Agenda – Children, Young People and Education Committee

Meeting Venue:
Committee Room 1 – Senedd
Meeting date: Wednesday, 28 June 2017
Meeting time: 09.30

For further information contact:
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Pre-meeting

(09.15 – 09.30)

1 Introductions, apologies, substitutions and declarations of interest

(09.30)

2 Inquiry into Perinatal Mental Health – Evidence session 4

(09.30 – 10.15) (Pages 1 – 32)

Royal College of Psychiatrists

Dr Sue Smith, Consultant Psychiatrist and Welsh Representative of the Perinatal Faculty of Royal College of Psychiatrists

3 Inquiry into Perinatal Mental Health – Evidence session 5

(10.15 – 10.45) (Pages 33 – 38)

Royal College of General Practitioners

Dr Jane Fenton-May

Break

(10.45 – 11.15)

4 Inquiry into Perinatal Mental Health - Evidence session 6

(11.15 - 12.10) (Pages 39 - 43)

Ian Wile, Director of Operations for Mental Health Clinical Board - Cardiff and Vale University Health Board
David Roberts - Service Director, Mental Health & Learning Disabilities - Abertawe Bro Morgannwg University Health Board
Anita-Louise Rees - Team Manager for Perinatal Mental Health Services - Abertawe Bro Morgannwg University Health Board

5 Inquiry into Perinatal Mental Health - Evidence session 7

(12.10 - 12.40) (Pages 44 - 48)

Welsh Health Specialised Services Committee

Carole Bell, Director of Nursing and Quality
Carl Shortland, Specialist Lead for Specialist Mental Health

6 Paper(s) to note

(12.40)

Letter from the Minister for Lifelong Learning and Welsh Language

(Page 49)

Letter from the Children's Commissioner for Wales to the First Minister

(Pages 50 - 52)

Letter from the Chair of the Finance Committee - Scrutiny of draft budget

(Pages 53 - 54)

Letter from the Minister for Lifelong Learning and Welsh Language

(Pages 55 - 60)

Agenda Item 2

Document is Restricted

The Children, Young People and Education Committee Inquiry into Perinatal Mental Health

The Royal College of Psychiatrists in Wales welcomes this opportunity to respond to the CYPE Committee's inquiry into perinatal mental health. In February, we responded to the First 1,000 Days inquiry and proposed that the Committee further explore the provision of perinatal mental health services. There have been significant improvements in recent years with the injection of funding for community perinatal mental health but more must be done to meet the needs of those with serious mental illness requiring specialist inpatient treatment.

The leading cause of maternal death is mental health related illness. Postpartum depression affects 10 to 15 out of 100 women having a baby. It is more prevalent in women who already have a mental illness, who have suffered with depression during pregnancy, or recently experienced a traumatic event such as bereavement. A smaller number (1 in every 1,000 women having a baby) will experience psychotic episodes, or postpartum psychosis, which is classed as a serious mental illness. Postpartum psychosis can happen to any woman, although the risk is higher in women with bipolar disorder or schizophrenia. The symptoms of the illness can change from hour to hour or day to day. Women who suffer with postpartum psychosis are often not able to look after themselves or look after their baby and require specialist help.

Key Points

- Community-based perinatal mental health has improved considerably after the Welsh Government agreed the recurrent funding of £1.5m in 2015. Specialist healthcare staff have been in place in community teams across Wales since 2016.
- However, there has always been a shortfall of perinatal mental health services in Wales so we are working from a very low baseline. More investment is needed to meet the needs of those requiring treatment, to improve the availability of training in perinatal mental health to health professionals, and to address the shortfalls in some areas across Wales.
- In 2013, the only Mother and Baby Unit in Wales was closed. There are no inpatient services for women who need admission with their babies so patients must either be treated on an adult psychiatric ward with no contact with their baby, or be treated out of area in England.
- Service provision for expectant mothers from some populations continue to receive below standard treatment. These include those with dual diagnosis or those with learning disabilities.
- Service redesign and delivery is coordinated by the Community of Practice, administered through Public Health Wales and a multidisciplinary steering group including mental health professionals, representatives from maternity and

obstetrics and the third sector. Although this is excellent it falls short of an adequately resourced "managed clinical network", currently being developed in England.

The Welsh Government's approach to perinatal mental health, with a specific focus on accountability and the funding of perinatal mental health services covering prevention, detection and management of perinatal mental health problems. This will include whether resources are used to the best effect.

1) The Welsh Government has developed a positive approach to perinatal mental health and is keen to improve existing services available to women before and after giving birth. It has provided significant recurrent funding to strengthen community perinatal mental health services across Wales and the College is pleased with these developments. Since the injection of money the provision of such services has improved considerably. New money promised for perinatal mental health reached clinical services far quicker in Wales than in England.
2) Wales is now a more attractive place to train and work for those interested in community perinatal mental health; this at a time when recruitment and retention is very low. We do have some way to go to understanding the specific needs of pregnant women with mental health needs and to gather a stronger evidence-base for detection and treatment. Across the border, the NHS England and Health Education England have commissioned the College to manage and deliver the *Building Capacity, Psychiatry Leadership in Perinatal Mental Health Services project*.[1] One of its aims is to expand the numbers of psychiatrists with perinatal training, to develop local specialist perinatal mental health services where these are currently lacking. This is to ensure that the Five Year Forward View can achieve the outcome of reaching over 30,000 women needing community and inpatient care can receive treatment closer to home.
3) There is a general lack of awareness among many health professionals and the public around the importance of treating maternal mental illness, particularly around the use of medication. There is a perceived risk to the baby if taking medication during pregnancy or whilst breastfeeding. There is growing evidence that the management of the risk of the mother's mental illness is crucial, not just to the mother but to the baby, who may be at risk of neglect, or may not bond with the mother. It is important to weigh the risk of taking medication versus not taking medication. Suicide is a significant cause of maternal death. We are only beginning to understand the trends, which means that evidence to provide suicide prevention in this group is scarce.[2] Many

[1] http://www.rcpsych.ac.uk/workinpsychiatry/faculties/perinatal/buildingcapacityinperinatal.aspx
[2] Khalifeh, H. et. al. (2016) *Suicide in perinatal and non-perinatal women in contact with psychiatric services*. The Lancet. vol. 3. pg. 233.

professionals do not feel equipped to detect or treat maternal mental illness therefore we would recommend that all relevant health professionals are given training in preventing, detecting and treating the risks in perinatal mental health.

4) There is further apprehension in the health service to treat expectant mothers who have learning disabilities or who are alcohol and drug dependent. This is perceived as added complexity and added risk which has led to a lack of awareness, reluctance, and even fear to treat such patients.

The pattern of inpatient care for mothers with severe mental illness who require admission to hospital across both specialist mother and baby units (designated mother and baby units in England) and other inpatient settings in Wales. (Since 2013, there has not been a mother and baby unit in Wales).

