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

28/06/2017

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Others in attendance

Carole Bell	Cyfarwyddwr Nyrsio ac Ansawdd, Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru Director of Nursing and Quality, Welsh Health Specialised Services Committee
Dr Jane Fenton-May	Coleg Brenhinol yr Ymarferwyr Cyffredinol Royal College of General Practitioners
Anita-Louise Rees	Rheolwr Tîm Gwasanaethau Iechyd Meddwl Amenedigol, Bwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg Team Manager for Perinatal Mental Health Services, Abertawe Bro Morgannwg University Local Health Board
David Roberts	Cyfarwyddwr Gwasanaeth, Iechyd Meddwl ac Anableddau Dysgu, Bwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg Service Director, Mental Health and Learning Disabilities, Abertawe Bro Morgannwg University Local Health Board

Dr Sue Smith	Seiciatrydd Ymgynghorol a Chynrychiolydd Cyfadran Amenedigol Coleg Brenhinol y Seiciatryddion ar gyfer Cymru Consultant Psychiatrist and Welsh Representative of the Perinatal Faculty of Royal College of Psychiatrists
Carl Shortland	Arweinydd Arbenigol ar gyfer Iechyd Meddwl Arbenigol, Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru Specialist Lead for Specialist Mental Health, Welsh Health Specialised Services Committee
Ian Wile	Cyfarwyddwr Gweithrediadau Bwrdd Clinigol Iechyd Meddwl, Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro Director of Operations for Mental Health Clinical Board, Cardiff and Vale University Local Health Board

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

Sarah Bartlett	Dirprwy Glerc Deputy Clerk
Rebekah James	Y Gwasanaeth Ymchwil Research Service
Llinos Madeley	Clerc Clerk

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**: Morning, everyone. Can I welcome you all to this morning's meeting of the Children, Young People and Education Committee? We have received no apologies for absence. Can I ask whether there are any declarations of interest, please? No. Okay, thank you.

Ymchwiliad i Iechyd Meddwl Amenedigol: Sesiwn Dystiolaeth 4
Inquiry into Perinatal Mental Health: Evidence Session 4

[2] **Lynne Neagle:** Item 2 this morning is an evidence session on our inquiry into perinatal mental health, and I'm really pleased to welcome Dr Sue Smith to the committee this morning. Sue is a consultant psychiatrist and Welsh representative of the perinatal faculty of the Royal College of Psychiatrists. Thank you very much for coming this morning and thank you for the paper that you provided in advance. If you're happy, we'll go straight into questions.

[3] **Dr Smith:** Yes, that's fine, yes.

[4] **Lynne Neagle:** If I can just start by asking about funding. Your evidence points to the fact that recurrent funding was made available by Welsh Government to strengthen community perinatal mental health services, but you've alluded to a continuing unacceptable variation in services, but you've also, in your evidence, pointed to concerns about the way the funding was allocated in the first place. Can I ask you to expand on those two points?

[5] **Dr Smith:** I'm not sure about concerns. I mean, I think, first of all, to say it's very positive, because a couple of years ago, I wouldn't be talking about there being perinatal mental health services all over Wales. There were literally just some in Cardiff and some in Bridgend, so it was very welcome when the Welsh Government decided to give some money. What they did was, rather than give it on the basis of what services were where, they gave it on the basis of population and number of births. So, I suppose what I'm saying is we're all starting from different baselines. So, in Cardiff we already had a reasonable service—certainly not a fully comprehensive one, but a reasonable service. Bridgend had something. But we still had money to provide additionality, which was the key phrase, and so I suppose we're all starting from a different base, really, so—

[6] **Lynne Neagle:** So, it's the way the funding was allocated.

[7] **Dr Smith:** Yes, which is not really a criticism; it's just an acceptance that we had some services and I think it's good that we weren't disadvantaged with, 'Oh, you've already got something so we won't give you as much', because I think once you've got the services, it's actually much easier to then expand on that and to make arguments for why you then need

more. So, I think it's a really good start, but there's still a way to go, particularly in some of the health boards—some of the health boards.

[8] **Lynne Neagle:** And in terms of the continuing variations, can you tell us a bit about that?

[9] **Dr Smith:** Well, again, because it was starting from different baselines—some were starting from scratch, and so they had to look around for the best ways to actually use that money in their particular service. It's different depending on the amount of rurality, the number of births, obviously, and the way that existing services are configured, and how much input there is, perhaps, in primary care and voluntary services. So, there is that variation, but it is growing, and I think there needs to be a service there in the first place to then look at to say, 'Well, what else do we need in our particular area?' and it's going to be different in different places.

[10] **Lynne Neagle:** Okay, thank you. Hefin, question 2, and then you can do your questions.

[11] **Hefin David:** Question 3, I think—

[12] **Lynne Neagle:** Yes, and 2.

[13] **Hefin David:** Okay, yes. Your written evidence suggests there's more investment needed, and if there aren't sufficient resources to create and maintain an efficient and effective service, what more can be done to raise the standards?

[14] **Dr Smith:** Right. I think as soon as you develop a service, you realise what more you can then do, so I think there's always going to be a cry for more. And I think if you're looking at where the endpoint is, what the outcome is, I think—. I think you are going to ask me later about standards, and there are some standards from the Royal College of Psychiatry's quality network, and I think what we should be looking for is for all services to meet those—to meet the least basic ones. So, that's what we're looking for. As to how much that would need, it's very difficult to say, but yes, there is more.

[15] **Hefin David:** With your permission, Chair, I've got a very personal experience with some of this. My wife, who has given me permission to mention some of these things this morning, had issues with breastfeeding after our first child, and it was a very difficult time. One of the key things she

said—. And she's e-mailed me some of the things, some of her comments; she's shared this with friends and discussed these things with other parents. She said,

[16] 'There should be a way for family and friends to raise concerns about a mum's mental health. Only a significant time after my baby was born did my mum, husband and friend tell me that they felt that I may have had some mental health problems throughout the course of the pregnancy and afterwards.'

[17] So, the question would be the referral criteria for patients—there was no sign of my wife being referred. So, do you think the referral criteria are good enough, and do they catch those people, and support those people, who have what might be considered a lower threshold level of mental health issues?

[18] **Dr Smith:** That's certainly what we should be striving for, absolutely. And it's not an unusual story to hear that, perhaps, a woman hasn't presented with what turns out to be depression, which might have started either immediately postnatally or during pregnancy, until much later on. And that's certainly something that we are really trying to capture, which is why a lot of referrals to quite a few of the teams come from maternity services. So, it's about educating maternity services to pick up that, and to ask, sensitively, the questions that they're meant to, to pick up those. I mean, it's always going to be, because pregnancy is a time that's meant to be seen as a happy time, when women are blooming and happy, and postnatally, then often there's the reluctance to mention that they're not doing well. And the breastfeeding thing in particular, can I pick up on that—is that okay?

[19] **Hefin David:** Yes, sure.

[20] **Dr Smith:** I think, quite rightly, there's obviously a push for breastfeeding, to say that that's really best if you can do that. But I see a lot of women whose depression seems to have been triggered by not being able to breastfeed, and feeling that that makes them an absolute failure, and it's that key. So, I spend quite a bit of my time encouraging women in pregnancy that, 'Great if you can do it, but please don't beat yourself up if you can't', because that's not as uncommon as you think. There was actually an article in *The Times* magazine this weekend, from a lady who'd had a very similar experience to that, which I did cut out and share around with my colleagues. So I think that's a really sensitive one. So, I think, with the messages about

breastfeeding should also be mixed in somewhere that, if you can't do it, please don't worry about that, but I think because the official line is breastfeeding is best, that's a bit in conflict.

[21] **Hefin David:** Yes, and the 'Please don't worry about it' I don't think goes deep enough into the feelings that mothers might have. I'll give you just some of the things she said, for example, that the advice at times she received was so conflicting and confusing that it caused her significant stress, was most prevalent with her attempts to breastfeed. In her words:

[22] 'I found it difficult, and didn't have consistent advice. When my husband told the midwife that I was confused, upset, and in pain, there was no referral for support given. I stopped feeding a few days later, and this decision haunted me for months, as I felt I'd failed my baby. Only now do I understand that many mums struggle, and have the same feelings of guilt.'

[23] One of the issues she had was she never saw the same midwife more than two times—she had five different midwives. And she said,

[24] 'It's highly unlikely to disclose feelings of stress and depression to a stranger, despite them asking, "How's your mood?"'

