those services, moving forward. So it'll provide, as you would expect, the looking back as well as a looking-forward function as well.

[61] **John Griffiths**: Could I ask in terms of perinatal mental health services generally and service developments that are reported to the NHS collaborative? And then, though that process, chief executives of the health boards are informed by steering groups, which seems like quite a convoluted process, but that's the process as I understand it. Could you tell the committee what the governance arrangements are, the mechanisms in place, so that Welsh Government is able to hold the health boards to account on their performance in terms of those perinatal mental health service developments?

[62] **Vaughan Gething**: Jo, do you want to take that?

[63] **Ms Jordan**: Yes, fine. So, first of all, just in terms of the collaborative, that's an arrangement that exists amongst the chief executives within the NHS. So, they will be taking some assurance themselves through reports to that collaborative, but that's not what Welsh Government is relying on. So, as part of our normal governance and performance management of local health boards, a discussion around development of perinatal services has come up in most of the end-of-year joint executive committee meetings that we've had with the health boards, so that's a part of our normal procedures.

10:00

[64] But, separately to that, as we're doing with all of the additional money that's gone into mental health services for specific things over the last few years, we're asking for very regular updates from the health boards about where they are with their plans, where they are with recruitment, are people being seen, how many referrals are they're getting. And we are seeking that from them on a very regular basis, apart from the regular returns that they give to us for their progress overall with 'Together for Mental Health'. And that is reported through to the all-Wales mental health partnership board as well. So, there are a number of formal things that happen regularly, but there's been some quite intensive scrutiny on the development of new services, because we don't release the money until we've got that assurance, so—.

[65] **John Griffiths:** And when lessons might be learnt by other health boards from good performance in one particular health board, are there mechanisms in place to ensure that that happens consistently and systematically?

[66] **Ms Jordon:** Yes. So, some of that's happening through the community of practice that's been established, which Karen will be able to talk more about, but that was set up to ensure that health boards were learning from each other and they weren't repeating the same sort of learning curve, et cetera. Karen can probably say more about that, but that was in place to support that more informal learning.

[67] **Ms Jewell:** Yes, the community of practice has been set up to basically share best practice across the whole of Wales. So, it involves the statutory and the voluntary sectors—so, perinatal Cymru were part of that—and what it's enabled is that areas that already had some provision of service are able to share some of their learning with people who are already starting up, but also there's joint training that's able to take place during those, and they have got two sub-groups that have started looking at training and the pathways as well. So, there are lots of things going on within that community of practice that enable that sharing and learning to go on on an all-Wales basis.

[68] **Lynne Neagle:** Thank you. Julie.

[69] **Julie Morgan:** Yes, I was going to ask you about standards. Obviously,

there's a range of standards. The National Institute for Health and Care Excellence have got standards and the Royal College of Psychiatrists have quality standards. In evidence that we were given, it was suggested that—. Are these sort of standards, the Royal College of Psychiatrists's standards—are they being adopted throughout Wales?

[70] **Vaughan Gething:** I think all health boards are working to the College Centre for Quality Improvement standards and I know that two of them—Cardiff and Vale and ABMU—have already reached them. It might be helpful if Karen sets out how the standards have been agreed and how that fits into the service that we're planning and delivering.

[71] **Ms Jewell:** The process of standards is actually peer review. So, it would be any perinatal service that's set up across England or Wales that would actually come in and look at the service that you've got locally and review that against the standards, and then you would then go and do similar. So, there's actually some cross-learning that takes place between units. All of the health boards have agreed that they do want to work towards the standards. There are obviously different levels of standards, and what we would expect is that health boards would work up through those standards so that, initially, when they're newly set up, they look at the minimum standards, but then they gradually build on that so that they build their service up.

[72] **Julie Morgan:** So, is there an overall knowledge from the Welsh Government in terms of how each area is doing?

[73] **Ms Jewell:** We would see it very much as best practice for the standards within the community of practice. So, it's very much a clinical learning, but, obviously, we want to know that they're actually working through the standards and they're doing that, but we would look at outcomes that were measurable that we could look at that would identify things that may fit into some of the standards and may not. But those are things that Public Health Wales are looking at at the moment. So, the standards, yes—it's more of a clinical basis, on learning and building your service.

[74] **Julie Morgan:** So, what would those outcomes be?

[75] **Ms Jewell:** Again, Public Health Wales are looking with the community of practice at the moment at what the pathways look like and then what

some of the measurable outcomes could be at the end. So, those are being looked at at the moment.

[76] **Julie Morgan**: At the moment. Right, so this is work in progress.

[77] **Ms Jewell**: Yes.

[78] **Lynne Neagle**: Thank you. Darren.

[79] **Darren Millar**: I just wanted to ask, if I can, about those pathways. You've just introduced the subject there, Karen. You might know that there was a very sad case in my own constituency just yesterday of a newborn being left in a bus shelter. I've no idea what the frame of mind of the mum of that newborn must have been, but she was clearly a very poorly woman who may well have benefited from some support, may well have been looking for some support during her pregnancy, and, for whatever reason, hasn't been able to achieve that. So, it brings home, really, to me the importance of us getting these services right in the future.

[80] We received evidence last week from Action on Postpartum Psychosis and another third sector organisation, but one of the things that shocked me was some evidence from Sally Wilson. She was a young mum from Flintshire who had been under the care of the Betsi Cadwaladr health board. All of the options in terms of her care appeared to have been exhausted. She ended up in an adult mental health unit, but was still getting no better, and it wasn't the health professionals who signposted her to an alternative option, this secondary sort of psychiatrist referral team in Cardiff, it was actually the charity that was working with her to try and improve her mental health. That, to me, suggested that, clearly, the pathways for those healthcare professionals aren't appropriate, they're not complete pathways. And I know that this is something that is being looked at. But, clearly, in those sorts of situations, it would seem to me that it would be helpful, although there will be some local differences with pathways, if there was an overarching pathway, if you like, that those pathways could fit within. I just wondered what the Welsh Government's position is on whether there ought to be a national pathway, and why you think it is that health professionals don't always appear to be familiar with the last-chance-saloon referrals that could be made to these sorts of secondary psychiatry teams.

[81] **Vaughan Gething**: Well, there is work ongoing about developing that all-Wales pathway. That's work that is being carried forward now, actively.

That's not just looking at work within Wales; it's quite properly looking at work across the rest of the UK as well. We don't want to try and shut ourselves off and pretend that nothing is happening across our border. I think that's one of the things that are actually quite motivating about this area. I think that midwives and health visitors—people involved in early years—are actually really quite reflective and supportive of each other, and I think there's a real willingness to learn and to improve. So, I think that's a really positive place to start from.