5) One of the most pressing issues in Wales is the lack of provision for inpatient services for women who need admission with their babies. These services have specialist knowledge of the risks and benefits of medication during pregnancy. They provide specialist treatment and management of women with serious mental illness and enable them to support the needs of their babies. The College recommends that "all women requiring admission to a mental health unit in late pregnancy or after delivery should be admitted with their infant to a specialised mother and baby unit, unless there are compelling reasons not to do so".[3]
6) This has become more of an issue with the development of community services and the increased identification and realisation of the need for women to be admitted with their babies if they need to be in hospital. Because we have no specialist beds available, if a woman needs admission with her baby we must look across the border into England. Bristol will not take Welsh women because they are not NHS England patients. The nearest options are Birmingham, Winchester or London. However these are often full with a waiting list so some patients have been sent as far as Derby and Nottingham. When there is a bed available closer to home, it is often the case that women and their families do not want them to travel such a distance and so they remain on the acute ward separated from their baby. This is clearly deleterious to both mother and baby; women take longer to get better and babies are denied close contact with their mum at this crucial stage.
7) The lack of specialist beds is costing the NHS in Wales in staff time and resources and it denies healthcare professionals the opportunity to gain valuable skills and experience in this specialised area. Trainees wishing to specialise in perinatal mental health will

[3] The Royal College of Psychiatrists in Wales (2015) *CR197 Perinatal Mental Health Services: Recommendations for the provision of services for childbearing women*. London: RCPsych.

choose to work elsewhere. Many hours, sometimes days, are spent looking for an available bed, which is a poor use of staff time and skills.

8) Fathers who wish to be close to their partners and new-born babies must pay for travel and accommodation. This can be expensive as some hospital admissions may last up to several weeks. Very often many patients will chose to stay on an adult psychiatric ward where they can be closer to their families even if this means that they are not getting the right treatment. We are seeing a number of women being admitted into adult psychiatric wards with no contact with their babies.

9) We urge the Welsh Government and the Welsh Health Specialists Services Committee to consider opening a centrally funded Mother and Baby Unit in Wales, which can provide services in the medium of Welsh. 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 for the women of Wales. There is work going on with WHSSC to look at this but this is likely to take some time. We would hope the Committee can consider ways in which this could be brought forward.

The level of specialist community perinatal mental health provision that exists in each Health Board in Wales and whether services meet national standards.

10) Prior to the injection of funding, the baseline of service provision differed widely between health boards. Cardiff and Vale UHB already had a community perinatal team and has been able to expand on this and now provides a service which meets the standards of the Quality Network of the Royal College of Psychiatrists. Abertawe Bro Morgannwg UHB already had a service in Bridgend which is now extended to the Swansea area. Other health boards around Wales have begun developing their services. Their aim is to be able to meet national standards and to be part of the Quality Network and we have learnt recently that ABUHB has received funding to take part in the programme. We have consultant psychiatrists with specific perinatal sessions in Cwm Taf, ABUHB, Hywel Dda, Cardiff and Vale and the Bridgend part of ABMU but are awaiting appointments in BCUHB, Swansea and Powys. In areas where provision is good, we regularly see patients during their subsequent pregnancies who wished that these services had been available in the past. However, there is still an unacceptable variation in provision, which has arisen from the way the funding was originally distributed.

The current clinical care pathway and whether current primary care services respond in a timely manner to meet the emotional well-being and mental health

needs? Of mothers, fathers and the wider family during pregnancy and the first year of a baby's life.

11) The current clinical care pathways do not meet all patients' needs in a timely manner, however there is work in progress to identify and address the specific issues. The Community of Practice, administered through Public Health Wales, is chaired by Professor Ian Jones and Dr Sue Smith. This is a multidisciplinary group including mental health professionals and representatives from maternity and obstetrics. Third sector representation is also much valued on this committee and issues such as education, training for health professionals and provision for preconception advice are discussed. There is much work to do but there is a clear commitment to developing a clinical care pathway that can meet the needs of families antenatally and reduce the likelihood of mental ill health postnatally.

Consideration of how well perinatal mental healthcare is integrated, covering antenatal education and preconception advice, training for health professionals, equitable and timely access to psychological help for mild to moderate depression and anxiety disorders, and access to third sector and bereavement support.

12) (See paras. 3 and 4) We note below that there are a number of health inequalities with regard to service provision, in particular those who are dual diagnosed. We are concerned that there is lack of consistent Public Health messages in relation to drugs and alcohol in pregnancy by the Department of Health, Public Health Wales, Welsh Government and academics. Dr Raman Sakhuja, Chair of the Substance Misuse Faculty in RCPsych in Wales says, "No amount of alcohol in pregnancy should be 'the' message but inconsistent messages are still heard at various levels of healthcare".

Whether services reflect the importance of supporting mothers to bond and develop healthy attachment with her baby during and after pregnancy, including breastfeeding support.

13) Social relationships in early life have crucial influence on the infant brain. Brain development is dependent on strong, early bonds with an infant's main caregiver – most often the mother. The interaction with the primary caregiver in the first year of life shapes the infant's social, emotional, cognitive and language development, facilitating development of good mental health through childhood and into adulthood.

14) Supporting mothers to bond and develop healthy attachment with her baby is therefore an important aspect of the provision of services, both generic antenatal and postnatal care and in mental health services and specialist perinatal mental health care. For

many women with mental health problems, treating the mental illness will allow them to develop a health attachment and bond with their babies. However, for some women more in depth work will be needed to address attachment issues specifically. Even where maternal mental ill health is effectively treated, additional work may be required to help strengthen the mother–infant relationship. Prompt treatment of mental ill health in pregnancy can bring about improvements for a child growing up, as well as help to develop a child's ability to manage stress in later life. A comprehensive service will enable women who need this specialist care to receive it no matter where they live in Wales. Local perinatal mental health networks should include professionals providing infant mental health services and those from CAMHS to help develop and share best practice in mother-infant interventions

The extent to which health inequalities can be addressed in developing future services.

15) **Substance Misuse:** This inquiry needs to look further into whether the needs of pregnant, dual diagnosed (addiction plus mental illness/disorder) women and their children are met during the perinatal period. There are many women seeking treatment for alcohol and opiate dependence syndrome who are pregnant who face many obstacles, including the diagnosis of addiction that hamper accessing appropriate services to assess and manage perinatal health and well-being.
16) In Cardiff, the community perinatal service has limited input with women with substance misuse issues who are already under the Community Addiction Unit (CAU). The CAU prioritises women with substance misuse who become pregnant and work with a specialist midwife. The community perinatal team in Aneurin Bevan also relies on a specialist midwife who will be responsible for these patients.
17) This is the tip of the iceberg. Many women with dual diagnosis are not picked up by specialist teams for several reason, including the stigma attached around mental health and around substance misuse. Those who then fall pregnant may continue not to seek help so will be missed by the system altogether. We would argue that community perinatal mental health services need to work more closely with these patients and their families by integrating knowledge of substance misuse management within the Perinatal Teams and employing a liaison worker from specialist drug and alcohol services within the Perinatal Team.. We would also argue for a better early screening and identification process to detect substance and alcohol misuse. There is a much greater role of public health, primary care and all other primary prevention strategies along with education and awareness within the Community Midwifery and antenatal service providers.

18) **Intellectual Disabilities:** Expectant mothers with intellectual disability similarly face many barriers and their needs often are not met due to lack of expertise and resources. We would welcome the inclusion of the service for expectant mothers with intellectual disability and their families. It is important that their specific needs are met within generic services that have a better understanding for their vulnerabilities and management of risks. Unfortunately, people with ID continue to receive poor treatment from the NHS because of their disability.
19) **Teenage Pregnancy:** The risk of depression is higher for teenage mothers and for women living in poverty, experiencing domestic abuse, poor housing or homelessness. Perinatal mental health services should ensure that there are no barriers to access for childbearing women with other conditions who develop serious postpartum disorders. These include adolescent (teenage) mothers. In these circumstances perinatal mental health services should work closely with other colleagues and services, for example those in CAMHS, intellectual disabilities, eating disorders and Social Services, contributing to the patients' care as appropriate.
20) **Welsh Language provision:** It is important that Welsh language speakers are able to access services in Welsh if they so wish.