[25] So, there's two issues there. First of all, the fact of those feelings of failure—very deep feelings—and then the fact that it's very difficult to tell, when you see different people, different health visitors, different midwives.

[26] **Dr Smith:** Yes, and I can only agree with you, and say that that's something that, in both our local service and in the wider college discussions, we are very aware of, and really try to tackle as much as we can, and try to encourage, and try to educate on as much as we can.

[27] **Hefin David:** Do you think there's a consistency of advice given?

[28] **Dr Smith:** No, there probably isn't. And, to a certain extent, I don't know how much you can do about that, because everyone has slightly different views. And it's very common, for instance, for me to see women postnatally who have had different advice. And we've got a couple of nursery nurses working in our team, who give lots of very good breastfeeding advice, and they are excellent at actually sometimes saying the same things that other people have said, but saying it in a way that comes over maybe as more—I don't know, I shouldn't use the word 'compassionate' because it

sounds like I'm saying that the health visitors aren't. I'm not saying that. But there's something different, because they're used to dealing with women who are struggling with it.

[29] **Hefin David:** And I feel, Chair—just one last question—that there's a gap between what is understood to be a mother's feeling of failure to breastfeed, and the official advice that says, 'Don't feel like a failure; it's that you're deciding not to,' when it's manifestly not what you're doing. You are feeling these feelings of failure, and they've kind of been brushed aside, saying, 'No, feel like you're choosing not to.' You can't tell someone how to feel, and there's no support for that.

[30] **Dr Smith:** Yes, I think that goes along with one of the groups that we run in our service, and I've seen represented in the college, and this is something that is standard throughout services as well. It's a therapy called acceptance and commitment therapy, which, instead of trying to encourage people to, 'Oh, feel okay about that', you're allowed to feel awful about something, actually, and that's okay, and you're bound to feel like that.

[31] **Hefin David:** I think that's really important.

[32] **Dr Smith:** Yes. And that is the rationale—that is very much what we try to do.

[33] **Hefin David:** Okay. Thank you.

[34] **Lynne Neagle:** And in terms of the referral criteria that Hefin asked about, what are the criteria for the specialist perinatal mental health service?

[35] **Dr Smith:** Right. I mean, strictly speaking, the general criteria are that it would be women who can't be managed in primary care, who have significant symptoms of mental illness that need a secondary service. What we're very aware of in the perinatal world is that that is lower than perhaps in community mental health teams, because we recognise that women may not be ill enough to actually be referred to a community mental health team, but because they are pregnant or postnatal at that time, it reaches that much more significance, and that also, seeing a woman who's pregnant at the moment—who's very well and very cheerful and seems very happy—if she's had a severe postnatal depression before, then that still needs to be part of the criteria. So, risk of, as well as actual symptoms at the time.

[36] **Hefin David**: You've got to be able to address continuity of care if you're going to be able to deal with those issues.

[37] **Dr Smith**: Yes. I suppose all I can say is that at the point of referral, when someone is taken on, that will happen, but it's very difficult to account for exactly all that happens before. All we can do is try to educate. We work closely with midwives in Cardiff and in all the other areas now there are specialist midwives working with the teams, who do provide that consistency. So, if I see women who've had postnatal depression previously, I will tap them into our midwife, so they will have that consistent approach. They've got smaller caseloads, more time to do home visits and prepare a birth management plan, which we do in the case of the more serious cases.

[38] **Hefin David**: But you recognise there's a lack of consistency up to that point.

[39] **Dr Smith**: Yes.

[40] **Lynne Neagle**: Oscar.

[41] **Mohammad Asghar**: Thank you very much, Chair.

[42] **Lynne Neagle**: On perinatal mental health services now, not the mother and baby unit.

[43] **Mohammad Asghar**: Yes, mental health. This is something very serious. There are certain areas, before the child is born and after the child is born, where mental health starts—depression is the beginning and then there are a lot of other factors: family, age, baby's gender. We've got different areas to tackle here. Does each Welsh health board have the capacity to provide for the needs of perinatal mental health patients?

[44] **Dr Smith**: I would probably say 'not yet'. Some have more so than others. But, the services are starting—it's only in the last couple of years that we've been able to say that every health board is starting to have a service. So, I would say that they're not at that stage yet, but we'd really hope to be working towards that. Obviously, extra investment and input to that would be most appreciated. I think we know where we're trying to go, but we're not there yet in all of Wales, definitely.

[45] **Mohammad Asghar**: We all know the mother's health is very, very

important for the child.

[46] **Dr Smith**: Absolutely.

[47] **Mohammad Asghar**: What would be the most effective way to improve mother and child care in Wales? Does each health board require a specialised mother and child care unit?

[48] **Lynne Neagle**: We're coming on to that now—.

[49] **Dr Smith**: Certainly, everywhere needs a community service, yes. I think we're coming on to the mother and baby unit itself.

[50] **Mohammad Asghar**: All right. Thank you.

[51] **Lynne Neagle**: Just before we move on to the mother and baby unit, are there any recruitment issues you'd like the committee to be aware of that impact on the provision of these services?

[52] **Dr Smith**: I don't actually think so. I mean, it's hard to be absolute for everywhere, but what I would say—I was thinking about this—is that the reason why we were able to set up services so rapidly following the money was because there were already loads of people waiting in the wings who had been desperate for ages to provide these services and who had been saying that this was needed. So, when the money came in, there was absolutely no shortage of enthusiastic people.

[53] **Lynne Neagle**: That's good.

[54] **Dr Smith**: Certainly, in Cardiff, we had no problems recruiting to all our posts. So, I'm not saying that as more posts are created there won't be a problem, but it seems to be an area that, once people get into it, they really stay. So, I think, even if recruitment's a bit of an issue, retention doesn't seem to be because people seem to want to stay.

[55] **Lynne Neagle**: Thank you. Okay, we'll move on now to the mother and baby unit. Julie.

[56] **Julie Morgan**: Thank you. There seems to be some confusion about the history of the mother and baby unit and why it was actually closed. Certainly, there were views that it was closed because of lack of demand and it was not

being used. But, in the evidence given to the committee, there's a strong feeling that there should be a mother and baby unit available. So, I wondered, from your position, whether you're able to tell us how you see what's happened with the mother and baby unit that used to exist in the University Hospital of Wales and what you see is the need.

09:45

[57] **Dr Smith:** Right. Okay. I'm trying to be careful about keeping my college hat on with this, but also because of my personal experience of having seen the closure and opening and then closure again of mother and baby units in Cardiff, I have seen the whole thing, so, I'm really in quite a good position to say why it closed. It wasn't through lack of interest; it wasn't through lack of admissions. There were times when we were empty or we had small numbers in. We only had three beds anyway. Arguably, three beds isn't enough to create that degree of specialisation and expertise, but, having said that, we looked after some women who said, 'Gosh, I don't know what I'd have done if we hadn't been able to come in here'. It's complex as to why it actually closed. It may come up again, because I'm coming for Cardiff and Vale as well, so it may come up a little bit more, but it wasn't through lack of need at all. It was probably underused, because of—. Originally it was commissioned by Bro Taf Health Authority and opened in January 2001. In 2003, Bro Taf Health—sorry, in March 2001, Bro Taf Health Authority ceased to exist and was taken over by Health Commission Wales and there was a bit of a—nobody was quite sure what then happened, because we were only commissioned to take women from the Bro Taf area, which was Merthyr, Pontypridd and Cardiff. Then Health Commission Wales, after a few years, decided it was an all-Wales service. So, it was never funded properly as an all-Wales service, and I think in other areas of Wales there was a feeling that, 'Well, we can't refer to Cardiff because they don't take', even after it was made clear that they did. So, that was one of the problems.

[58] Also in Cardiff we had quite a well-developed community service already, which had been built up gradually from when I'd started in 1998, sort of piece by piece, without, really, any resources, just by pulling things from here and there. So, fewer women were going in from Cardiff because we were looking after them in the community, so we were getting women from elsewhere. So, Cardiff were funding the service and often not looking after Welsh [correction: Cardiff] women. So, those were some of the reasons why it closed, but it absolutely is needed. We do really need one.

[59] **Julie Morgan:** Right. So, certainly I was told as a Cardiff MP and AM that it wasn't needed, and that was the reason it was closed—because the referrals were so small, and the resources would be better put into the community. So, that was certainly a view that was expressed, but you're saying that that wasn't true.