[82] I don't try to pretend, though, Darren, that every single healthcare professional knows every single thing about every part of the service. What we try to do is to construct a range of outcomes that make sense for people to work to, that support clinical decision making, and actually support the need to provide care for that person in their context. That does sometimes mean that sometimes people will get things wrong, and it's important that we start off in being reflective and wanting to learn from those in the first place, as well as understanding that there will be times when, even with the right standards and the right approach, we can't always prevent people from being unwell and making poor choices. This really is about giving ourselves the best possible prospects to understand who is at risk, how we help that person, how we help them to make their own choices, and how we then have the right support available. I do think the all-Wales pathway will be helpful in us doing that, as well as then understanding what exists on a local level, which will differ. We talked earlier about the variation in third sector support, which will differ in different parts of the country. We talked earlier, before you came in, about the fact that some service models will be different, and entirely appropriately different as well—Powys being the most obvious example—but to understand how all of those things make sense with a national pathway and then have local healthcare professionals make choices with women and their families.

[83] **Darren Millar**: So, just to confirm, you are expecting a national sort of—

[84] **Vaughan Gething**: Yes.

[85] **Darren Millar**: —overarching pathway, to redevelop that. That's very useful. Can I just ask as well about the non-urgent referral processes? Again, we heard from the health boards that waiting times for psychotherapy services mean that, very often, if a mum presents with having a mental health need, it would be pointless referring them on to a psychotherapy team

through a routine appointment, because they're just not going to get it, even before their baby is born, in most parts of Wales. So, obviously, lots of people are being supported, particularly for lower level needs, through the community teams, and sometimes through secondary care teams as well.

[86] I noticed in your paper that some of the health boards aren't even giving you information in terms of the number of referrals into community teams. Is there any reason for that?

[87] **Vaughan Gething**: We're working—I'm sure Jo will give you more information on the stuff on being on top of performance, but we're working with people to make sure we're getting the same data in the same way. And, as we start off, there is a need then to regularise that, and it's why we expect to be able to publish more information in the future, as we have, so that it's properly comparable between health boards working to the same definitions. The problem is, if you don't get all that process stuff right, if you end up telling a story that isn't accurate, you can end up creating an impression, not just with the public but with the service, that doesn't reflect what's happening on the ground. So, it is important we get that right because that should then help us to improve our services, not just from an accountability point of view, but to then understand where we think we have challenges and then what we think we need to do about them as well. So, the reporting and the accuracy of the data isn't just about accountability; I do think it really is an important part of service improvement.

[88] **Ms Jordan**: We have the data on people being referred through primary mental health services. That was put in place as part of the work we did to implement the Mental Health (Wales) Measure 2010, so we have reasonable data for that. The bit that we are missing is in terms of referral for more specialist psychological therapies, the secondary care bit, and that's the bit—we've set a new waiting-time standard, and we are now trying to put in place arrangements that will enable us to collect that, on the back of quite a significant investment Welsh Government have made over the last few years to improve access to psychological therapies. We still have some way to go on that, but new data collection methods will help us monitor the improvement in that over time. And, in terms of this service, it will be interesting to see how much is able to be delivered in house from the perinatal team, and how much actually has to be outsourced to the other services within a health board area. And that—as the teams develop and really get into the stride, we'll have a better feel for that, I think.

[89] **Darren Millar**: So, is there any reason why Betsi Cadwaladr university health board isn't telling you how many referrals are being made to community mental health services for women with perinatal mental health problems? They appear to be the only health board that's not.

[90] **Vaughan Gething**: I appreciate you came in a little late; we did deal with the fact that Betsi have started their service this month, so they couldn't provide data on a service that formally came into being at the start of this month. So, we'll expect to see that now being reported, now that that service is active.

[91] **Darren Millar**: No, I'm not sure you're appreciating the question—

[92] **Vaughan Gething**: You asked about community perinatal mental health services.

[93] **Darren Millar**: I'm just asking about the number of referrals to community mental health teams more generally.

[94] **Vaughan Gething**: Oh, if you're talking about referrals to community mental health teams more generally, that's part of our issue about getting the data in, yes.

[95] **Darren Millar**: So, they don't record those data, then, or—.

[96] **Ms Jordan**: They haven't been specifically asked to separately record referrals for perinatal previously, which has been one of the issues in trying to build the service, actually trying to understand what the need is and things. So, that is part of the development of it.

[97] **Darren Millar**: Yes. I was just trying to understand why there were no figures for them or Powys.

[98] **Ms Jordan**: Yes. So, they've been asked.

[99] **Darren Millar**: So, we're heading towards a sort of overarching pathway. There will be some differences, obviously, locally within that, but, in terms of this final end point of the pathway, because presumably there will be all sorts of interventions on the way to the end point, this issue of the secondary psychiatrist referral team in Cardiff with this sort of ultra-specialism in this area will be an avenue that people can be signposted to

from across Wales, will it? Because this is the one that made a massive difference to Sally and helped her to recover.

[100] **Vaughan Gething**: Yes, we'd expect the pathway to cover those potential services, and, again, it's about the appropriateness of each referral, because that will be a small number who would need that and where it would appropriate for them to travel such a distance away from their family setting for that. But we do recognise that that specialist end is something that we're currently reviewing and need to review, as well. So, the risk work is really important in reviewing it, and then understanding how that fits into our overall pathway and the standards and the outcomes framework. All these things do need to be joined up to be effective, otherwise I could come back here in a year's time and you would quite properly ask me why I haven't thought about how all these different things actually add up and make sense with each other.

[101] **Ms Jordan**: And we would hope that the new local teams would be able to provide that level of specialism locally, and that clearly didn't exist at the time that you heard from a young lady of her experience. But that's what we're seeking to resolve, that that expertise would be available or shared amongst the services that are available.

[102] **Lynne Neagle**: Okay, and, just on the data issue, can you tell us, then, when you would expect to be in a position to have that full data picture for all health boards, including the women who have been either referred to a psychologist and seen one, or referred and can't access one?

10:15

[103] **Ms Jordan**: I don't think I can give you that precise answer today. That will depend, I think, on the work that's being done through the community of practice, and what's possible. I can set a deadline, but it may not be possible for services to achieve that. So, I think, if it's okay, I'd rather refer that back and write to the committee with a timetable that is agreed by the services, rather than me—

[104] **Lynne Neagle**: I've just got a couple of questions about psychology as well, because I think the committee was concerned about the evidence that we took last week from the British Psychological Society. We were provided with a grid that showed the recommended number of perinatal psychology sessions, and none of the health boards were complying with that

recommended number. And, then, when we took individual evidence from the psychologist from Betsi Cadwaladr, she was expressing some concerns that suggested that a lot of her work, really, would be disseminating training, and what have you, which is all very valuable, but I think it did leave us with a doubt that women would be able to actually access that face-to-face talking treatment. So, I wanted to ask about that, and also the comment that she made that, because there are no specialist perinatal psychology sessions, she was having to get supervision from outside Wales.