We are delighted to be providing oral evidence to the Committee in June. If you have any further questions in the meantime, please contact Manel Tippett, Policy Administrator at the College (manel.tippett@rcpsych.ac.uk.)

Dr Sue Smith
Consultant Psychiatrist and Welsh Representative of the Perinatal Faculty of RCPsych
May 2017

CYPE(5)-20-17 – Papur | Paper 2
Ymateb gan: Coleg Brenhinol yr Ymarferwyr Cyffredinol Cymru
Response from: Royal College of General Practitioners Wales

Royal College of General Practitioners
Coleg Brenhinol Meddygon Teulu

4 May 2017

Inquiry into Perinatal Mental Health

RCGP Wales represents GPs and doctors training to be GP across Wales. We welcome the opportunity to respond to the Children, Young People and Education Committee's consultation on Perinatal Mental Health.

Overall Recommendations:

a. Improve public awareness of PMH services
b. Improve communication between health professionals managing perinatal care
c. Improve education about PMH for health professionals
d. Enhance support for all women with mild to moderate PMH with CPN based in localities
e. Improve psychiatric provision for patients requiring specialist mental health service including mother and baby units.
f. Investing adequate resources into primary care including General Practice and other healthcare professionals.

1. General Practitioners are the only professionals, who manage patients and their families in a holistic cradle to grave fashion. GPs now often have limited input into the management of pregnant mothers, which is now mainly done by midwives with or without input from obstetricians and/or GPs. Potentially GPs would be in an important position to identify those patients, who may be at greater risk of Perinatal Mental Health (PMH) problems due to a prior mental health risk, bereavement or adverse childhood experience as highlighted in the recent Public Health Wales report (1). Unfortunately, GPs are often not even aware that their patient is pregnant until there are additional non-maternity concerns around the pregnant woman. Treatment is usually effective, so that GPs can offer women hope. PMI not only affects women but can also affect

fathers and partners, plus wider family and the development and future wellbeing of the child, but this is by no means inevitable.

2. There are current NICE (2), SIGN (3) guidelines, and NICE Quality Standards (4) covering identification and management of PMI. Many of the recommendations are based on evidence from other countries, specialist research or consensus and there is a paucity of good evidence directly relevant to UK general practice.

3. Many women are reluctant to disclose (PMI). However, if a woman does disclose problems this may be an indicator that there may be PMI. PMI is the commonest complication of pregnancy, affecting 15-20%. See table below(5). Post-natal depression is the most commonly recognised but the highest incidence is of adjustment disorders with stress affecting (6). Anxiety and depression may occur together. This is a time of intense life style change and there are expectations that young parents will welcome this change easily. Fathers, partners and other family members may also find the adaptions difficult and this may be enhanced if there are other co-morbid mental health or physical problems in the family as well as social stressors.

Rates of perinatal psychiatric disorder per thousand maternities

Postpartum psychosis	2/1000
Chronic serious mental illness	2/1000
Severe depressive illness	30/1000
Mild-moderate depressive illness and anxiety states	100-150/1000
Post-traumatic stress disorder	30/1000
Adjustment disorders and distress	150-300/100

JCC-MH: Guidance for commissioners of perinatal mental health services. RCPsych 2012 (5)

4. Perinatal psychiatric disorder has been a leading cause of maternal mortality for the last two decades contributing to 15% of all maternal deaths in pregnancy and the first six months postpartum (6). Over half of women who tragically die during this time have a previous history of severe mental illness and over half of the deaths are caused by suicide.

5. Postnatal depression, anxiety and psychosis together carry an estimated total long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK (7). Nearly three-quarters (72%) of this cost relates to adverse impacts on the child rather than the mother. Over a fifth of total costs (£1.7 billion) are borne by the public sector, with the bulk of these falling on the NHS and social services (£1.2 billion). The average cost to society of one case of perinatal depression is around £74,000, of which £23,000 relates to the mother and £51,000 relates to impacts on the child.

6. Mental illness is as common during pregnancy as following birth (8, 9) and covers the same range of psychiatric conditions and severity as after birth. The risk factors for antenatal depression are broadly social vulnerability, childhood abuse, domestic abuse and a previous history of depression (1,10). The impact of poor mental health can be greater at this time, particularly if left untreated because of the impact on the cognitive, emotional, social, educational, behavioural and physical development of infants. Disturbances in the infants are not inevitable; they are increased from 5 to 10%. When disorders occur in the absence of social adversity and if they are of short duration, the risks to the child are generally low, and despite adversity many children in such situations develop normally and remain healthy (11).

7. Risk factors for postnatal depression are antenatal depression or previous depression (10). Bereavement by miscarriage, stillbirth or neonatal death are also more likely to lead to mental health problems in both parents (12). Bipolar disorder is significantly associated with postnatal psychosis, although 50% of women who develop postnatal psychosis have no history of previous mental illness (13). In most of Wales there has been a move away for GP referral to midwifery services or even joint maternity care with a move to self-referral, which limits the history following the patient.

8. There are a range of effective interventions for mothers affected by PMI (2,3), so potentially if involved GPs can offer women hope about recovery. Many women receive sub optimum treatment (14) and there are no specialist Perinatal Mental Health Units in Wales to care those needing specialists perinatal psychiatric care. In some areas Local Health Boards, have commissioned Clinical Psychiatric nurses (CPN), who can receive referral from community health professionals but may be limited to only patients who are allocated to flying start health visitors. This is in line the Mental Health Delivery Plan (15) and is welcomed but not universal as yet.

9. Following delivery, the care of the patient and baby (if live born) is in the care of first the midwife and then the health visitor. These health professionals may only have limit awareness and understanding of managing mental health problems. Health Visitors visit from 10 days. Although there are reporting mechanisms between midwives, health visitors and GPs, these are often not robust and may not always highlight the concerns of one group to another. The linking of health visitors and midwifes to GPs makes this more robust. In some areas, different teams may deal with a GP practices' patients from geographic or team reasons making this hand over more difficult, e.g. generic and flying start health visitors may have little communication despite having patients on opposite sides of the road. Only one team may attend the GP surgery for baby clinics so concerns about the other's patients are not highlighted to the GP. This leads to inequalities in care based on post code rather than need.

10. GPs may have limited contact with the mother following delivery. When maternity services where shared with GPs visited mothers and babies after delivery and did a post-natal maternal check at 6 week, but these are no

longer part of routine management. A lost chance to highlight potential problems and lack of wellbeing. Removing this element of care has also meant GPs have less experience in this area. These services have been lost due to time constraints and workload issues affecting general practice. This is compounded by as the paucity of services to support patients if identified. The Primary Care Mental Health Support Service can act to sign post patients to services to help mild anxiety and depression, but waiting times are often long and sessions may be difficult to access for a mother with a baby and other young children.

11. Further barriers to disclosure come from public poor awareness of perinatal mental illness particularly among women, their partners and families. There is also considerable stigma and a fear among women that their baby might be taken away if they admit their difficulties. This is enhanced by the lack of mother and baby units for admission of severe mental and physical conditions. In addition women may also feel dismissed or overly reassured when discussing their problems with health professionals. This could be helped by improving public awareness and professional education.

12. For those mothers experiencing impairment of their relationship with their infant, there is also promising evidence that interventions promoting parent/infant relationships can generate improvements in the quality of attachment (2,3,7). In a meta-analysis of adult patients with depression in primary care 47.3% were identified correctly as depressed, although there were more false positive diagnoses than missed diagnoses (16). There is no UK study of the detection of perinatal depression by GPs, but it is probably similar.