[60] **Dr Smith:** It wasn't quite like that, no. I'm not saying that it was ideal, and it was probably too small, we were isolated, we didn't have the correct number of staff and a multidisciplinary nature on there—we didn't. So, I'm not saying it was ideal, but what we should have done at that point was probably look at actually having something bigger and better rather than nothing at all.

[61] **Julie Morgan:** So, in terms of what actually happens now when somebody does need, a mother does need, admittance to hospital—?

[62] **Dr Smith:** Well, I suppose the first thing we look at, which we do all the time anyway, is to look at whether community treatment is possible, and to work with the home treatment team. What's different, I suppose, about providing home treatment for a woman with a small baby is you're expecting family—because although there's home treatment, that's not somebody there all the time; that's someone popping in maybe once, twice a day. The rest of the time you've got to hope—or not hope, make sure—that the family is supporting. So, the family's not only supporting the mum who's ill, but they're supporting the baby as well. So, we have a lower threshold generally for admission to a mother and baby unit than to an acute ward.

[63] But obviously we can do home treatment. We have successfully managed home treatment for a couple of women who otherwise might have gone into a unit, but if it's established that they do need admission then to try and actually get a mother and baby unit bed is very difficult. Although Bristol is the nearest, they won't take. I notice there are a couple of different things written about why Bristol won't take, but mainly it's because they have only four beds themselves at the moment, and if they took Welsh women they'd be full and they'd be sending their own ladies out of area, which is not an unreasonable reason for not taking. Birmingham and Winchester are probably the nearest, but they're often full; when you phone up, they will put someone on the waiting list. I've tried in the past to proactively, if I've got a lady who's pregnant who's quite at risk—perhaps she's had a previous puerperal psychosis and been in hospital before—do something to plan, because when we had the Cardiff unit we used to say, 'Right, we'll do all

these things to try to prevent you getting unwell, but, if you do get unwell, this is where you'll go', and they would visit and feel reassured by that. I try to do that, but it's pointless to get someone to go all the way to Birmingham to visit somewhere that, if they do get ill, may not have a bed for them anyway. So, that proactive planning that we used to do we can't do.

[64] So, then it's a case of trying to find a bed. If you do manage to find one it's applying to the Welsh Health Specialised Services Committee for the funding, which they are great about now. They do understand that there is a need, and it is something that—. So, that's not normally a problem. But then it's somebody going miles away. So, we've got a lady at the moment in Derby. I was actually on leave the week before last, and my team had to spend quite a number of hours and cancel regular appointments to actually spend time on the phone arranging this, for this lady to go up to Derby. A lady went to London last Christmas and she—. It didn't take too long to find the bed, but then it took 24 hours to get an ambulance to take her from the maternity ward up to London because it kept getting put down the list of priorities because she was deemed safe because she was on the maternity ward. Anyway, to come back to it, so, then, if we do find a bed—.

[65] But what generally happens more often than not is, if they're ill enough to be admitted, they go to an acute ward and they're separated from the baby. And, often, the family, and the mum themselves often say, 'Well, that's better, I'd rather do that', because they don't want to go away. And, sometimes, if they're feeling quite inadequate about their ability to cope with the baby, they think, 'Oh, well, the baby will be better off with others anyway. They'll be better able to look after them.' And so perhaps they might choose, and if they're deemed to have capacity to make that choice then that's what will happen, even though one lady who recently went to London—not from the Gwent area actually—said that she was persuaded to go to London. She didn't really want to, but, when she got there, she just walked in and just felt 'Ah, such a relief, this is where I need to be'. And she said, 'I think women often don't know what they're saying "no" to.' Because they imagine it's going to be an acute ward just with some babies, but, actually, it's a very different set-up of care, it's a very different atmosphere—yes, it's just different.

[66] I think women get better quicker when they go to mother and baby units. But it might not look like that, because perhaps their average length of stay seems to be a bit longer, but that's because women stay on units until they're better, whereas, on acute wards, with the best will in the world these

days, people often get a bit better and then they go out on leave, that goes okay, so then they go home. We don't do that for mother and baby units. We make sure women are properly able to not only be better themselves, but able to look after their babies. So, they may stay longer, but they get better quicker, in my opinion.

[67] **Julie Morgan**: And what are the consequences of the mother being separated from the baby at this particular time?

[68] **Dr Smith**: The problem sometimes can be that, on the surface, it maybe looks like there are not. Last year, we had a few women who were admitted, they eventually got better, went home with their babies, everything looked like it was okay. It's very hard to actually predict what the long-term consequences of that are, but, for women themselves, they find, looking back—they go, 'That was just a dreadful time to be separated', and the implications for the bonding and attachment are long down the line, and it's very hard to predict exactly how. But, as I say, it can look as though it's okay, because they're happy now, everything seems to be going okay now—maybe no damage was done, but it's really hard to be sure about that, and the evidence is that probably some is.

[69] **Julie Morgan**: And, last question: can you make any estimate about how many women are actually admitted and separated from their babies?

[70] **Dr Smith**: That's very difficult to do, because, unless they come to us and the babies are very young, we sometimes end up not knowing about them. But I know that, last year, I went back and looked through and there were 10 ladies, some who definitely would have gone into units, and some who I think their quality of care and their outcome would have been a lot better had they, even though it maybe wasn't essential. And that's just in the Cardiff area. So, it's very difficult to actually extrapolate how many, but I think certainly a lot of women are losing out.

[71] **Lynne Neagle**: And, in terms of the admissions, are they mostly voluntary, or are any done under a section?

[72] **Dr Smith**: Some are under a section, but in my experience, and the experience of colleagues as well, a woman is much less likely to need to be detained on a mother and baby unit than they are on an acute ward. So, it's less of that, but it is sometimes necessary, yes. And so it may be that they're detained in order to get into hospital, but, often, once they're there, they feel

looked after and they feel that there's a lot of compassion. Certainly, on the Cardiff mother and baby unit, we often had women saying 'Oh, I'm not sure I want to go home now, because this is more confrontable than my own house.' We had that quite a few times, which does say something, I think.

[73] **Lynne Neagle**: Thanks. Michelle, did you want to come in on this?

[74] **Michelle Brown**: Yes, please. What would you say the consequences are for the mental health of the mother if—okay, they're in a mother and baby unit with the baby, but they're a long way away from their partner and their other children? What would you say the consequence of that is?

[75] **Dr Smith**: What most women would say when that has happened to them is they would much prefer to have been at home, but they really appreciate the care they had in the unit. So, it's a bit mixed. I had a lady, the one who was in London last Christmas, and for the first few weeks she was just so relieved to be there, and she said, 'This is definitely the right place for me' and then she got a bit better, but not quite well enough to go home, and that was at the point where she was saying, 'This is just getting really silly, I really want to be home. I'm not quite well enough, but it's so hard to be so far away', and, certainly, most women who that's happened to would advocate for being at home. Having said that, I did have one lady who went to the Birmingham unit, who said that, when she was getting well enough to go out on leave, it was actually quite nice to be somewhere where she knew she wasn't going to bump into anyone. And so, for her, it wasn't an altogether negative experience, but that's not to say that, therefore, that's okay. But it's just balancing these things up, but, generally, it's travelling all that way. Although what a lot of women will say is that some of it's about the travelling, but it's also about knowing what to do, because the uncertainty of, 'Oh, might you get a unit. It might be here, it might be there—'. If they were told, 'Well, we've got a unit, it's for Welsh women. It's going to be about an hour and a half to get there, but this is where you all go,' that's a bit different. So, some of it's that uncertainty.

[76] **Michelle Brown**: If a mother and baby unit were to be opened in Wales, what kind of model would you like to see and how would you like to see it work?

[77] **Dr Smith**: Well, I think it's hard to have this without knowing the discussions that we've already had with WHSSC about this, because we have had quite a lot. I think you certainly need a unit that's got at least six beds,

because smaller than that maybe doesn't develop the expertise and the busyness. Realistically, it wouldn't be appropriate to have one in every Welsh health board, because that just would be too small numbers. It wouldn't develop the expertise: it just wouldn't be—. So, it would have to be somewhere that women, unfortunately, depending on where they were, would have to travel to, but, hopefully, minimising that as much as possible and then having MHWs set up, then, community services that could then take women out as soon as they were well enough to go home.

[78] **Lynne Neagle**: Thank you. Darren, on this.

[79] **Darren Millar**: I just wanted to follow up on the reference you made to WHSSC and the funding arrangements for those beds that are out of area. Can you tell me how straightforward that is? How long is the decision-making process? What is that process?