[105] **Vaughan Gething:** Well, in terms of coming back about the structure of the service—I don't think I can come back to you about the supervision point, but I think it would be helpful for us to come back and to explain how that should work, and, equally, the points about workforce as well, and about both where we are and where we expect to get, because, broadly, in psychological services, we know there are challenges in workforce. And it's a UK issue. We're not immune to it, but our challenge is what we are not just prepared to do about it and with it, but what we think we can do as well. And that's why the interventions at different levels all matter as well. So, it isn't simply a case of saying there is no provision for you; it is about, 'Well, what can we do and how do we provide it? I think that would be a sensible thing for us to provide to the committee, in something rounded about the issue, because I know it's a real concern.

[106] **Lynne Neagle:** Okay. Thank you. And just—

[107] **Ms Jordan:** Sorry, I was just going to add, I think as the services, particularly in north Wales, now begin to see people, the health board will get a better feeling of the actual level of demand and need, which will enable them then to—. We would then expect them to respond to that. I think part of the problem is they haven't known the level of need in order to plan and put services in place to develop that, so that's one of the things we would be expecting health boards to be picking up on fairly quickly, actually.

[108] **Lynne Neagle:** Okay. Darren on this.

[109] **Darren Millar:** Can I just come in? I know you said that you'd want them to determine what the level of demand and need is, but every bit of evidence that we've received so far says that this is entirely predictable in terms of the levels of demand, the numbers of women, the proportion of women, that will have perinatal mental health problems, particularly those that might need access to very specialist treatment who might benefit from a

mother and baby unit. So, why is it necessary to keep waiting on this rather than just getting our act together and plugging these gaps in services?

[110] **Vaughan Gething**: I don't think it's that simple at all, and, actually, part of the point about having the community service in place is, actually, there's then a better understanding of how that need could be managed appropriately. Because, even where people have been assessed as potentially needing or benefitting from an acute service, lots of people will then opt to still stay locally because they don't want to go somewhere away from their family. That could be just 10 miles down the road, but people still say, 'No, I don't want to do that'. So, it's about understanding how we provide the right sort of care and how much we provide on a community basis, and then how we still understand what we really do need in terms of the specialist hospital-based service as well, and how we provide that appropriately, whether that is within Wales or outside. And, again, that will depend on some of our geography, as to what is appropriate.

[111] **Lynne Neagle**: We're going to come on to the mother and baby unit, but, just before we leave the data question, there is an issue with local health boards not collecting data on women who are admitted to adult psychiatric wards for perinatal mental health problems. Is it your intention that this new data collection will deal with that?

[112] **Vaughan Gething**: I think we'd want it to.

[113] **Ms Jordan**: Yes. I think that's already being discussed in the context of assessing the demand, the work that the Welsh Health Specialised Services Committee are doing, actually, in terms of assessing the level of need and what's appropriate. So, that should be possible.

[114] **Vaughan Gething**: We want data that makes sense. And it goes into some of the questions around how we provide a service, but, actually, we'd want to see that we're accurately reflecting the numbers of people coming into the service and receiving it, even if it isn't on a named ward, but that, actually, that provision is being made available, and that's one of things we'll need to reflect on how we do it accurately as well.

[115] **Lynne Neagle**: Okay, thank you. Llyr, on the mother and baby units.

[116] **Llyr Gruffydd**: Yes. Well, clearly, a situation where mothers are having to travel long distances to access a mother and baby unit isn't acceptable.

I'm sure you'd agree with that.

[117] **Vaughan Gething**: Well, I think, actually, the reality is that women right across the UK will likely need to travel a distance to get to a mother and baby unit, and, as we discussed earlier, most people want to have their care as close to home as possible, and when you get to that genuinely specialist area where that just isn't appropriate and isn't possible—. You know, even if we had five mother and baby units across Wales, for the sake of argument, well, actually, there'd be lots of women who'd still have to travel quite a long distance. So, it's really about how we understand the real level of need that exists, bearing in mind the investment we've made in community services and what that's been able to do, and then how that is then appropriately managed. And there are open questions that the WHSSC review is looking at as to what is the level of need, how do we appropriately manage that, is it about continuing to refer people to a service outside of Wales, will it be part of what the service looks like in the future, will it be about having a number of centres within Wales, or will it be about having a staff who can provide a service in different hospital settings. So, I think all of those are live questions to consider, and I don't have any preconceived ideas about the numbers of units or about what that model should be like. You know, I have to remind myself regularly I'm not the chief executive of NHS Wales, I'm not the chief medical officer or the chief nurse, and I need to understand what does that advice look like and then what's the ability to deliver on a service model that is suggested.

[118] And it depends on whether the WHSSC say, 'Here is the answer', or they say, 'Here is a range of options to work within'. And I'm sure that, when WHSSC have their meeting, which I think was originally going to take place before this meeting but is now going to take place towards the end of this month, I'll definitely be interested and I'll make sure, Chair, that the committee are informed as to what that meeting produces, whether it's an answer or a range of answers, because I'm sure that'll be of interest to you as you complete your report.

[119] **Llyr Gruffydd**: So, I'm not even going to be able to tempt you into giving me some sort of meaningful timescale post that meeting, in terms of potential implementation, or—it depends what they say, I suppose.

[120] **Vaughan Gething**: Well, I need to see what they say in the first place. I need to understand what the response of the service is going to be and about how we then get to an agreed point as well. The thing about where we

come to with an evaluation in March, it'll be really useful to have an agreed service model before we get to March next year, from an evaluation point of view, about how the community services fit in with a wider model, but I do need to understand what that looks like. And, whilst it would be tempting to be able to give you an answer that makes me look like a shining champion today, I just think that ad-libbing something now is the wrong thing to do.

[121] **Llyr Gruffydd**: No, I understand. I understand and appreciate that, but, if they make a clear recommendation, are you committed to, if possible, delivering what they recommend?

[122] **Vaughan Gething**: Well, if there's a clear recommendation it makes it easier to try and deal with—you know, the obvious caveats about resource, and the biggest resource caveat is staff and the staff to deliver against a service model. I think, if you have the numbers, it's about making sure that the requisite training is in place so we have the right skills, because part of the reason why the previous mother and baby unit didn't work and was eventually decommissioned was about the numbers going into that unit and about the ability of staff to maintain their skills to an appropriate level of practice. So, there is something about understanding how you maintain that proper level of practice by getting the right service, and equally that we're getting women who do need the service to the right place. Because, actually, one unit in Cardiff: I'd be surprised if that was the answer, because that didn't work previously, and, as I've said in the Chamber, Cardiff is a long way from St Davids and, actually, it can be a long way from Merthyr, frankly, let alone anywhere else, to think about where people are going to go for a service.

[123] **Llyr Gruffydd**: The data point you made about one of the reasons for closing—of course, we've already been discussing that we don't have robust enough data potentially to be able to make that call in a meaningful sense, and you even admit in your paper that the figures in the table don't actually take account of mothers who may have elected to be admitted to local adult mental health units so that they could be closer to their families. So, there's a long way to go in recognising, you know, those data as well, and I appreciate that we've addressed a lot of that already. But we do know that the NHS in England, of course, have been undertaking a transformation programme. Has there been any dialogue with them around whether changes on one side of the border could complement provision on this side, or vice versa? Because we've also heard reference to the possibility of a north Wales unit actually supporting parts of north-west England.