13. The reasons that these illnesses are poorly recognised and treated are complex and include maternal and GP factors. One qualitative paper, conducted in areas of the country where there was poor access to specialist perinatal services, suggested that women with postnatal depression had made a conscious decision about whether or not to disclose their feelings to their GP or health visitor (17). In this paper GPs described a reluctance to label women with a diagnosis of postnatal depression, as they had few personal resources to manage women with postnatal depression themselves, and no specialist perinatal services to refer to for further treatment.

14. Where specialist medical services have been available in the past they have proved beneficial to both patients their families and health professionals especially GPs. The unit in Cardiff prior to closure had outreach services to monitor patients once they went home and offer support. In patient units if close to family improve family involvement and support enabling the transition home to be easier for all.

Acknowledgement: This document takes into account work done by Dr Judy Shakespeare, the RCGP Clinical Champion in Perinatal Mental Health.

References

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National Assembly for Wales' Children, Young People and Education Committee Inquiry in to Perinatal Mental Health and Well being:

The ABMU Perinatal Response and Management Service current provision (April 2017)

The Welsh Government's approach to perinatal mental health, with a specific focus on accountability and the funding of perinatal mental health services covering prevention, detection and management of perinatal mental health problems. This will include whether resources are used to the best effect

PRAMS currently have an ABMU Perinatal Mental Health Stakeholder Development Group which meets quarterly, chaired by PRAMS, with representation from Maternity Service, Health Visiting Service, Psychological therapies and Mental Health. The is a review of membership with a view to including Service User representation, Primary Care (GP) and 3rd sector involvement.

ABMU PRAMS are represented at the All Wales Perinatal Mental Health Steering Group, from both a mental health and Maternity perspective. ABMU have directly requested, via the steering group, that a nationally agreed data set be finalised, the discussion remains ongoing.

There is ongoing work nationally to establish an agreed clinical care pathway of best practice for meeting Perintial mental health Needs and ABMU PRAMS are involved with this work which is being led by Andrea Gray, Mental Health Development Lead for Public Health Wales.

Prior to January 2017 PRAMS had no robust data collection methods or reporting processes in place, the Service is currently working to establish a regular data set in order to report clinical activity within the health board, this will also be reported within the local Stakeholder steering group and fed in to the All Wales National Steering Group. Reporting will include qualitative information from service users regarding their experience during the Perinatal period as well as data around activity.

Maternity lead for Perinatal Mental health and the ABMU PRAMS service manager meet regularly to enhance cross department links and to share themes arising from service user and clinician experiences/feedback, with the aim to directly inform and improve clinical practice and the experience of women and their families during the Perinatal period.

PRAMS are currently strengthening the process for gaining service user/family feedback to inform service development and quality. This month we have adopted the Wales Friends and Family Test as a means of offering women and families opportunities to provide their feedback online and feed into organisational governance structures. We are currently in the process of developing a bespoke service user questionnaire to enable women and families to have an

opportunity to shape the development and delivery of services through their detailed experience and feedback.

0.4 WTE Consultant Psychiatrist 0.2 WTE Band 8a Psychologist 1 WTE Band 7 Team Leader 1.4 WTE Band 6 Community Psychiatric Nurse 1 WTE Band 6 Occupational Therapist 0.8 WTE Band 3 Administrator	£236,422

Perinatal Response and Management Service (PRAMS)

The data below relates to the number of referrals to Bridgend Perinatal Response and Management Service (PRAMS) from April 2013 to March 2016

Referrals	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Average per Month
2013/14	19	28	33	23	21	21	41	40	29	45	43	57	400	33
2014/15	40	45	41	51	33	42	39	36	41	34	45	43	490	41
2015/16	30	27	51	39	41	41	41	45	35	42	42	52	486	41
Total	**89**	**100**	**125**	**113**	**95**	**104**	**121**	**121**	**105**	**121**	**130**	**152**	**1376**	

The Bridgend Service received an average amount of 38 referrals per month, or 459 referrals per annum.

Until the recent allocation of WG monies to improve perinatal services there was not a dedicated team in either Neath Port Talbot or Swansea. Women with perinatal issues were cared for by generic mental health services.

The new teams, established during 2016/17, have been added to our patient information system and data has been recorded from the 28th of January 2017.

The referral data below relates to Bridgend, Neath Port Talbot and Swansea. From February 2017, the average monthly referral has increased to 56, equating to an average of 672 referrals per annum.

Referrals	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Average per Month
2016/17	54	35	33	62	49	42	37	49	40	28	64	49	542	60
2017/18	42	69											111	56
Total	**143**	**135**	**158**	**175**	**144**	**146**	**158**	**121**	**105**	**121**	**130**	**152**	**1688**	

The pattern of inpatient care for mothers with severe mental illness who require admission to hospital across both specialist mother and baby units (designated mother and baby units in England) and other inpatient settings in Wales. (Since 2013, there has not been a mother and baby unit in Wales).

ABMU health board has approximately 6000 live births per year. Until January 2017 there was an inequality of Perinatal Specialist mental health service provision across the ABMU Health

Board locality. This included the Perinatal Response and Management Service (PRAMS) providing dedicated specialist Mental Health Assessment and Treatment for women presenting with Perinatal Mental illness within the Bridgend locality, however for women presenting with perinatal Mental illness in the Swansea and Neath Port Talbot locality, assessment and treatment was accessed via generic Mental Health services in line with existing generic eligibility criteria (with some informal links and ad-hoc consultation provided to Secondary Care/CMHTS in the Neath Port Talbot locality by the PRAMS consultant psychiatrist).

Following WAG ring-fenced perinatal mental health funding in 2016 a dedicated service is currently being rolled out across Neath Port Talbot and Swansea, with the remit to establish an equitable and high quality dedicated Perinatal Mental Health Service across the Health Board area.

Prior to the roll out of dedicated perinatal mental health services there was no robust data collected from within mental health services across ABMU re: the pattern/number of women being admitted to psychiatric hospital **specifically during the perinatal period** presenting with a severe mental illness.

Between January 2016 and January 2017 the ABMU perinatal service (Bridgend) received approximately 544 referrals.

Since January 2017 recorded **3** acute admissions to psychiatric hospital for women presenting with severe mental illness (x2 postnatal depression and x1 acute relapse of existing psychotic illness) during the perinatal period. None of these admissions resulted in transfer to mother and baby specialist unit. The available Recorded data reflects that since April 2013 there has been only one admission to a mother and baby unit (England), it is highly likely that there have been other admissions to acute in patient units in wales linked to perinatal metal illness in recent years however the data is not centrally available for this. Work currently ongoing to establish more robust data collection process – with the aim being that perinatal MH service is notified of all admissions for women within the perinatal period and the reason for admission to collate data and identify patterns.

The level of specialist community perinatal mental health provision that exists in each Health Board in Wales and whether services meet national standards.

ABMU Perinatal Response and Management Service – Provides pre-conception advice, professional advice and consultation, facilitating multi-agency birth planning for women with existing mental illness/history of serious perinatal illness, specialist mental health assessment, Perinatal mental health and well-being focussed interventions (including specialist Occupational Therapy intervention, psychologically based interventions and group interventions) and sign posting to appropriate services (Statutory and/or 3rd sector) where appropriate.