[80] **Dr Smith**: In the last year or so, it's become a lot more straightforward. It is a case of filling in the form, because there are a couple of ladies in WHSSC now who are very familiar with this. When we first started off, it would go to someone who wasn't quite sure what to do with it, and they'd want more information. Now, they understand that if we are saying, 'This lady needs a bed,' and we provide evidence on the form—. The form's a bit unwieldy, it doesn't really fit for what we're saying, but we know how to do it now, we know how to fill it in, so it's pretty straightforward, and they're very helpful and very supportive of it now.

[81] **Darren Millar**: So, it's an immediate decision, is it?

[82] **Dr Smith**: Well, maybe not immediately—well, pretty immediate, actually, yes. If we say, 'This is urgent. This lady is on an acute ward and she needs to go to a mother and baby bed', and there is one there, then they would push that through pretty quickly.

[83] **Darren Millar**: On the same day, usually.

[84] **Dr Smith**: Well, certainly within a day or so, yes. It would depend, obviously, whether it was a weekend and—

[85] **Darren Millar**: And how many applications would WHSSC received from—? You said that around 10—

[86] **Dr Smith**: Out of those, I think I only made about five referrals, because five of them were ones who, if we had an unit that was local, this might be beneficial, but it's really hard to argue that we should absolutely push for that when it's going to involve them travelling, so it's about weighing up these things. So, I think about five I put in last year, and two of them, actually, ended up going in—no, three of them ended up going in. Going to the year before that, six, and—

[87] **Darren Millar**: And what about Wales-wide? How many applications would WHSSC be receiving?

[88] **Dr Smith**: I couldn't exactly tell you that—

[89] **Lynne Neagle**: We've got WHSSC coming in later.

[90] **Dr Smith**: Yes, WHSSC are coming in, so I think they can tell you about that. But it's only the tip; it doesn't cover the numbers by—

[91] **Lynne Neagle**: Just to be clear, because it's an IPFR application, you don't have to demonstrate exceptionality then for—

[92] **Dr Smith**: No, because it's seen as something that should be needed, but—

[93] **Lynne Neagle**: Okay, thank you.

[94] **Dr Smith**: I've got a phrase that I put on the form.

[95] **Lynne Neagle**: And what is the average length of stay, then, in a unit, roughly, for one of the women who might be admitted?

[96] **Dr Smith**: Again, the last lady, who went in at Christmas—it's hard to say the average, because there have only been a few of them, but maybe between six weeks and eight weeks, something like that.

[97] **Lynne Neagle**: So, it's quite a while. Okay, thank you. Llyr.

[98] **Llyr Gruffydd**: On care pathways?

[99] **Lynne Neagle**: Yes.

[100] **Llyr Gruffydd**: You say in your written evidence that

[101] 'current clinical care pathways do not meet all patients' needs in a timely manner'.

[102] Can you expand on what those issues are?

[103] **Dr Smith**: Well, I think it's just that it's difficult, within given resources, to say that you will absolutely be able to see everybody. I'm not sure what—can you remind me exactly which bit that was of the—?

[104] **Llyr Gruffydd**: Well, there's a paragraph here:

[105] '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.'

[106] **Dr Smith**: Yes, I think that's the thing, that, at the moment, it's not quite like that, and I like to think that in Cardiff we are pretty close to being—

[107] **Llyr Gruffydd**: Well, I was going to ask how confident you are that you are getting there, then.

[108] **Dr Smith**: But, everywhere else, everyone else is trying to get there, at least. Having a care pathway, or having a process, is such an advance from where we were not that long ago. It's a good start, but it needs—

[109] **Llyr Gruffydd**: But you still feel that you need more—

[110] **Dr Smith**: Yes.

[111] **Llyr Gruffydd**: —resources in order to do that effectively. Okay. And do you consider that there should be a consistent national care pathway so that we could have more equality across Wales?

[112] **Dr Smith**: I think the only difficulty with that is that, because the areas are very different, depending on rurality and need, as I was saying before, it's difficult to have one consistent pathway that everyone has to follow. So, there's got to be a bit of flexibility within that. So, I think to have—. And, certainly, one of the—. I think you're going to ask me about the all-Wales

steering group and the community of practice. One of the task and finish groups is looking at a standard pathway, but just hitting problems—that would work in that place, but that wouldn't work there. So there's got to be, perhaps, one, but with quite a bit of flexibility written in, really.

10:00

[113] **Llyr Gruffydd**: But there needs to be a degree of greater consistency.

[114] **Dr Smith**: Yes.

[115] **Llyr Gruffydd**: Okay.

[116] **Lynne Neagle**: And linked to that, your paper refers to your own standards in the Royal College of Psychiatrists—

[117] **Dr Smith**: Yes, yes.

[118] **Lynne Neagle**: Can you just say what kind of standards exist and any guidance that exists that health boards should be meeting, and whether they're actually complying with that?

[119] **Dr Smith**: Yes, okay. Well, it's the quality network of the perinatal part of the college, and their standards are—some of them are based on generic standards for good mental health care, and then obviously quite a lot of them are very specific to the needs of perinatal, then there are ones for mother and baby units, and ones for community. They've got three standards—they've got one, two and three. So, one is basic standards that everyone should be meeting, and, actually, to meet those standards is probably not as hard as it may seem, and I think a lot of the new teams are going, 'Gosh, we're not going to be able to meet those standards', but some of the ones are fairly basic and are possible to meet. In Cardiff we've just had our fifth review last week, actually. We haven't got the results of that yet, but this is the fifth one we've done and we've always, even when we were a much smaller team—we still managed to meet the basic needs. Then, two is things that you really should have, and they should be definitely striving towards. Then three is maybe things that some services will have but you can't expect everyone to have. As I say, Cardiff has been signed up to that for quite a few years now and Aneurin Bevan has just signed up, and the plan should be that all health boards should be signing up to those and should be trying to meet those standards.

[120] **Lynne Neagle**: Thank you. John.

[121] **John Griffiths**: In your evidence you pointed to some difficulties where there's a dual diagnosis of pregnant women. I think you consider that there might be some lack of confidence within the service as to how women with perhaps addiction problems and learning disabilities—or some other dual diagnosis—should be best treated. So, I just wonder whether you might expand on that a little and tell the committee what improvements need to be made.

[122] **Dr Smith**: Okay. Some of that comes from consulting with colleagues about whether they had anything to say about that and, actually, people in addiction were saying 'This is an issue for us.' Certainly, just speaking about the college in general, it's something we have had many discussions about, about perhaps women being excluded from perinatal services because of substance misuse, and that, actually, maybe we should be looking at that more seriously and having a bit more of an understanding of that. I think some of it is not that different to the tension that sometimes arises between general psychiatry services and addiction services when someone has a significant depression or psychosis—who should be looking after that patient? It's not that different. So I think, generally, education levels and understanding a bit more, perhaps more joint working with addictions and learning disability services—. Certainly in Cardiff, I've always been fairly confident with women with primary addiction problems because the addiction service will prioritise them if they're pregnant, and there's a substance misuse midwife and we've had very little to do with that. But there probably is scope, as we expand, to actually be looking to work more jointly and more collaboratively with them.

[123] **John Griffiths**: Is that a significant issue? Does it affect quite a lot of pregnant women?

[124] **Dr Smith**: I think that the women who get referred to us—it's not unusual for there to have been a co-existing drug or alcohol problem in the past. Quite a lot of women we see stop when they're pregnant, and the ones that we see then, actually—it's something that they find that pregnancy is a way of having abstained and staying off. So, it can sometimes be a really good start. I suppose it's the ones who don't who are more likely to end up then in the addiction service, rather than for us, and they're the ones, perhaps, who we're then not quite sure what to do about. It's not a

significant part, and certainly one of the college documents—the CR197 that was on perinatal services—specifically excludes addiction services. It really only talks about general perinatal mental health, which is what we tend to deal with. But it's something that I've, on and off, thought, 'We really should be doing something more about that', but then you've got so many other priorities, it's difficult to get that in.

[125] **John Griffiths**: And is anything happening at the moment to make the improvements that you suggest are necessary?

[126] **Dr Smith**: Not anything that I'm specifically aware of, no.

[127] **John Griffiths**: Okay.

[128] **Dr Smith**: That doesn't mean to say there aren't things that I'm unaware of going on, on the side.

[129] **Lynne Neagle**: Thank you. Oscar on training.

[130] **Mohammad Asghar**: Thank you very much, Chair. Are the teams responsible for perinatal trained to deal with both adult and child parents? Have different provisions been established for the unique requirements of parents under the age of 18?