[124] **Vaughan Gething:** Well, it does require both sides to want to talk.

[125] **Llyr Gruffydd:** Indeed, and my question is: is that happening?

[126] **Vaughan Gething:** Well, I think that NHS Wales is really open to having that conversation properly. The problem is that the English system is really quite compartmentalised. You see this, just in a different subject, but related to this area, in the future fit conversation, where the Shropshire and Wrekin clinical commissioning groups are deadlocked and just cannot agree on what to do with some of their services, and that's a big problem. It's part of the challenge—take away the party policy and think about challenge that the transformation plans have in England. Actually it can be very difficult to get commissioning groups to agree with each other about what to do about a regional service, because often those people are retreating to being local first. That makes it really, really difficult for them then to have a conversation that say, for the sake of argument, is about Bristol and Gloucestershire talking to each other, but then talking to us about what does that mean for south Powys, what does it mean for Gwent and what does it mean, potentially, for the Cardiff and Vale population. We don't have a very open door for us to be able to walk through to have that conversation. I think it would help all of us if there were a change in approach and a more open-minded approach, because, potentially, you could have services outside of Wales that support people in Wales as part of the proper service planning of that—we do some of that on some services already—but actually, to think properly, also, about services in Wales that support people in England, too. There are some flows where that happens already. The most obvious ones are burns going to Morriston and other issues where people come to Cardiff for a service. But actually, in this area, too, I think there is room for a sensible conversation, but it requires a slightly different approach from our colleagues across the border.

[127] **Llyr Gruffydd:** Yes, and you've pointed to difficulties between commissioners and on the ground level, but have there been government-to-government discussions about this, then?

[128] **Vaughan Gething:** Well, to be fair, officials in the two Governments do talk to each other. The challenge is about how far that goes and actually, of course, the conversation is really with NHS England on the operational side of stuff, as opposed to DH, because the Department of Health have put a firewall between themselves and the service in creating NHS England. So,

actually, it's about what NHS England do, and then, actually, what those wider partnerships are trying to do together. As the picture is changing in England—and it is, because they're thinking about reorganising different parts of their service, having integrated organisations that don't sound a million miles away from integrated health boards in Wales—that, again, could change the picture and the nature of the conversation, which might make it easier for us to have a conversation with a similar body on our border in England. I'm not trying to say I blame England for the fact that we haven't had this conversation, but actually I think it's in their interest, as well as ours, to be able to have that conversation on a more meaningful level.

[129] **Llyr Gruffydd**: So, the frustration is there in terms of that dialogue not happening, but the real impact is, of course, that, for example, Bristol won't be accepting people from south-east Wales or other service—. There's nothing to stop the service in England from saying, 'Well, we're not going to accept people any longer.' Does that not present a risk, then?

[130] **Vaughan Gething**: Of course it does, but that's about commissioning the service, and so it's the commissioning agreement that's in place and how far that agreement works. In a whole range of different areas of the health service, with the commissioning agreements we have, both within Wales and also commissioning a service for Welsh patients from England, well, a lot of that is natural and readily takes place. You'd know yourself, being a North Wales Member, that people are used to care pathways that lead to a specialist service in England, whether it's roughly in the Liverpool area or even into Manchester. That's quite normal as well as, if you like, standard parts of elective care, where people are used to going into England as well. The challenge is, as we plan this service, what could we and should we do within Wales, and, as we undertake the review, what is it realistic to say we could and should commission from England? What is it that we should say, 'Actually, we could and should provide something uniquely within Wales'? And, again, what does that model look like? All of these things are in the round. Sorry it's all a bit hypothetical, but at the moment they are hypothetical questions because we'll have a review to give us a more concrete basis to have that conversation moving forward.

[131] **Llyr Gruffydd**: But there are also services in Wales that England could commission from us, which you omitted in your list of options, but, yes—

[132] **Vaughan Gething**: No, absolutely. That's very much part of what could happen.

[133] **Lynne Neagle:** I've got Mark then Darren on this. I'm going to appeal, because we've still got a lot of questions to cover, for brief questions and brief answers, please. Mark.

[134] **Mark Reckless:** Cabinet Secretary, I'm concerned about your answer just now in terms of the mother and baby unit at Cardiff, in light of the evidence we had from the Royal College of Psychiatrists, who say:

[135] 'It has wrongly been accepted that the previous mother and baby unit in Cardiff closed because of lack of need. This was not the case and there is an urgent need for such a service to be provided'.

[136] I just wonder, particularly in light of the £1.5 million not being there, there not having been this agreed pathway, and the evidence we've had about referrals not having been made, isn't it at least possible that there was at least sufficient demand for this service, but it wasn't properly used and integrated into the health system across Wales?

10:30

[137] **Vaughan Gething:** I don't think there was any lack of understanding that the unit existed, but actually the referral behaviour isn't just about healthcare professionals making choices; it is about the individual women and their families making choices as well. That's part of what we want to understand about the future, and our understanding of what we want to do and what it's appropriate for us to do. What do we think our level of need is? And then, how do we appropriately meet that level of need? I actually think trying to run around the track of understanding and arguing the decision in the past isn't terribly helpful. I actually think the most helpful thing for us to do is to say: given the level of need we have, with the services that we now have in place, with the demand that we think we're managing in a different way, what level of need do we still have for a specialist hospital-based service, and how do we meet that need, and what model does that look like?

[138] **Mark Reckless:** And the evidence we had last week was that, at least compared to the NICE guidance, there are, certainly in south Wales, or even in the core area between Swansea, Newport and Merthyr down to Cardiff, at least enough women and births such that you would expect to have a mother and baby unit. For someone suffering from postpartum psychosis, I'm really concerned about your suggestion that even there, someone from Merthyr

shouldn't be coming to Cardiff to have that residential mother and baby specialist unit, compared to inadequate community service or going into a general psychiatric ward, surely.

[139] **Vaughan Gething:** Well, with respect, that isn't what I said, and I think you put several words into my mouth that are just not appropriate at all. It's really important we have a properly mature and searching conversation about this. If there is a level of need, and no-one from the Government is saying, 'There is no level of need; it doesn't exist', it's about how we appropriately manage and meet that level of need, and recognise how people feel at the time, as people make their own choices about treatment. With respect, if you live in Merthyr, Cardiff can seem a long, long way away, and you need to respect and understand that's how people feel, and how they will make their own choices. If they're in a position to make their own choices, people are already electing to make choices to stay local and not to move somewhere else for treatment. We need to understand that as we plan and manage a service.