Current skill mix (PRAMS):

1 WTE Band 7 Team Manager

1 WTE band 7 Occupational Therapist

1 WTE Band 6 Occupational Therapist

2.4 WTE Band 6 Mental Health Nurses

0.2 band 8a Clinical Psychologist

0.6 WTE consultant psychiatrist (split allocation of 0.2 WTE for Bridgend locality and 0.4 WTE for Swansea/Neath Port Talbot, the health board is currently in process of recruitment for 0.4 wte consultant psychiatrist for Swansea/NPT locality)

1.8 WTE band 3 administrator

Maternity Services:

1 WTE Band 7 Public Health Midwife with a lead role for Perinatal mental Health

Since the allocation of WAG monies for the development of perinatal services, work has been undertaken to roll out the dedicated perinatal mental health service across Swansea and Neath Port Talbot localities, which went live in January 2017.

The current clinical care pathway and whether current primary care services respond in a timely manner to meet the emotional well-being and mental health needs? Of mothers, fathers and the wider family during pregnancy and the first year of a baby's life.

All women are risk assessed at their initial assessment with the midwife and those women identified with a risk of Perinatal mental health illness are offered a referral to the Perinatal services. The developing operational policy and clinical care pathway includes local service level agreement that assessment of women presenting to generic mental health services (including LPMHSS) during the perinatal period will be prioritised. Within ABMU women presenting to perinatal mental health service reporting mild to moderate symptoms of mental illness will access formal specialist assessment within 28 days, local mental health pathway enables women to access emergency assessment of acute mental illness or acute onset of significant risk within same or next working day through psychiatric liaison and crisis home treatment services.

Consideration of how well perinatal mental healthcare is integrated, covering antenatal education and preconception advice, training for health professionals, equitable and timely access to psychological help for mild to moderate depression and anxiety disorders, and access to third sector and bereavement support.

Providing support during pregnancy and assisting women with making choices in relation to their care and birth is given by the maternity services. This can assist women experiencing anxiety during pregnancy. Women experiencing antenatal anxiety disorders which require specialist input can be referred to the Perinatal services.

The ABMU Perinatal mental health service offers an advice and consultation service for any professionals working with families experiencing difficulties linked to poor mental health and well-being.

PRAMS currently run an email advice and consultation service for GP's/psychiatrists/obstetricians/midwives to enable them timely access to best practice guidance in the prescribing and monitoring of psychiatric medication to pregnant /breastfeeding women.

Established local care pathway and the supporting departmental operational policies developed in collaboration between maternity, health visiting and mental health services.

Collaborative multi agency local steering group established to consult on operational arrangements. Currently reviewing membership to include GP's and service user representation during 2017.

Collaborative training events and information sessions undertaken between midwifery/health visiting colleagues and PRAMS to support the development of knowledge and skills in the early identification of women/families with increased risk factors for poor early attachment and wellbeing.

PRAMS offers preconception advice for women diagnosed with a significant mental illness. This advice can be accessed by professionals involved in the existing care team or women can be referred directly to PRAMS for face-to-face preconception advice with a PRAMS clinician.

Women presenting with PTSD relating to recent birth trauma are able to gain timely access to specialist assessment and when indicated commence EMDR therapy with the PRAMS clinical psychologist within 3 months of referral. Maternity services provide clinical input when required to discuss the birthing experience, using the maternity records to clarify any of the events. In some cases the Perinatal team will attend as a support for the woman.

Whether services reflect the importance of supporting mothers to bond and develop healthy attachment with her baby during and after pregnancy, including breastfeeding support.

PRAMS and local maternity and health visiting services work collaboratively to support women in developing early positive attachment to unborn babies through antenatal and postnatal care, delivering psychoeducation and adopting principles of encouraging positive early attachment into all interactions with families.

50% of women invited to attend PRAMS post-natal depression treatment group during January and February 2017 were unable to attend as they were unable to find suitable child care/leave babies due to breastfeeding and/or lack of transport. There is currently no funding within the PRAMS budget for access to suitable childcare or nursery nurses, however in collaboration with health visiting services/flying start and maternity services we have been able to identify suitable venues within some of the areas of highest prevalence of need and are preparing to pilot a post-natal depression treatment group which will enable mothers to attend with their babies and support mothers who maybe breastfeeding their babies and enable a focus on bonding and attachment to be included into the intervention group in an effort to improve access to treatment and wellbeing outcomes for mothers and babies.

The extent to which health inequalities can be addressed in developing future services.

Currently the initial phase of service development is focussed on implementing an equitable operational service across the ABMU locality

The service plans to be able to increase the therapeutic options accessible to women and their babies across the ABMU locality over the next 12 months as the specialist perinatal metal health service new work force develop the appropriate skills, training and experience.

Paper from the Welsh Health Specialised Services Committee (WHSSC)

1. BACKGROUND

1.1 In 2009 there was consultation on specialised services for Wales, which recommended improvements on how the NHS in Wales planned and secured specialised services. Following this consultation, in 2010 the seven Local Health Boards in Wales established WHSSC to ensure that the population of Wales has fair and equitable access to the full range of specialised services. In establishing WHSSC to work on their behalf, the seven Local Health Boards recognised that the most efficient and effective way of planning these services was to work together to reduce duplication and ensure consistency.

1.2 Accordingly, WHSSC is a joint committee of each Local Health Board in Wales. It was established under the Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35). The Joint Committee was a new arrangement and, brings Local Health Boards in Wales together to plan specialised services for the population of Wales. This is a fundamental change in the way these services are planned and has required the creation of new systems and processes to reflect these new arrangements. These have included completely new corporate and financial reporting arrangements. WHSSC is a “hosted body” and at the moment it is hosted by Cwm Taf University Health Board.

1.3 WHSSC plans, secures and monitors the quality of a range of specialised services. The specialised services include mental health services, which itself includes specialist perinatal beds.

1.4 In terms of budget, every year WHSSC receives money from the LHBs to pay for the specialised healthcare for everyone who lives in Wales and is entitled to NHS care. The Chief Executives of those health bodies are members of the Joint Committee who meet and decide how much of their annual budgets will be allocated to WHSSC. The Joint Committee is chaired by an Independent Chair who is appointed by the Cabinet Secretary for Health, Wellbeing and Sport. The amount of money which is allocated is based on the previous year’s budget and what demands

were made during a particular year for a particular type of specialised service through an agreed Integrated Medium Term Plan (IMTP).

2. PERINATAL SERVICES

2.1 Current Commissioning Arrangements

2.1.1 There is currently no mother and baby unit provision in Wales following the closure of the service in Cardiff in 2013. The closure was due to a combination of staffing/resource issues and low demand. WHSSC therefore commissions and funds inpatient care at mother and baby units in out of area beds in England. All placements are funded on a cost per case basis from English providers designated to provide such services. Placements are subject to bed availability and clinical acceptance of patient referral. If a Welsh patient is placed in a mother and baby unit, that placement will be funded by WHSSC at an agreed daily bed rate until the patient is discharged. If a person with perinatal mental health issues requires an adult MH inpatient bed or community services, the individual health board responsible for that individual will commission and fund that type of care.

2.1.2 If a Health Board wishes WHSSC to commission a mother and baby placement, it will ask the responsible clinician to undertake an assessment on behalf of WHSSC and present it with a clinical opinion that indicates the type and level of service that is required. The responsible clinician will identify a suitable placement and confirm costs as part of completing an Individual Patient Funding Request (IPFR). WHSSC will confirm funding on receipt of the fully completed IPFR form.