[131] **Dr Smith**: What we tend to do—and in most services it's the same around Wales—is that if there is an under-18 who becomes pregnant, it's about doing joint work with the CAMHS teams in that we both have a role to play. They have the expertise for them being younger people and we have the expertise for the perinatal. So, it's about working together. Depending on the age—. In Cardiff—just talking about Cardiff specifically, because until relatively recently, although it's probably quite a while ago now, CAMHS services only took up to 16, and then we would then maybe see 17-year-olds—but now I can remember going to give some specific training to CAMHS services about postnatal depression and perinatal mental health so that they would feel more comfortable in being responsible now for those up to 18.

[132] **Mohammad Asghar**: And also, is there provision for the child and adolescent mental health team to receive training in perinatal care?

[133] **Dr Smith**: I did that one session, but that was quite a while ago. So, I'm not 100 per cent sure about that. That's something that they would

probably be able to answer more. Certainly, we would want to try and provide that training if we could. It has been done in the past.

[134] **Lynne Neagle**: Darren.

[135] **Darren Millar**: Yes, just a brief follow-up question on the training. So, to what extent do you think that identification of perinatal mental health issues should feature in the initial training of midwives, and, indeed, nursing staff?

[136] **Dr Smith**: Yes, it definitely should.

[137] **Darren Millar**: It doesn't at the moment, not specifically.

[138] **Dr Smith**: Well, it does to a certain extent. There's a small amount of it. I know the senior nurse who works with us is involved in midwife training, and we have a midwife on our team, and I think almost informally, by her being educated by working with us, she feeds some of that back to her team as well. But, yes, it definitely should be part of training, probably more than it is.

[139] **Darren Millar**: To a greater extent than it currently is.

[140] **Dr Smith**: Yes. To a greater extent than it is now.

[141] **Darren Millar**: That would deal with any new people coming into the profession, of course. But with the existing people who are out there working on the front lines at the moment, how are we going to embed this within their continuing professional development?

[142] **Dr Smith**: There are sessions that do go on; there is training. I can't account for exactly how it is over all parts of Wales, but it is something that we constantly talk about, especially with front-line staff.

[143] **Lynne Neagle**: So, would you agree that all front-line professionals, then, who come into contact, including health visitors, should have perinatal mental health as a core part of their training? Would you agree with that?

[144] **Dr Smith**: Yes. And from the psychiatry point of view and the college point of view, actually trying to incorporate training on perinatal mental health into the curriculum, into making sure the trainees have experience

and an understanding of it, is very important, and then right down to medical students as well. I had a medical student the other day who actually came and did a project, had heard about perinatal mental health: 'I don't know much about that—I'll go and do a project on it'. So, it's quite encouraging from the bottom up that that's increasing.

[145] **Lynne Neagle**: Thank you. Hefin.

[146] **Hefin David**: Is this on medication?

[147] **Lynne Neagle**: Well, I think both of you want to come in on that, so you go first.

[148] **Hefin David**: I just wanted you to elaborate on the risk of using medication to treat mental health—and affecting bonding with the baby. How do you balance that risk?

[149] **Dr Smith**: I will almost answer them slightly separately. They were put together in the question. But in terms of medication, I think there's been a move over the years that actually women shouldn't take medication when they're pregnant because that's risky for the baby. I'm not saying that we shouldn't consider those risks, and there are some known risks, but there are often also a lot of unknown risks, and what we do know is that being depressed and anxious when you're pregnant isn't good for the baby either. So, it's always about weighing those things up. Certainly, our experience is that sometimes we'll see women—. One of the most common referrals to come to perinatal services: this lady had depression, she was being treated, she got pregnant, we stopped her antidepressants, and now she's depressed again. I'm not saying that in all situations it wasn't correct to stop those antidepressants; it may well have been. The woman may well have been saying, 'I've been feeling better for quite a while now so I don't think I need those tablets', but—

[150] **Hefin David**: That was based on an underlying condition of depression that wasn't associated with the pregnancy.

[151] **Dr Smith**: Yes. Or maybe they've had postnatal depression before and then they've got better and they've got pregnant again so they stopped the medication. There are all sorts of scenarios of that, really. So it's about educating professionals in primary care, in particular, about what's safe and what's not, and being able to weigh those things up. I mean, there is a lot

more work going on about that. But the trouble is we can't say definitely. You can never say to a woman, 'It's absolutely safe'. So, it's about discussing risk, and often saying to women, 'Even though the risk is very small, that doesn't mean it won't happen. So, if it does happen, you've got to consider how you would feel if something did go wrong.'

[152] **Hefin David:** Would you say there's a rush to medication—too fast to medicate—or is that not the case?

[153] **Dr Smith:** I think that very much varies, and I think we do certainly, in perinatal—when a woman's pregnant, you very much try to look at other ways of helping, and we don't just say, 'Get back on the medication and that's what will help.' If you see a woman who has actually been doing really well in life, everything's been fine and then actually she's stopped something and then, a few weeks later, she's feeling really down again, not enjoying the pregnancy, feeling really awful, and other things don't help, then it is a consideration, but I wouldn't say we rush into that.

[154] **Hefin David:** Okay—

[155] **Dr Smith:** And if we do rush into it, it's only because we know that we're going to get you better.

[156] **Hefin David:** There's no judgment there. What are the alternatives?

[157] **Dr Smith:** Psychological therapies, and that's something that is—. I think, to meet the standards—. The quality network standards on psychological therapies are quite difficult to meet—

[158] **Hefin David:** With resource issues?

[159] **Dr Smith:** —in terms of taking them on. And even though now we have psychology in our team, it still falls short of what we would like, and so, to actually sort of get treatment quickly—. But we do have antenatal groups and postnatal groups on a more formal and less formal basis as well.

[160] **Hefin David:** Is that a resource issue, or availability of resource?

[161] **Dr Smith:** Well, what I'm saying is that we have a lot more than we did, but we could always have more, and that's the same for the rest of the teams as well.

[162] **Lynne Neagle:** Llyr.

[163] **Llyr Gruffydd:** It's been largely addressed, really, but we had some very powerful testimony in our stakeholder event—

[164] **Dr Smith:** Yes, absolutely.

[165] **Llyr Gruffydd:** —where people had had real experience of being told, 'You can't take antidepressants and breastfeed at the same time'. They were clear in their minds that the GP didn't know, so they were erring on the side of caution, although one stakeholder told us that the pharmacist in the hospital wasn't even sure whether that was okay or not.

[166] **Dr Smith:** I think the problem with that is, when you consult the books, they will say, 'Caution advised', or sometimes even, frankly, that they're contraindicated in the *British National Formulary*. So, if you read that, 'Oh, no, you can't take that'—

[167] **Llyr Gruffydd:** Well, there was reference to the BNF in the evidence we received, really, as being the bible, and I suppose you do need a bible in that respect. But surely—is there a piece of work that's happening, or has happened somewhere, looking at the most popular medications?

[168] **Dr Smith:** Oh, yes, there's a lot of work on. I used to say to women, 'We can't tell you exactly what the risks are because we haven't got the evidence'. There was something—and Ian Jones may well have said this because he was the one who told me—but, in the last year or so, there have been something like over 100 studies looking at medication in pregnancy and breastfeeding, and we're still not sure what the risks are, but that certainly tells you that, if there was anything really serious, we'd know about it by now. Also, there are so many factors that could lead to a problem with the baby. Medication's only one of them, and yet that's the one that is quite easy to be maybe blamed.

[169] **Llyr Gruffydd:** So, whose job would it be to try and sharpen that up a little bit?

[170] **Dr Smith:** I think it's a sort of collective responsibility, really. I certainly encourage—if I get referrals from GPs where a woman's medication has been stopped, I will, when I write back, sort of explain. I will quite often get phone

calls from GPs just asking for a bit of advice, and I certainly encourage that, because you know that once you've given some advice, then they'll remember that and they maybe might pass that on to their colleagues. But it's a general increase.

[171] **Llyr Gruffydd**: Okay. Thanks.

[172] **Lynne Neagle**: You mentioned access to psychological therapies and we know that the waiting times are too long for psychological therapies generally across Wales. If a woman needed that when she was pregnant and it was a choice between an antidepressant that she didn't want to take or a psychological therapy, will she get any priority for that psychological therapy, or does she just go on a general waiting list?

[173] **Dr Smith**: Well, within the perinatal team, if you've got a psychologist within the perinatal team, it would depend on their availability and it would go in the waiting list within there. We used to be in a position of having to refer to psychologists from the community mental health teams, and often they would struggle to prioritise them just because of the rate of that, and I suspect that that is still the case.