[140] The challenge is: how do we provide a service where we understand there's a level of need that is appropriate and meets the needs that we recognise in our population? Will that be a model where there is a unit, two units, three units, or will it be that we have a different model that looks at how you provide appropriately skilled people within settings to provide that care on a different basis? I don't know the answer to that, and I'm not pretending that I do. I'm not setting any parameters to say that I will not endorse a decision that proposes a model of care that has a different range of those possible options within it. I'm saying that I need to wait for that, and I think all of us do, to then understand what's being proposed, what it is possible for us to do, and then actually making a decision and committing to do something to deal with that level of need, and provision that is as appropriate as possible. But I just think that trying to run on the basis that one answer for one form of provision is going to resolve this, I just don't think that's a sensible way to approach it.

[141] **Mark Reckless:** You said—very quickly, Chair—that women in Merthyr choose to stay local, but they don't have the option of accessing a mother and baby unit in Cardiff because—

[142] **Vaughan Gething:** With respect, I didn't say women in Merthyr choose that. I'm saying Merthyr can seem a long way away from Cardiff, and for some people, they may then decide, 'I don't want to.' That doesn't mean to

say that someone else won't do, and it's exactly the same for someone in St Davids. They may say, 'Cardiff is a long way away. If that's the option, I don't want to go', but actually some people may say, 'Look, I can't cope as things are. I need to go somewhere else. If that's the appropriate option and that's available, I want to do it.' That's the same in this area as in many others. So, that's why I'm not getting stuck into saying there is one form of service provision that I will or will not endorse. I'm just recognising the reality of treatment flows, and how people feel, and actually how people are supported.

[143] **Mark Reckless**: I'm much happier with the third answer than the first.

[144] **Lynne Neagle**: Darren, briefly.

[145] **Darren Millar**: Just a very brief question. We know what the level of need and demand ought to be for a mother and baby unit—between 60 and 80 births a year in Wales. Women will make the decisions about whether they're treated in a mother and baby unit if an offer of a referral is being made, and it's not always being made, based on the information that is given to them. We heard from a mum last week—two mums last week—who said to us that, had the benefits of mother and baby units been properly explained to them, they would absolutely have opted to go into a mother and baby unit as opposed to the adult units that they were eventually admitted to, which has caused all sorts of longer term bonding issues for them and their children. So, do you accept that you're not going to get an accurate picture of the levels of need if you simply look at the actual referrals that have been taking place, which have been going to WHSSC, and based on this—? You keep emphasising women's choice. Absolutely, I agree with you, we need to have women making these decisions, but it's got to be from a fully informed position. They're not getting the information at the moment, are they?

[146] **Vaughan Gething**: Well, with respect, you're asking me to get into the minds of a lot of professionals and to say that professionals aren't making those choices—

[147] **Darren Millar**: I'm just asking you to reflect on the evidence we've received.

[148] **Vaughan Gething**: Well, no. Don't interrupt, Darren. Let me answer the question. If you just say, 'Women aren't getting to make those choices', actually, that's a broad statement that I don't think is a fair one to make. The

challenge is: how do we equip our professionals to have that conversation with people so they get to make choices with their healthcare professionals? There's that level of improvement we need to make in virtually every area of the service, and I would not try to pretend that this is an area where that uniquely does not exist.

[149] Our challenge is—. And, again, picking up on what I said earlier, I think that the midwifery professionals are really reflecting, and the willingness to learn, I think, is palpable. So, there's the understanding of how do you have that conversation with women that you're supporting, how do you provide the options, and what that looks like and what it means, and then help that person to make that choice. Then, it's how do we make sure the information that we have available to us across the whole system about need is properly borne into how we have a model of care that could and should work, with the staff to provide it, and to meet the need that we understand within our population.

[150] There needs to be an understanding of all the different information we have about what the level of need is, rather than just drawing a simple mathematical formula that says, 'This is the level of need, now how do meet that?' Actually, the introduction of the community services has been an important part of understanding the level of need and how it can be met appropriately. So, I think we're actually doing the review at the right point. I would always want the review to be done earlier, frankly. As a politician, I'd always like to make an earlier decision and not have it delayed. But, we'll get the review, we'll get the evidence, and that will be shared with the committee in an appropriate form. Then, we'll get to be able to make open choices about service development for the future.

[151] **Darren Millar**: In the evidence session with WHSSC, it was very clear that they're giving every single application that comes through the nod at the moment, but obviously that's causing some delay in those decisions being made in terms of the referrals actually being able to happen, because obviously WHSCC have to make a decision. It seems to me that it's pointless having WHSSC's involvement in commissioning those tier 4 services to mother and baby units at the moment. You ought to be able to just say to health boards, 'Send the women that might need access to these services', and WHSSC will pick up the tab afterwards, retrospectively. Why are WHSSC involved at all if clinical judgment—

[152] **Vaughan Gething**: Look, I just think that's a really cavalier approach to

service planning that is just not—

[153] **Darren Millar**: It's not cavalier at all.

[154] **Vaughan Gething**: It just isn't helpful—

[155] **Lynne Neagle**: You can't have an argument across the table.

[156] **Vaughan Gething**: It just isn't helpful to say, 'It's going on the nod, why bother having WHSSC involved at all?' Actually, it's a specialist service where WHSSC has a proper role. There's a different view about how you get decision making streamlined and how you understand need, but that also is about commissioning the right form of service. So, this is an argument and a question about how we equip our service now, before we have our future service model—

[157] **Darren Millar**: It's the future now, why are they involved at the moment?

[158] **Vaughan Gething**: And, with respect, if you take something out of WHSSC and put it back into local health boards, you'll then take away the ability to actually have a proper strategic choice about commissioning the specialist service. With respect, I don't think your suggestion is one that we'll be following through.

[159] **Lynne Neagle**: Okay, right. Before we move on now to other areas, I just wanted to check on process. The meeting that WHSSC were having to consider the options paper didn't happen as it was meant to just before they came to committee last week. It's rescheduled for 25 July. What assurances can you offer that that meeting will go ahead and that they will consider that paper? I also wanted to ask you, Cabinet Secretary, whether you would be prepared, once you get the options paper, to share it with the committee, because it will help the consideration of our report.

[160] **Vaughan Gething**: I met the chair of WHSSC this week. I am confident that the meeting on 25 July will go ahead to consider this issue and I will share as much information as possible after that meeting has taken place, and after I've received an understanding of the options available. I do want the committee to be properly informed as to what they're saying, because lots of conversations we're having now are hypothetical because that meeting hasn't taken place, and that may well affect recommendations that

you do or don't wish to make.

[161] **Lynne Neagle**: And are you able to give us any indication of timescale for you to make that decision once you've had that paper?

[162] **Vaughan Gething**: I can't really do that because I haven't seen the paper.

[163] **Lynne Neagle**: Okay.

[164] **Vaughan Gething**: But, what I can do is, I can say that I want to make sure the committee have information as soon as possible after that meeting, because I do appreciate you're going to want to write a report with recommendations and that will be an important consideration for you.

[165] **Lynne Neagle**: Okay, thank you. Hefin.

[166] **Hefin David**: Thank you. You've mentioned the communities of practice as an effective vehicle for learning. To what extent are you satisfied that it will make the strategic connections across Wales that it should?