2.2 National Picture

2.2.1 NHS England has recently announced a committed to a phased, five-year transformation programme, backed by £365m in funding, to build capacity and capability in specialist perinatal mental health services. This will include plans to:

- Increase Mother and Baby Unit (MBU) provision including development of new MBUs in areas with significant access issues and increasing capacity in existing units, as needed.

- Strategic collaborative commissioning models including the development and implementation of new commissioning models so that inpatient MBUs serve the needs of large populations and are closely integrated with specialised community perinatal mental health teams.

2.2.3 The map on page 4 shows the number of mother and baby units across England & Scotland.

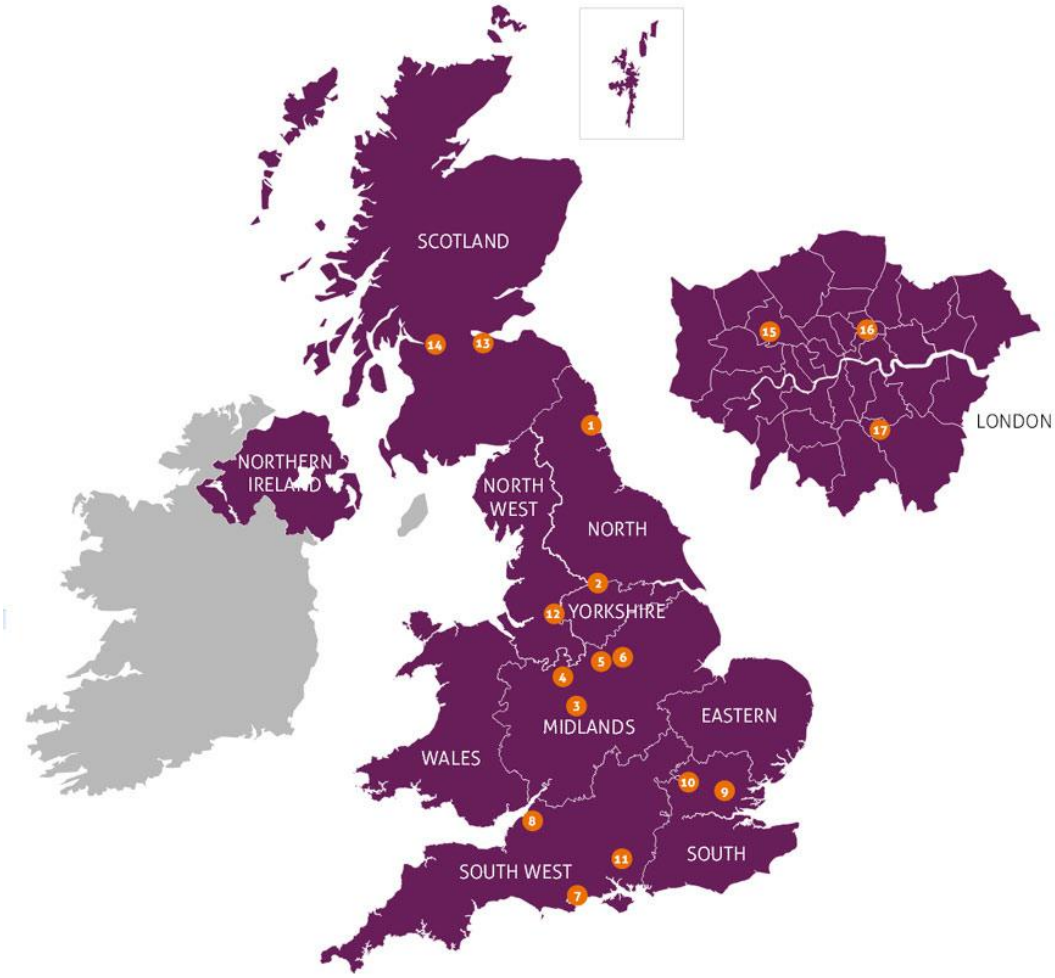
2.3 Number and Costs of Inpatient Placements

2.3.1 The number and costs of inpatient placements in mother and baby units commissioned by WHSSC for the last 3 years are shown in the table 1.

2.3.2 Please note that WHSSC will not provide specific details where the figure is for fewer than 5 patients. It is considered there is the potential for the individuals to be identified from the information provided when considered with other information that may also be in the public domain.

Placements outside Wales	2014-15	2015-16	2016-17
Number of funding requests for placements at mother and baby units	6	7	13
Number of inpatient placements at mother and baby units	Less than 5	Less than 5	6
Cost of inpatient placements at mother and baby units	£321,000	£150,000	£327,000

Table 1



2.3.3 The costs of placements range from £670/day to £850/day. What is unclear is the number of women accessing inpatient adult psychiatric services from their local Health Board or being treated in the community as an alternative to being referred to a specialist inpatient bed. This is despite the National Institute for Health and care Excellence (NICE) Clinical Guidance CG192 point 1.10 which states

> Women who need inpatient care for a mental health problem within 12 months of childbirth should normally be admitted to a specialist mother and baby unit, unless there are specific reasons for not doing so.
>
> [2007]

2.3.4 This may be for a number of reasons one being patient choice due to the non availability of beds in Wales and the impact that has on the family as well as the current capacity issues described previously.

2.3.5 A piece of work is currently being undertaken by a Tier 4 Perinatal Mental Health Services task and finish group of the All Wales Perinatal Steering Group (AWPMHSG). This is chaired by the Director of Nursing at WHSSC.

2.3.6 A number of service visits have been undertaken to support the work and a multi-professional stakeholder workshop has developed a shortlist of models which will be presented to the All Wales Perinatal Steering Group (AWPMHSG) on the 25th May. A final report will be presented to the CAMHS /ED Network on the June 23rd, 2017 and the recommendations from the work will be considered in an update to the Joint Committee of WHSSC on the June 27th, 2017.

2.3.7 The following third sector organisations have been involved in the work:

- Action on Postpartum Psychosis (APP)
  Perinatal Mental Health (PMH) Cymru
  NSPCC
- Mind Cymru is also a member of the AWPMHSG.

Alun Davies AC/AM
Gweinidog y Gymraeg a Dysgu Gydol Oes
Minister for Lifelong Learning and Welsh Language

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: MA-L/ARD/0378/17

Lynne Neagle AM
Chair of the Children, Young People and Education Committee
Ty Hywel
National Assembly for Wales
Cardiff
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7 June 2017

Dear Lynne,

Thank you for the Children, Young People and Education Committee's report on the Additional Learning Needs and Education Tribunal (Wales) Bill.

I am grateful to the Committee for the comprehensive and inclusive approach it has taken to its Stage 1 consideration of the Bill.

There is clearly a great deal to consider in the Committee's report, which I hope we can use to strengthen the Bill and Transformation Programme. What is encouraging, and came across clearly from the evidence presented to the Committee, is that the fundamentals of the system outlined in the Bill are just about right. I look forward to continuing to work with the Committee to ensure the system we prescribe delivers the improvements in the expectations, experiences and outcomes of children and young people with additional learning needs that we are striving for.

Once I have considered the report in detail, I will write to you again outlining my response to each of its recommendations.

Yours sincerely

Alun Davies AC/AM
Gweinidog y Gymraeg a Dysgu Gydol Oes
Minister for Lifelong Learning and Welsh Language

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Comisiynydd Plant Cymru
Children's Commissioner for Wales
Sally Holland

First Minister
Rt. Hon. Carwyn Jones AM
Welsh Government
Cathays Park
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CF10 3NQ

7 June 2017

Dear Carwyn

Thank you for replying to my letter of 31st of March in some detail. It seems that while we share the same desire to improve the experiences and outcomes for children with additional learning needs, we differ on some aspects of how to go about this. I agree with you that many aspects of the Bill as it is currently drafted fit with articles of the UNCRC, but I feel strongly that it would be a missed opportunity for Wales if a stronger duty on those exercising duties under the Bill was not included.