[174] **Lynne Neagle**: And has every team got a psychologist in Wales—every perinatal team?

[175] **Dr Smith**: Yes, in varying degrees. So, some have very small amounts. Certainly our experience in Cardiff of having a psychologist, though, was that even though when he first started, he was only one day a week, he actually trained the nurses to develop and to deliver psychological therapies and to run groups. In some ways it feels quite good that we've got psychologists and that we've even got a psychologist that can have a waiting list. That seems such a positive advance. Maybe that's where we are. So, we should obviously—. We've got a long way to go if we're going to completely meet that.

[176] **Lynne Neagle**: Okay. And just a final question, then. We know we've got this community of practice, but we have had evidence that it would be better to have a managed clinical network for perinatal mental health. What is your view on that?

10:15

[177] **Dr Smith:** I've thought about this, because community practice comes more from education, really: interested people meeting together and sharing views and sharing practice. That's a really good thing to do, but it sometimes feels that perhaps we haven't got that much clout in terms of actually insisting that certain health boards do certain things. In that way, a managed clinical network would maybe have a lot more influence. We can only advise and maybe write letters saying ,'The community practice advises this', but individual health boards, when they've got lots of other priorities, are not necessarily going to take that over something else that they need to be addressing.

[178] **Lynne Neagle:** Okay, thank you. We've run out of time, but thank you very much for coming and answering all our questions. We do appreciate your time, and we know that you'll be coming back to see us later.

[179] **Dr Smith:** I'll be back.

[180] **Lynne Neagle:** But thank you again. You will receive a transcript to check for accuracy. Thank you very much.

10:16

Ymchwiliad i Iechyd Meddwl Amenedigol: Sesiwn Dystiolaeth 5
Inquiry into Perinatal Mental Health: Evidence Session 5

[181] **Lynne Neagle:** Good morning. We will move on now then to our fifth evidence session. Can I welcome Dr Jane Fenton-May from the Royal College of General Practitioners? Thank you very much for coming this morning, and thank you too for your paper in advance. Are you happy for us to go straight into questions?

[182] **Dr Fenton-May:** Yes. Thank you for inviting me.

[183] **Lynne Neagle:** Michelle.

[184] **Michelle Brown:** Can you tell us a bit about the referral process for women with perinatal mental health problems?

[185] **Dr Fenton-May:** Basically, from a general practice point of view, we see people with mental health and generally have to make a decision about whether we're going to manage them ourselves or refer them for additional

support through the primary care mental health support service—it's a very long name; sorry—or refer them to community mental health. This is general. It is easier if all patients can be channelled through those things. The other thing that we have is in-house counselling services. We need to make that decision.

[186] Now, we don't always—and I think, if we're looking particularly at the non-severe end of the spectrum of perinatal mental health problems—have an ongoing relationship with the lady during her pregnancy because they're being managed by the midwives. So, we very often are not aware that things, even if we know the patient, are not as they should be, and so we're not in the position to make that referral.

[187] The other problem that occurs around perinatal mental health is that, I think as Sue Smith was telling you previously, there's a lot of non-disclosure of the problems because people are frightened about what's going to happen to them. So, we need public awareness. I'm getting off the subject, I know, of the referral, but we need public awareness so that we know that patients can be supported and treated, and improved services for the treatment and management of patients around that pregnancy, both before they deliver and after they deliver, of their mental health issues, whether they're severe or mild. They're all severe in some degree because of the ongoing effect on the mother and the baby, but the ones that need hospital treatment are obviously much more severe.

[188] We need improved access through the different services to ensure that we get things like talking therapies, psychological therapies, for the patients in a timely manner, and they need to be triaged by those services to ensure that they get services sooner, probably, because of the impending risk to the baby. Does that answer your question? There are pathways, but they should almost be the same as the pathways for all mental health. That's what I'm trying to say. Because we don't sometimes know that the patients are pregnant. Sometimes they don't tell us they're pregnant when they come in, and we may not be aware. Obviously, if they're well advanced and they've got a big bump, you know, but sometimes, it's not very obvious that somebody's pregnant. You're so involved in trying to sort out their mental health, you may not pick that clue up, because patients are quite often now self-referring to midwives and being managed by the midwives, and they aren't seeing GPs through their pregnancy at all.

[189] **Michelle Brown**: Do you think there's a better process involving GPs a

little bit more?

[190] **Dr Fenton-May:** Personally, yes, but that's not how the services have devolved over the years, because now midwives are able to manage the patients themselves. GPs are overworked and under-resourced, and we've got a recruitment problem, so a lot of GPs are happy to lose that part of the service, but it's not part of the holistic care, unfortunately. There should be better communication across the services, I think, so that we are aware—and a backward-and-forward communication. If I've seen somebody who had mental health issues prior to becoming pregnant, or before in a previous pregnancy that is recorded in my notes, and I get information from midwifery that they are now pregnant, I would probably try to contact the midwife to let them know.

[191] Sorry, I have retired, but when I was working, the midwife used to come to do clinics down the corridor, so I'd talk to her in between patients or go to seek her out if I was really worried about patients, but that doesn't happen in all practices, because some of the midwives are not in the same building and they never see their GPs. So, in some ways, in order to enable that communication you need that personal link, but it should be possible to have a more formalised linking of notes, and that is happening across various systems. We need it to be a little bit faster and more efficient.

[192] **Lynne Neagle:** Llyr.

[193] **Llyr Gruffydd:** One issue that's been flagged up to me is a concern that people aren't sure who's in charge, because you have a GP, you have a health visitor, you have a community mental health team and you have a perinatal mental health team. The worry is that nobody seems to have a handle or an overview. You'd think maybe it's the GP, but I think it comes back to the point you were making about people working in different places and not, maybe, seeing each other and that personal touch being lost a little bit. Who is driving this package of care? Ultimately, I'd imagine, is it the GP who would have that overview?

[194] **Dr Fenton-May:** In theory, the GP does, but, again, if the patient isn't coming in and seeing the GP, it's very difficult to go out to chase up that patient if somebody else is managing them. So, we may have information coming in to us, but unless the patient presents in the surgery, it's very difficult to influence the care management. Also, as I say, for the more 'minor'—I've already stated that they're all major from the patient's point of

view—or the less severe conditions, they may not be presenting to anybody, and that is a real difficulty. There is care out there, and public awareness needs to be raised about the fact that there are ways that we can help and support people. We need to be consistent in the way that we send those messages out—to schoolchildren, almost.

[195] **Llyr Gruffydd**: So, there might not be a magic or silver bullet, but you recognise the concern—you know, multiple assessments and speaking to a number of different people—that the feeling might be, or the perception might be, that it's a very compartmentalised process and that coherence, maybe, isn't what it should be.

[196] **Dr Fenton-May**: That's correct. Sometimes, if the mother has previous children, it can be the health visitor who is bringing the issues, but, again, health visitors have been separated from GPs quite often, so they don't have that dialogue with the GP—it doesn't necessarily come back very easily. In our practice, we used to see one group—we used to see the ordinary health visitors, but we never saw the Flying Start health visitors. Obviously, they were dealing with the most at-risk patients, and actually having communication with them was quite difficult.

[197] **Llyr Gruffydd**: Yes, okay.

[198] **Lynne Neagle**: Hefin.

[199] **Hefin David**: This reflects exactly the experience my wife had at this stage—you've got the midwife, the health visitor and the GP, and there seemed to be exactly the kind of compartmentalised issues that you've discussed. How hard can it be though, in an age when we've got computer technology, to have a centralised data-stored set of medical notes that the midwife, the GP and the health visitor have input into? Are there confidentiality issues in there? Are there problems with achieving that?

[200] **Dr Fenton-May**: I think you need to talk to our IT NHS experts about that.

[201] **Hefin David**: But are there confidentiality issues?

[202] **Dr Fenton-May**: We are working on different systems, so it is difficult to do that. I think in some areas, I think up in the Cynon valley, they have given some of the community workers iPads so that they can input stuff into

the GP records in real time—iPads or their equivalent. There are mechanisms that you can do, but it's slow progress and there are confidentiality issues because—

[203] **Hefin David:** What are they?

[204] **Dr Fenton-May:** You need to make sure the patient is giving consent, because sometimes patients may not wish other members of the team to be aware of their mental health problems, particularly. It all goes back to this concern and worry about who knows about my mental health, and it shouldn't because we should be open and treat mental health the same as physical health.