[167] **Vaughan Gething**: I think we've had buy-in from every part of the country thus far, and a willingness and a desire to want to be part of the communities of practice. So, it's a developing movement, and we're investing in a service. We made a decision two years ago and you've seen that one health board came on-stream this month, so, I am as content as I can be that people want to be part of the community of practice and that they are taking part and that learning is being shared. We'll have some reassurance in the evaluation we're going to have, as I said earlier, at the end of March as to how far that is taking place and the development that could then take place with the community of practice thereafter.

[168] **Hefin David**: So, what distinction would you make between the community of practice and a managed clinical network, as they have in England? What's the distinction?

[169] **Vaughan Gething**: I think that might be helpful for Karen to answer, actually.

[170] **Ms Jewell**: So, the community of practice is very much about sharing best practice and I think that, with the landscape as it is at the moment, with

a lot of services setting up and starting out, the community of practice is probably the best thing to be in place at the moment so that they can share that practice across Wales. A managed clinical network is more about having specialist clinicians who meet and share practice a bit later on. So, definitely, it would be something that we would be open to later on, and it may well develop into a managed clinical network, but, probably, at this moment in time, so that it's open and inclusive, a community of practice is probably the best way to go.

[171] **Hefin David**: So, could a community of practice be an embryonic step towards a managed clinical network?

[172] **Ms Jewell**: Absolutely.

[173] **Hefin David**: Okay. That's a possibility, Cabinet Secretary—you would endorse that, yes?

[174] **Vaughan Gething**: Yes.

[175] **Hefin David**: Okay. With regard to training, in your paper, you said that the Welsh Government has provided funding for specialist perinatal training in 2016-17 at the total cost of £9,750. To what extent is it fair to say that that is severely limited?

[176] **Vaughan Gething**: In terms of health board sums of money, it's not huge, but the challenge is what you do and how you can provide that training. It also depends on the support that people provide to each other. There's peer-to-peer stuff but, actually, you know, sometimes when we look at training, it's as if that is the only area of activity. I don't think that's quite fair, but it's about how we then equip the service to be able to deal with the need that we recognise exists with the new way of working and having the community service.

[177] **Hefin David**: So, I take it from your answer that you're making a distinction between training and learning.

[178] **Vaughan Gething**: Yes. I think it's important to make that distinction as well.

[179] **Ms Jordan**: I don't think our intention was to fund all the training that needs to be going on in this. We funded some specific parts of the training

for some psychiatrists to go on a specialist course, that sort of thing. There were particular bits of it that we were directly funding, but we would be expecting, within health boards, other training to be going on.

[180] **Vaughan Gething**: And, you know, the community of practice is learning, and that's part of developing and improving the service as well.

[181] **Hefin David**: Are you satisfied, therefore, that that learning is taking place, in addition to the training and these complementary—?

[182] **Vaughan Gething**: Yes.

[183] **Hefin David**: Okay. One of the things that surprised me in questioning clinicians was the appearance of a limited amount of professional development and reflective practice that seem to be happening between training events. There was a lot of talk about the kind of training events going on, but I didn't see enough, in my view, evidence of reflective practice, particularly amongst midwives and health visitors. Would you say that's a fair thing to say, or would you challenge that? If you challenge it, what evidence would you suggest to the contrary?

[184] **Vaughan Gething**: Well, there's always a challenge in a busy service to find the time to be genuinely reflective and to be able to take a step back, but that's part of what we're trying to do in protecting the time to be able to do that within the service, but also the way in which we're developing our whole service. For example, the frailty tool that health visitors are having—there's an evidence base about the time and the level of need and how we see that moving forward, and that should put us in a better position in other health visiting services across the country. Around that, you need to have the time and the space to be properly reflective. I don't think I'm picking up any particular weakness in either health visiting or midwifery about being appropriately reflective in their practice.

[185] **Ms Jewell**: Shall I take—?

[186] **Vaughan Gething**: Yes.

[187] **Ms Jewell**: You may be aware that the Nursing and Midwifery Council have actually changed part of the practice around revalidation. So, revalidation came online last year, and, actually, it's now something that is part of everybody's practice to ensure that they reflect on events or training

that have taken place so that they can actually use that towards their revalidation. So, it's something that, definitely, is being built upon, and we would want people who have attended training events to think about that and do formal reflections that they can discuss later.

[188] **Hefin David:** That sounds really interesting and something I'd like to find out more about. Putting myself in the position of a midwife, imagine I've just been through a birth and I've recognised the potential for postnatal depression as a result of perhaps a difficult birth or the experiences that I've had. How would I, as a midwife, share that with other clinicians? Is there a mechanism by which these experiences—these on-the-job experiences—can be shared?

10:45

[189] **Ms Jewell:** You may be aware that we've set up clinical supervision for midwives in relation to the change in statue for supervision of midwives, and one of the things that the health boards now have got set up in every single health board is clinical supervision, which enables midwives to reflect on what's happened recently in their practice. They have group supervision events where they can actually share those events with other clinicians around the table—midwife to midwife—so that they can have joint learning from it.

[190] **Hefin David:** And would health visitors then be able to pick up on this learning?

[191] **Ms Jewell:** Health visitors again also have group supervision events, and they've had that for a long period of time. That may be in relation to safeguarding initiatives, or it may be in relation to things like perinatal mental health. So, they do have that group supervision activity that they are able to take something from.

[192] **Hefin David:** Okay. One last question. How are we connecting learning between midwives, health visitors and GPs? How is the community of practice, reflective practice or professional development allowing that learning to be shared?

[193] **Ms Jewell:** The community of practice in relation to perinatal mental health would bring about that learning and then we could translate that into training so that that was then taken out into the respective areas.

[194] **Hefin David**: Okay, but the training is limited.

[195] **Ms Jewell**: Training, at the moment, is in development, so the community of practice have got a training group that's looking at the training that's needed across all spheres of health. So, that could be from GPs, to midwives and to health visitors. They're also looking at scoping what's actually already in pre-registration training so that we can build upon that as well.

[196] **Hefin David**: Okay. Cabinet Secretary, this is a tough nut to crack.

[197] **Vaughan Gething**: Well, as are many in the portfolio. But that's the joy of doing the job, of course.

[198] **Hefin David**: Okay. Fair enough.

[199] **Vaughan Gething**: It's also an opportunity, because, if you were having this review three years ago, we wouldn't have announced the investment in community perinatal mental health, we wouldn't have these new staff on board, we wouldn't be talking about how we develop them and how we share the learning between them and other healthcare practitioners and how we have a different level and a better level of information about need, services and what we do for the future. So, it's difficult, but part of the job.

[200] **Lynne Neagle**: So, is it the Welsh Government's intention that all front-line staff—all midwives and all health visitors and possibly some GPs—would have an element of training of awareness in perinatal mental health? Is that where you want to be?

[201] **Vaughan Gething**: Yes. The NMC are currently reviewing their educational standards, and perinatal mental health is part of what's been raised about the core training requirements for nurses and midwives.