I am convinced that a legal duty will consistently promote and underpin the cultural change and innovative practice that is required to secure improved outcomes for children, explicitly setting the Bill within a coherent, politically neutral and internationally agreed set of values.

I met with your officials, Emma Williams and Ruth Conway, from the ALN Bill team last week for a constructive discussion about the potential benefits and risks of strengthening Wales' implementation of the UNCRC through this vitally important Bill. We have agreed to continue to work together to find ways forward on this issue, and we will be providing the team with a technical briefing on the legal implications of the Due Regard duty and service providers.

Whilst detailed discussion about the Bill and code of Practice will continue between my team and both the Welsh Government legislative team and the Assembly's Children, Young People and Education Committee, I do wish to briefly respond to some of the concerns you raised in your letter about placing a Due Regard duty on service providers, as this is an issue that is likely to apply to a number of pieces of new legislation in the future. I also have a statutory obligation to comment, and on occasions review, how government treats children and respects their rights.

For clarity, I have picked out the four key concerns that you raised in your letter and provide my brief response to these. I discussed these in more detail with the legislation team during our recent meeting.

1. **The Convention is not targeted at frontline providers of services**

While the State and devolved government is responsible for taking legislative and administrative measures to fulfil its obligations, very many children's rights are fulfilled or denied through children's direct experiences with frontline providers. The government needs to ensure that frontline services are being delivered by institutions and practitioners who understand and are committed to advancing children's rights. The most effective way of doing this is by placing a duty on service providers to pay due regard to children's rights under the UNCRC in their policies and practice.

Croesawn ohebiaeth yn y Gymraeg yn ogystal â'r Saesneg ac mewn amryw o fformatau/We welcome correspondence in the medium of Welsh and English as well as alternative formats.

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2. **It will not lead to improved outcomes**

In my work and publications, I am aware of many examples where schools state that incorporating a children's rights approach has led to clear improvements in their pupils' experiences and outcomes. This includes children disclosing that they are not safe at home or in the community after discussing their right to be safe in school, increased confidence among children with additional learning needs who understand that they are rights-bearers, and improved attendance and reduction in fixed term exclusions when children have been involved in policy-making.

Unfortunately not all schools take this approach and by incorporating it as a duty in primary legislation we will achieve a more universal implementation of a children's rights approach. My recent publication: *The Right Way: A Child Rights Approach for Education in Wales* provides practical help for schools on how to achieve this and highlights a number of case examples where such an approach is having a significant, positive impact on the lives of pupils in Wales.

3. **It will distract frontline practitioners from supporting learners by creating layers of red tape and bureaucracy.**

Under the ALN legislation, practitioners will be compiling IDPs with and for children. I have suggested to the Bill team that the guidance and paperwork is simply framed within a children's rights approach throughout. Therefore instead of creating an additional procedure, the assessment questions and analysis will be overtly linked to the UNCRC. This will give a principled coherence to the processes without adding to the paperwork, and make the purpose of the process more understandable to children and their parents. I would contend that rather than distracting practitioners it will help them and their partners in the process (other professionals, families and children) *focus* on the task using a shared language and set of values.

4. **It puts schools and colleges at risk of litigation. Protecting against this takes time and resources away from providing resources.**

As you state, the Bill already places a number of duties on governing bodies that may be challenged by a tribunal. I do not believe that the duty of due regard would add to this risk. As you note, many of the new provisions are related to children's rights. Therefore any challenge by children or their families on the grounds of Due Regard to the UNCRC may also be open to challenge through other duties in the Bill. Indeed I would contend that by explicitly following the principles of the UNCRC, governing bodies may be less liable to face challenge because hopefully they will have considered the most important rights of the child during the process of assessment and provision.

Whilst we await the formal evaluation of the implementation of the Social Services and Well-being (Wales) Act 2014, I am not aware of any reported increase in bureaucracy within social services, nor any increase in litigation as a result of the Due Regard duty included on the face of the Bill. Indeed as a social work educator when the Act was passed, I noted a clear difference in students' thinking and approaches to practice, and students were keen to consider how children's rights could be incorporated into their everyday work from the outset.

I am the first to acknowledge the Welsh Government's commitment, historically and currently, to children's rights. In Wales we have the advantage that this commitment enjoys cross-party support, as was evidenced by the recent backing of my call for a Due Regard duty in the ALN Bill by the Children, Young

People and Education Committee. This means that Wales has the opportunity to be, again, world-leading in its implementation of the UNCRC, with far more potential benefits than risks.

As your independent Children's Commissioner I am duty-bound to challenge where I feel that the Welsh Government is missing opportunities to take concrete steps forward in realising the potential of the UNCRC to improve children's experiences and outcomes. However, I do not wish to simply criticise from the side lines and continue to be committed to finding constructive, practicable solutions with Government and service providers. That is why I am committing much of my current resource to producing materials and support to public sector providers and policy makers in the areas of curriculum, social services and mental health to aid them to implement a Child Rights Approach throughout our public services that will drive long-term, positive change to current and future generations.

In keeping with our previous correspondence on this matter, I am copying in Lynne Neagle as chair of the aforementioned Committee, and relevant Ministers.

I look forward to continuing to work with Government and the public sector to improve children's experiences and outcomes.

Yours sincerely

Sally Holland
Children's Commissioner for Wales

cc Carl Sargeant AM, Cabinet Secretary for Communities and Children
Kirsty Williams AM, Cabinet Secretary for Education
Alun Davies AM, Minister for Lifelong Learning and Welsh Language
Lynne Neagle AM, Chair of the Children, Young People and Education Committee

Agenda Item 6.3

Children, Young People and Education Committee

15 June 2017

Dear Lynne Neagle AM

Scrutiny of the draft Budget

I am writing following the Business Committee's consideration of their draft report on changes to Standing Orders in relation to scrutiny of the draft Budget, prior to the Standing Order changes and the Budget Process Protocol being considered in Plenary next week.

The changes to the Budget process are the culmination of a piece of work started by the Finance Committee in the Fourth Assembly; the devolution of fiscal powers in the Wales Act 2014 have meant that the Assembly's scrutiny now has to consider not just Welsh Government spending plans, but how these plans will be financed, through taxation and borrowing.

The main changes which are being proposed are that the budget scrutiny becomes a two stage process, whereby the higher level information which would be scrutinised by the Finance Committee is published prior to the detail needed by the policy committees, and more time is allowed for scrutiny. Specifically, it is hoped this additional time will allow the policy committees to undertake more detailed scrutiny of the spending in your portfolios, and you will no longer be required to report to the Finance Committee, you are able to report in your own right should you so wish.

I have requested a discussion on these changes at the next Chairs' forum, to enable us to talk through the changes in more detail and we can consider how:

- the Committee scrutiny will work in practice,
- the Finance Committee can maintain an oversight role,
- we can work together to maximise public engagement,
- any training and development needs for committees can be met

Prior to consideration in Plenary the proposed changes to Standing Orders have been tabled, as has the revised protocol.

Should you have any queries on this please do not hesitate to let me know, and I look forward to discussing these changes further at the Chairs' Forum meeting on 12 July 2017.