[205] **Hefin David:** The problem you're getting is that the patient is explaining themselves on multiple occasions and that information is coming directly from the patient, which can, then, be inconsistent. So, is there a confidentiality barrier to the health visitor having access to the patient's medical notes and inputting data? Is that beyond the realms of possibility?

[206] **Dr Fenton-May:** It's not beyond the bounds of possibility, but it needs to be—. Just like there is a system so that hospital doctors can look at the patient records of the GPs now, when patients are admitted—

[207] **Hefin David:** Is that happening now—that happens?

[208] **Dr Fenton-May:** It is happening, but it's a bit patchy, I think, still, it would be fair to say. The out-of-hours services can do that, but they have to ask the patient's consent. So, there are mechanisms to do that and GPs can look at some of the information that's on the hospital record, and there's been a global consent for that kind of thing to happen. So, there are mechanisms to go around and we're learning all the time how to do it better. And we are joining up systems, but it's not universal.

[209] **Lynne Neagle:** We need to move on.

[210] **Hefin David:** Okay.

[211] **Lynne Neagle:** Can I just ask: you said that you would refer women with non-severe mental health issues into the usual routes—primary mental health care or secondary mental health care—can you give us an estimate of what the waiting time would be for a pregnant woman via those routes, or

someone who's just had a baby?

[212] **Dr Fenton-May:** Well, they're supposed to see their patients within a month, but they're supposed to triage them and assess them, so that if you have somebody that is urgently needing treatment, they will be seen quicker. I don't know what the current waiting times in all the different areas are, but I think that, for somebody who's got severe mental health issues, they're supposed to be seen within 24 hours now.

[213] **Lynne Neagle:** But what about actually having treatment, say, psychological therapies? What would be the wait, you know—

[214] **Dr Fenton-May:** For the psychological therapies, that's varied. For some places, that can be up to six months. The in-house counsellors sometimes have waiting lists of three to six months in the practices. But, sometimes you can look at other places. Sometimes, you can get psychological support if the patient is in work, if they have support through work. As a GP, you would try and find out the best way to get some psychological therapy for that patient if there were other channels rather than the health service. Obviously, there are these developing services that the midwives can access. So, this is like the perinatal mental health specialist services now, which presumably get them access to therapy quicker.

[215] **Lynne Neagle:** Okay. But, you don't have access to those as far as you're aware.

10:30

[216] **Dr Fenton-May:** Well, I think you can—in Bridgend, they can refer to the perinatal response and management service directly. But I understand in Cardiff the normal route would be through the normal mental health services—apart from the midwives, who might decide to send the patients to those services. I haven't had information from other parts of Wales, where we know the perinatal services are not so good, about how they work.

[217] **Lynne Neagle:** Okay. Darren.

[218] **Darren Millar:** You've made a few references in your evidence to counselling services within your GP practice.

[219] **Dr Fenton-May:** Yes.

[220] **Darren Millar**: They wouldn't be available in every GP practice in Wales, though, would they?

[221] **Dr Fenton-May**: I think all GP practices have some sort of counselling support that is provided through the LHBs.

[222] **Darren Millar**: Okay, but they won't always be embedded within the practice as such.

[223] **Dr Fenton-May**: I think nearly all of them do have those counselling services. But, as I say, they won't have specific mechanisms to pick up perinatal health issues, and they usually have very long waiting lists, and I don't think they have a system whereby they can fast-forward and triage urgent patients. So, those patients need to be dealt with in a different mechanism. But if they picked up a referral that they thought looked as if it was urgent or needed some more expertise, outwith their experience, they would then go back to the GP and say to the GP, 'I think this patient needs to go somewhere different'.

[224] **Darren Millar**: It sounds very much as though it's a judgment call on the part of the GP, if someone presents to you, as to where you refer.

[225] **Dr Fenton-May**: Well, I think all management of patients is a judgment call.

[226] **Darren Millar**: I understand that, but how can we be sure that that's a consistent provision, if you like, and that judgments are pretty consistent by GPs in each part of Wales?

[227] **Dr Fenton-May**: I think that the more serious patients go to the mental health services, the less severe patients, who you think need a bit of support, need to go to the primary care support services, and the people who need counselling, which is what the counsellors provide, go to the counsellors. So, you have to try and work out what you're doing.

[228] You may be deciding to manage some of the patients with medication as well, or to fill the gap with medication, if that is appropriate. Obviously, you've got to weigh up balances in a pregnant lady or a patient who's breastfeeding with a medication, and discuss it, obviously, with the patient, and the pros and cons of treatment or no treatment, and the pros and cons

of, you know, the side effects of the medication. You've got to balance that with the patient.

[229] So, there will be some sort of standards, but, within that, there is interpretation of how you manage that patient, at that time, in front of you. And you can only say, 'Well, one in 100 patients who has these problems needs to go down that route, and one in 100 will have side effects.' You've got to try and balance that with every consultation, and discuss it with the patient about what is best for them and where they go, and give them some insight about when they should come back to you if things are not going right, and what the potential harms and benefits of what you're doing are. And that's the same with any consultation.

[230] **Lynne Neagle**: Thanks. Julie.

[231] **Julie Morgan**: Thank you. I wanted to ask you about the mother and baby unit—the lack of one in Wales. We've had a lot of concern expressed to us, and I wondered what your view was and whether you saw a need.

[232] **Dr Fenton-May**: Well, I did have some patients who'd been through the mother and baby unit when it was in Cardiff, and they saw a lot of benefits. There are a lot of patients who are very, very worried that if they admit that they have mental health problems that they'll lose the baby, the baby will be taken away, and they'll be locked up forever. And some of those fears, sadly, are based on stories they've heard from other mothers who've gone through those processes. I think it's very difficult for the family when the mother is put into an acute mental health unit, or even outside mental health problems, when they have physical problems and they need to be acutely admitted to hospital and they have to have their baby taken away from them. I've seen that happen quite often and they can't look after their baby and then you get problems with the bonding, and it's even more pronounced if there are mental health issues involved. The family, also if the mother is sent a long way away, are not able to support the mother and visit regularly, and they may then be stuck in wherever it is because they're managing the baby. So, there are problems in the relationship for the whole family—the father and the extended family—because they can't be a close family unit, as they would be if the mother were fit and home and had good well-being.

[233] **Julie Morgan**: So, you're saying that there should be a mother and baby unit.

[234] **Dr Fenton-May:** I think there should be a mother and baby unit in Cardiff. I'm not quite sure what happens in north Wales. I think it's a long way from north Wales to come down to Cardiff to a mother and baby unit and there probably ought to be some links with somewhere else that is nearer to north Wales and the north Wales road corridor for people who live in places like Bangor and Anglesey, and places like that. Ideally, what we need is better support for mothers in their home and that is what, obviously, the perinatal services are trying to do. But there are some patients who have such severe problems that they do need that support in a mother and baby unit and I'd love to see one re-established in Cardiff.

[235] **Julie Morgan:** And so you would see the one for Cardiff covering the bottom half of Wales, really, basically.

[236] **Dr Fenton-May:** I think probably, yes. Obviously, there may be an option for people from north Wales to come down to Cardiff, but it is quite a long way to come from Bangor—you know, it's five hours driving and the trains are not awfully good.

[237] **Julie Morgan:** And what about the funding of such a unit because I know that the previous unit ran into funding problems?

[238] **Dr Fenton-May:** I think it would need to come from an all-Wales budget, rather than from the Cardiff and Vale University Local Health Board. Sorry, I don't really know an awful lot about the funding of hospital services.

[239] **Julie Morgan:** Thank you very much.

[240] **Lynne Neagle:** Okay, thank you. Oscar on training.

[241] **Mohammad Asghar:** Thank you very much, Chair. Thank you, doctor. Could you tell me: in your opinion, are the teams responsible for perinatal care trained to deal with both adult and child patients and has different provision been established to the unique requirements of patients under the age of 18?

[242] **Dr Fenton-May:** I think that the primary care mental health support services do have some problems in some areas and that was brought up during the mental health Measure review—managing children's services and those with learning disabilities, who—. Obviously, children or young people can be pregnant and people with learning disabilities can be pregnant. So, I

think that there are probably some problems with getting those people support. Improved training is always a good thing for services and equally I think we need greater emphasis among all health professionals and the general public, about the risks of perinatal mental health issues and the management of them.

[243] **Lynne Neagle**: Thank you. Hefin.