[202] **Lynne Neagle**: Okay. Thank you. John.

[203] **John Griffiths**: I wanted to ask questions on the extent to which these services are meeting socioeconomic needs and socioeconomic disadvantage. So, in terms of the £1.5 million, one of the factors, I think, was that the services should be delivered equitably across the health board area, and in Flying Start areas appropriate linkages should be made. Could you describe

to the committee what an appropriate linkage is with Flying Start in those areas?

[204] **Vaughan Gething:** Well, in every Flying Start centre, we expect there to be links not just between the enhanced health visitor service, but also the midwife service that exists as well. So, you're talking about the key early years professionals within that. I would be surprised if there were not any deliberate linkages between this community service and Flying Start. There'll be a deliberate and an obvious interest in Flying Start areas. Our challenge then in terms of things like the Healthy Child Wales programme is to make sure that we're actually spreading and using that learning across the piece. Because whilst we get to a high number of particularly deprived communities with Flying Start, we recognise that isn't the only place where there are deprived community groups within the country as well.

[205] **John Griffiths:** So, appropriate linkages then—it's quite general and there's nothing particularly specific that's required.

[206] **Vaughan Gething:** Well, I haven't set out any sort of formal reporting requirements in that sense, but within every part of our service we would expect people to understand what's going on within Flying Start—they are deliberately set up, and there are healthcare professionals working as part of teams, and with others. So, we expect there to be a link, as with every other part of the service. I don't think we should say that Flying Start is somewhere else and offered in an entirely different box and the health service needs to have a different way of working within it, because we have healthcare professionals working there who are part of the service and they'll need to reflect on their ability to meet the need that will exist within Flying Start communities as well as others.

[207] **John Griffiths:** I'm just wondering, given that it was put in place as a factor in terms of accessing this £1.5 million that appropriate linkages were made with Flying Start in Flying Start areas in terms of that equity of delivery of service—having set that as a requirement or made it as a factor—then what do you expect and to what extent are you in a position to say whether those appropriate linkages have been made in all the health board areas in Wales or not?

[208] **Vaughan Gething:** The information that we get back does show that health boards do think about Flying Start in the way they deliver the community mental health service. I could give a list of different things about

how they do that. But if you're asking about the assurance—'Does this take place?'—then I think the straight answer is 'yes', but it will obviously vary from one health board to another as to who's in the Flying Start setting, how that link is made, and actually whether there is a proper link between the community perinatal mental health services that have been set up and Flying Start, to make sure that it isn't just coincidental or accidental, but that there is deliberate thought given to how that service is planned to take account of the fact there are Flying Start areas and Flying Start services and people working within those settings.

[209] **John Griffiths**: Okay, Chair.

[210] **Lynne Neagle**: Julie.

[211] **Julie Morgan**: I think, actually, we've covered this, because it's about the psychological services.

[212] **Lynne Neagle**: Right. But is there a specific question about neonatal and the standards?

[213] **Julie Morgan**: Yes. Bliss have said that psychological support on neonatal units is woefully insufficient, and of course it is included in the standards, and I know we have discussed this a bit already. So, can you tell us whether any of the health boards are meeting the neonatal standards in terms of psychological support, given the high incidence of perinatal mental health illness amongst the mothers of neonates and their families?

[214] **Vaughan Gething**: Well, we recognise that there is often going to be a need given the stress and anxiety that exists. Our challenge is how we improve what we have, because we recognise that it isn't where it could or should be. So, it's still about getting the right staff in place, and we're investing in our neonatal services and reconfiguring the way they're provided to make sure that services are configured around them as well. We think, actually, the investment that we're making in those services should make it easier for us to do that, but I won't pretend to you that we'll sit back and say 'Actually, everything is fine as it is', because we recognise the comments that Bliss are making about needing to improve on the service. I'm not sure we'd use exactly the same language, but we recognise there is a need to improve the service. That's what I think is important. It's then how we work successfully with health boards to ensure that we deliver a level of service that is properly meeting the needs of parents who are understandably going

through a very stressful time.

[215] **Julie Morgan:** And does the Welsh Government intend to endorse the revised neonatal standards when they're published later this year?

[216] **Vaughan Gething:** We work to the standards that exist, so you won't find a position where the Welsh Government says, 'We don't like the new updated version of standards'. We will work to them. So, that will be part of what we expect health boards to meet and what we work to and plan for our service to deliver.

[217] **Julie Morgan:** Thank you.

[218] **Lynne Neagle:** Thank you. Attachment and bonding—Mark.

[219] **Mark Reckless:** Like Hefin's, my wife recently gave birth in Cardiff, and I just wondered if I could put to you two questions that might be relating to this inquiry, from what we saw. The degree of intervention and the number, length and quality of home visits we received from midwives was very impressive, and we felt it linked well into the hospital-based service. I just wonder, though, when you move on to health visitors, whether that degree of linkage and intensity becomes less to the extent that there will be challenges in picking up postnatal mental health issues—depression, for instance—that may only onset a few weeks or a few months later.

[220] **Vaughan Gething:** Well, I think there are two things. One is, of course, that we have an enhanced health visitor service in Flying Start. There is more intensive connectivity with families in those areas. The generic service that exists everywhere else—this is part of the reason why we've invested in the family resilience assessment tool. We're calling it FRAT—another one of those acronyms that we use not to have a mouthful all the time. But that is about trying to understand points about caseload and workload, but also how you have an individualised assessment to enable you to understand the level of potential need that exists within that family. So, there's an evidence base going into that. We're working with the University of South Wales, we've part-funded the development of that tool, and it should allow us to be in a position where other health services in the UK aren't, in having a proper evidence-based tool to understand the level of resilience, but also the level of potential need within families. Then, of course, the challenge is making sure we do something about it.

[221] So, this is—. I don't pretend that where we are now is absolutely perfect and we have everything right, but, actually, we're already developing and trying to get ahead of where we are now for the future. That should allow us to pick up more easily challenges and support needs within families, whether it's perinatal mental health or other.

[222] **Mark Reckless**: Thank you. I had a response last week, I think from a witness from the Powys health board. I asked about the emphasis on breastfeeding, and was told that the emphasis really on was getting attachment through feeding, whether that was breastfeeding or by bottle. And just having—or at least my wife having had a baby both in Wales, recently, and prior to that in England, our impression at least, tentatively, was that the degree of expectation, encouragement, of breastfeeding—perhaps pressure, in some instances to breastfeed—we detected was somewhat less through our interactions with providers in Wales than we'd had in England previously. I just wonder: is that something you would accept in terms of the breastfeeding rates and the degree to which health providers emphasise and press women towards that option?

[223] **Lynne Neagle**: Before you come in, Hefin has a similar question, so, if you can ask it, then perhaps you can answer the two then.