Yours sincerely

Simon Thomas AM

Chair of the Finance Committee

Alun Davies AC/AM
Gweinidog y Gymraeg a Dysgu Gydol Oes
Minister for Lifelong Learning and Welsh Language

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref MAP/ARD/2000/17

Lynne Neagle AM
Chair of the Committee
Children, Young People & Education Committee

21 June 2017

Dear Lynne,

Thank you for your letter of 25 May regarding the Children, Young People and Education Committee's ongoing scrutiny of Youth Work in Wales following the publication of their report.

As you are already aware, I have committed to reviewing Extending Entitlement, the statutory direction and guidance for youth support services in Wales. My officials are currently working closely with Margaret Jervis MBE to develop a consultation document ready for the autumn. Margaret is currently busy meeting with a range of stakeholders to help shape this document. We plan to publish our new updated Extending Entitlement in summer 2018. Following the publication of Extending Entitlement my officials will begin the process of consulting on a new National Youth Work Strategy. Therefore a new National Youth Work Strategy will not be in place before the launch of the Extending Entitlement. A copy of the youth work strategy review and implementation action plan can be found below.

On 9 March, we awarded a contract to Glyndwr University to carry out a review of the impact of our National Youth Work Strategy. We expect to receive their final report in July. I want the findings of this report to support the review of Extending Entitlement and the development of the consultation document, I believe this is essential. I understand that stakeholders were able to respond to the review by attending a focus group or by responding to an online consultation that was open for 4 weeks.

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All stakeholders will have further opportunities to have their voices heard, when we formally consult on Extending Entitlement later this year and again on the new national Youth Work Strategy. I have attached a copy of our action plan for the review and implementation of the National Youth Work Strategy.

You have asked for an update on how many local authorities have undertaken sufficiency assessments and if I am satisfied that these have led to a comprehensive overview of the current provision available to young people. Local authorities are not currently required to undertake sufficiency assessments however this is being explored as part of the review of Extending Entitlement. Following the formal consultation of Extending Entitlement I will decide if we should take forward sufficiency assessments for youth work in Wales.

The Welsh Government provides core funding for statutory youth services through the Revenue Support Grant. This provides local authorities with the flexibility to best deploy the resources to meet their local needs and priorities, including their youth work provision. The new Extending Entitlement will provide local authorities with direction and guidance for youth support services, including youth work and therefore providing them with greater clarity.

We are currently in the process of externally reviewing our additional youth work grants, including the National Voluntary Youth Organisation (NVYO) grant, all evaluations are due to be completed this summer. It will be at this point I will consider our options and then announce my decision, which will include any changes to the NVYO grant. I am fully aware of timescales for current NVYO recipients, including the need to know of any future funding decisions by 31 December.

My officials have recently met with the Principal Youth Officers Group (PYOG) and the Council for Wales of Voluntary Youth Services (CWVYS), where they shared information relating to all current reviews taking place and how they all link. In July I will be meeting representatives from the Boys and Girls Clubs and Youth Cymru to hear about the benefits of the NVYO grant and the extra resources that it has enabled them to bring into in Wales, I will also be meeting with the PYOG.

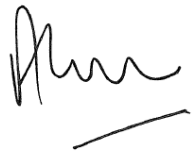
I'm sure you will agree that we are at a crucial point for youth work where we have the opportunity to take a step back and consider all our options relating to: funding, statutory guidance, sufficiency, the role of a new national board, a new youth work strategy and, how we support the youth work sector to work together. I can assure you that the Welsh Government is taking a strategic approach.

You have also asked what I mean by 'youth support' and how this relates to youth work. Extending Entitlement (2002) provides the direction and guidance to Local Authorities, relating to section 123 of the Learning and Skills Act (2000), for Youth Support Services. Youth Support Services is defined as services that will encourage, enable or assist young people aged 11 to 25 to participate effectively in education or training; take advantage of opportunities for employment; or participate effectively and responsibly in the life of their communities. Youth work contributes to Youth Support Services.

My officials are currently following our Public Appointments procedures to appoint the Chair for the new National Youth Support Service Board, once the Chair is in place we will then look to appoint the other board members. It is essential that we ensure the voices of young people are heard, I will therefore be exploring how we can work with the new Youth Parliament and Children in Wales.

I have also attached my update to the Committee relating to your recommendations.

Yours sincerely



Alun Davies AC/AM
Gweinidog y Gymraeg a Dysgu Gydol Oes
Minister for Lifelong Learning and Welsh Language

National Youth Work Strategy for Wales (2014-18)
review and implementation action plan

Issue invitation to quote for a review of the impact of the National Youth Work Strategy for Wales 2014-18	3 Feb 2017
Deadline for tenders	3 March 2017
Contract awarded	9 March 2017
Presentation to Youth Work Reference Group	23 June 2017
Final bilingual report and Executive Summary	Summer 2017
Report to feed into the draft Extending Entitlement consultation paper	Summer 2017
To note any comments relating to youth work from the Extending Entitlement consultation	Winter 2017
Work with the Youth Work Reference Group to begin to draft a new youth work strategy	Winter 2017 - Spring 2018
Formal consultation for a new Youth Work Strategy	Summer / Autumn 2018
Publish a new Youth Work Strategy	Spring 2019

Six month update to the Children, Young People and Education Committee report : What type of youth service does Wales want? Report of the inquiry into Youth Work

June 2017

Recommendation 4 was accepted in principle.

The Committee recommended that:

The Minister should introduce a national model for youth work, encompassing statutory and voluntary provision. The Minister should report to this Committee on progress within 6 months of the publication of this report.

Any consideration of a national model for youth work needs to be informed by the review of Extending Entitlement and the review of the National Youth Work Strategy.

The formal consultation for Extending Entitlement will take place in the autumn. Feedback from this consultation will inform the new Extending Entitlement direction and guidance which will be formally launched summer 2018.

A review of the existing National Youth Work Strategy is currently being carried our by Glyndwr University, this review will inform the Extending Entitlement consultation paper. A formal consultation process for a new National Youth Work Strategy will be carried out following the publication of Extending Entitlement. The Youth Work Reference Group will play a key role in the development of a new youth work strategy.

We have begun the process to establish an independently chaired, National Youth Support Service Board. The Board will be able to provide constructive challenge and scrutiny of the Welsh Government's policies and proposals for Youth Support Services, including youth work. The Chair and Board members will be subject to the Public Appointment process. I expect the Chair to be in place by the autumn. The Chair will then support me to appoint all other board members, who we will have in place by spring 2018.

Recommendations 5, 6 & 7 were accepted in Principle

The Committee recommended that:

5) The Minister should report back to the Committee within 6 months of the publication of this report on how he intends to assess the extent to which his commitment to universal, open access provision, in English and Welsh, is being delivered.

6) Within 6 months of the publication of this report, the Minister should commission an exercise to map voluntary youth work provision across Wales. The exercise should be refreshed periodically.

7) The Minister should ensure that youth work sufficiency assessments are undertaken by local authorities as part of their population needs assessments and report back to the Committee on progress within 6 months of the publication of this report.

My officials have begun to explore if sufficiency assessments might be a suitable vehicle and the best way forward to assist local authorities in mapping out and developing their local youth work offer. We plan to include the consideration of sufficiency assessments within the formal consultation of Extending Entitlement. This will ensure stakeholders have an opportunity to have their views heard.

I believe that sufficiency assessments may be able to provide a better understanding, at a local level, of what youth work provision within the statutory and voluntary sector looks like on the ground. I do not believe a national mapping approach is the best way forward. I am happy to report back to the Committee as this work continues to progress.