[224] **Hefin David**: Yes, I've got that experience. I've, probably much like Mark, found this inquiry to be quite difficult from my own experience. My wife, I believe, had undiagnosed postnatal depression from the birth of our first child, so I'm speaking a lot from personal experience, which I'm trying to objectify as much as I can. That directly arose from what she perceived to be a failure to breastfeed. Mair Parry from the Royal College of Paediatrics and Child Health gave evidence to this committee in February, separate to this inquiry, and I said that mothers feel they fail when they can't breastfeed, and she said:

[225] 'if we as a society use the word "fail", it's only going to add to'

[226] the pressure.

[227] 'There are some babies, who, for some reason, cannot take to breastfeeding…and it needs to be absolutely accepted that that happens. But there needs to be support for the mother to be sure that she has reached the point where she decides that she's going to give up breastfeeding—that she's not failed, she's decided to give up breastfeeding.'

[228] That's very, very different to the experience I had, and, in fact, breastfeeding may be the trigger to postnatal depression. What I'd like to understand is: to what extent are clinicians using peer-reviewed research to identify the extent to which breastfeeding can lead to postnatal depression? I, from my own subjective experience, reject the view that was presented to the committee in February.

[229] **Lynne Neagle:** Okay. Some complex issues there.

[230] **Vaughan Gething:** I think Karen will want to come in on some of the points, but I'm not aware of any evidence that breastfeeding is a trigger for postnatal depression. I don't think it's as simple as that, but they will understand evidence. Look, we've had a conversation previously in this committee and in the health committee about breastfeeding, and I think it's an important subject that we talk about, and about how—. One of the things that I was struck about was the comments about 'breast is best' or 'breast is normal', because I guess there's a challenge about making sure that people don't feel that they have failed if breastfeeding doesn't work. We should still positively talk up the fact that it is entirely normal to breastfeed, and there's something about societal attitudes and the support of partners, as well—it isn't just a job for the health service to make sure that mothers breastfeed. Actually, it's about how you encourage and empower people to breastfeed, and public attitudes to that are really important as well. The attitude of a partner is really important to being supportive as well. We also need to reflect on the fact that breastfeeding rates in Wales are not as we'd want them to be. There's a lot of evidence about not just the health of the child, but the health of the mother as well, about successful breastfeeding. But actually not then saying it is all about the mother, and it's down to the mother to make sure that it works, and it's their failure. I think it's right to say that using the word 'failure' is a really unhelpful and pejorative word and—

11:00

[231] **Hefin David:** My point is that's how the mother feels.

[232] **Vaughan Gething:** I know, but there's the point about how it's then described in our public conversation, and also, in the person-to-person conversation about how people are supported to breastfeed. And, if it isn't working, how that's then described as well. I understand that, if somebody

believes, 'Well, I haven't been able to do this and I should have been able to', particularly if they've been built up to wanting to do it, I accept that that's a real feeling that people have, and I don't try and say that isn't true, because it plainly is for some people how they feel. And part of this is how we support people to get through that and say, 'Look, if it hasn't happened, then here's what we can do to give your child the best possible start in life, even if that isn't with breastfeeding.' I think there's a real challenge there in, on the one hand, wanting to encourage more people to take breastfeeding seriously and to actually try it and to be supported in doing it, and, on the other, there's how we support people where that hasn't worked out.

[233] **Hefin David**: What I'm struggling with is the 'university' bit of the university health board. Where is the research into the consequences of being unable, or choosing not, to breastfeed, if we want to use that language, and the consequences for the experiences of the new mother?

[234] **Vaughan Gething**: Well, I think there are two different things there, aren't there? There are people who want to be able to breastfeed, and, for whatever reason, it doesn't work out, and those who make a different choice not to breastfeed. I think part of our issue is, whilst we want to try and encourage people to breastfeed, about not being judgemental about people who make an active choice not to do that, because I don't think that's very helpful. I think it just puts more people off, and it gets us into a worse position than we should be. It's about encouraging more people to want to take up the opportunity and be supported, too, and then about what you do to support people, which I think is your real point—how do you support people and what's the evidence about supporting people where breastfeeding hasn't worked out.

[235] **Hefin David**: Yes. And what is that evidence?

[236] **Ms Jewell**: There is some research around people's choices in deciding to breastfeed or not to breastfeed. To my knowledge, there's no evidence around breastfeeding being a trigger for postnatal depression, but I think sometimes it's around women's expectations of lots of things in childbirth. Childbirth is a really important event in everybody's lives, and that may be whether you have a normal birth, whether you perhaps have analgesia during labour, or whether you breastfeed. So, there's a lot of different expectations that we put on ourselves that sometimes we feel ourselves that we've failed. And it's about the clinicians' support and the family support around that. So, clinicians, yes, and I'm pleased to hear that you had a very good experience.

Because it's about clinicians supporting the choices that the mother and the family are making, no matter what those choices are, so that we can enable as happy an experience of childbirth and parenting as we possibly can.

[237] **Lynne Neagle:** Hefin, we really do need to wrap up, so you have to be really brief.

[238] **Hefin David:** Well, I'm just trying to square these experiences of a crying mother who is unable to breastfeed, and desperate to do so, with the pressure that then comes from the midwife, who says, 'Yes, you can do it, you can do it, you can do it' to the point where I had to say, 'She must stop, because this is causing problems'. And I just don't think there's enough research done into that.

[239] **Lynne Neagle:** Maybe it would be possible for you to write to us with the information on the research and something about what steps are being taken to ensure that front-line professionals are properly trained to support women with whatever choice they have to make, if that would be okay.

[240] **Vaughan Gething:** Yes.

[241] **Hefin David:** There's a number, Chair, just to—. There's a number of Facebook groups and networks and discussions that focus on this specific area.

[242] **Lynne Neagle:** I know, but it's a big issue on its own, isn't it, really? Okay, well we have come to the end of our time. Thank you very much. It's flown by. Thank you very much.

[243] **Vaughan Gething:** I'm sure we'll meet again, Chair. [*Laughter.*]

[244] **Lynne Neagle:** Thank you for attending, Cabinet Secretary, and also to your officials for their attendance. It's been a very useful session. As usual, you will be sent a transcript to check for accuracy in due course. Thank you very much.

[245] **Vaughan Gething:** Thank you.

11:04

Papurau i'w Nodi
Papers to Note

[246] **Lynne Neagle:** Okay. Item 3 is papers to note. Paper to note 2 is the information we requested on the all-Wales perinatal mental health steering group, and paper to note 3 is a letter from myself to the Cabinet Secretary for Economy and Infrastructure on the Learner Travel (Wales) Measure 2008, following our discussion on the forward work programme.

Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o Weddill y Cyfarfod
Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Remainder of the Meeting

Cynnig:	*Motion:*
bod y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod yn unol â Rheol Sefydlog 17.42(ix).	*that the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order 17.42(ix).*

Cynigiwyd y cynnig.
Motion moved.

[247] **Lynne Neagle:** Item 4 then is a motion under Standing Order 17.42 to resolve to exclude the public for the remainder of this meeting. Are Members content? Thank you.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 11:04.
The public part of the meeting ended at 11:04.