[244] **Hefin David**: With that in mind, what specific training do GPs receive with regard to perinatal mental health?

[245] **Dr Fenton-May**: They will be aware that there are mental health problems. It depends on whether they've done specific modules—working in a psychiatric hospital in their training, and even that may not have exposed them to perinatal problems, or how much obstetrics and gynaecology they've done as part of their training. When you train as a GP, you can opt, as part of your training, to go and spend six months in different specialisms, so you might have done psychiatry and you might have done obstetrics, but you might not have done that. But, having said that, you should be aware of the problems, from your undergraduate training and from reading the books that are advised and doing the core curriculum for general practice.

[246] **Hefin David**: What about a GP who's been 20 years a graduate? What kind of professional development with regard to perinatal mental health might be going on?

[247] **Dr Fenton-May**: I don't know whether there are any specific things on perinatal mental health, but I think when I was a trainee, quite a long time ago, we had quite a lot of training on perinatal mental health issues. I was very well aware of the issues.

[248] **Hefin David**: Was that when you started? I'm thinking about the professional—. What kind of professional development does go on throughout the career of a GP, and opportunities?

[249] **Dr Fenton-May**: Well, GPs have to make sure that they are, and prove that they are, looking after their own education through the appraisal and revalidation system. It's not specified what they have to do—it will be led partly by their experience and the kind of patients they are seeing. So, if they see a patient who has mental health issues and is pregnant, they might go and read up a bit more and look at the different guidelines on that.

[250] **Hefin David:** So, it's very much that the impetus comes from the GPs themselves rather than from any health board advice on the kind of training they require.

[251] **Dr Fenton-May:** There are days that the health boards put on, and they very often will focus on different issues, but, basically, it is GP led. It's not like mandatory training or something like that—there's no mandatory training. You have to do child safety as part of your training as a GP—so, you know, safeguarding issues are very important. I don't think this would necessarily be part of that, but maybe as part of safeguarding training there could be a mention in that training. I can't remember, because I haven't looked at it for a little while, whether there is anything about safeguarding newborn babies because of maternal mental health issues—that would be an easy place to put it.

[252] **Hefin David:** So, a 'yes' or 'no' question: is this sufficient? Is this approach sufficient?

[253] **Dr Fenton-May:** There are always ways you can do better. The only place I can think of doing mandatory training is in safeguarding and looking at putting something into those modules. I will go back and have a think about that further.

[254] **Lynne Neagle:** Thank you. Llyr—final question.

[255] **Llyr Gruffydd:** Yes, we've already touched on medication, although, again, stakeholders were very concerned that their GP didn't seem to be confident in what they could or couldn't take during pregnancy or while breastfeeding, in terms of medication. So, do you think that GPs have adequate knowledge of what can and can't be taken? Is there sufficient training in that respect? If not, what can we do to improve the situation?

[256] **Dr Fenton-May:** I think that the trouble is that the advice sometimes varies as you go along, as more research happens. There are drug information pharmacists who will look up the information and the current advice about different drugs for different circumstances, and you can have access through the hospital pharmacies to those drug information pharmacists. They're very helpful—I used to use them quite often. You mentioned the bible—the *British National Formulary*—and the Welsh formulary are very useful to look up things very quickly, but if you think that

a patient needs medication, you need to be sure what the current advice is. It might take a couple of hours, or a day or two, to get that information together for the patient and then go back to talk about the pros and cons of, 'Well, there may be a side effect of such-and-such, but I think that the risks and benefits are better for you', and discuss that with the patient.

[257] **Llyr Gruffydd:** So, is there a way of strengthening that a little bit, then, do you think?

[258] **Dr Fenton-May:** A lot of GPs will know, particularly with breastfeeding mums, because they're getting a little bit of depression or they're needing something—they will know how to do that fairly quickly. Antidepressants we're not giving very much to ladies who are pregnant or who are breastfeeding, so we may need to ask somebody, either somebody like Sue Smith, or the drug information pharmacy, for some specific advice in those circumstances about, you know, we maybe want to change the drug that we normally use and give a different drug because this one's not having the effect. So, there are mechanisms where you can do it. But it is a bit slow sometimes getting all that information, and, in a 10-minute interview, you can't look it all up. You sometimes have to say, 'Come back', or 'I'll give you a ring', or 'I'll leave you a prescription', or whatever.

10:45

[259] **Lynne Neagle:** Do all GPs, though, go to that trouble of following up, because some GPs might just give the information there and then? Is it consistently followed up, as far as you're aware, for patients?

[260] **Dr Fenton-May:** Well, if you're uncertain about something, you're not going to give somebody a prescription, saying, 'Well, I don't know about this, but here you are'. You'd need to have—. You would have a mechanism where you'd arrange for the patient to follow up. And, if you see somebody that you're not happy with, you might give them some advice and say, 'Well, go away, and, if things are not better in a week'—or whatever—'come back'. Now, getting the patient to come back is not always easy, because sometimes they think, as you say, 'The doctor didn't know' or 'they didn't give consistent advice'. And unless you flag it up to yourself as a doctor, which, with time constraints, is going to be difficult, that patient, unless they come back to you with their concerns, is lost to the system, and that is a problem.

[261] **Lynne Neagle:** Okay. Thank you.

[262] **Dr Fenton-May:** But we need to empower patients to do that coming back and not feel they've been brushed off just because we've said, 'Well, give it a week' and 'Maybe it's because you had a bad night last night; come back tomorrow if it's still the same'. And that's public awareness.

[263] **Lynne Neagle:** Okay. Lovely. Thank you very much. Well, we've come to the end of our time. So, can I thank you very much for attending and answering all our questions? You will receive a transcript to check for accuracy in due course, but thank you very much for your time this morning.

[264] **Dr Fenton-May:** Thank you very much for letting me come.

[265] **Lynne Neagle:** The committee will now break until 11:15.

Gohiriwyd y cyfarfod rhwng 10:47 a 11:15.
The meeting adjourned between 10:47 and 11:15.

Ymchwiliad i Iechyd Meddwl Amenedigol: Sesiwn Dystiolaeth 6
Inquiry into Perinatal Mental Health: Evidence Session 6

[266] **Lynne Neagle:** Can I welcome everybody back? We will move on to our next evidence session on perinatal mental health, and I'm delighted to welcome the health board representatives here today. So, welcome back to Dr Sue Smith and Ian Wile, both from Cardiff and the Vale health board; also to welcome Anita-Louise Rees and David Roberts from Abertawe Bro Morgannwg University Local Health Board. Thank you very much for coming, and thank you for the paper that you provided in advance as well. If you're happy, we will go straight into questions from Members, and I've got the first questions from John Griffiths.

[267] **John Griffiths:** Okay. Thank you, Chair. I'd like to ask about the funding that Welsh Government has provided for specialist community perinatal mental health services. Given that the health boards were required to set out plans as to how they would use that money, we'd be interested in what stage your health board is at in terms of fulfilling those plans, and also what you have set out for the future.

[268] **Mr Roberts:** ABM first?

[269] **Lynne Neagle:** Yes.

[270] **Mr Roberts:** A fortnight ago, we made our last appointment to the range of staff that we submitted as part of our plans, and that was a part-time consultant who commences with us in November of this financial year. That, then, completes the full complement of staffing. Currently, the medical support is being provided from a colleague in Bridgend, so we have been fully operational from the beginning of this calendar year. So, the service is still evolving, and we're looking forward to our new colleague joining us in the autumn and the service further evolving and flourishing.

[271] **Mr Wile:** Yes, similarly for Cardiff and Vale: all the appointments are made, now, into the service. I think the last post that we had appointed was a psychologist. We were quite lucky to have something of a service anyway, so the extra £248,000 that we had completed our plans to develop that service. I think it's fair to say that the service has gone now from a nursing and medical service into a—. The biggest difference is that it's gone into a full multidisciplinary service. We've got psychology, occupational therapy, midwifery support and extra medical support than we had previously.

[272] **John Griffiths:** Okay. Chair, I know that perinatal mental health teams is another matter that we need to address. Shall I ask on that, Chair? In terms of the confidence that you have in terms of having sufficient financial and staff resources to ensure an efficient service, do you have that confidence and how do you intend to evaluate the service to make sure that there is continuous improvement?

[273] **Mr Wile:** That is a good question, actually. We were talking about this previously, and it's probably a piece of work that Cardiff and Vale have to do over the next year or so. We know that, for example, between 10 and 20 per cent of mums have perinatal mental health problems. We know what the population of Cardiff is, we know what the live birth numbers are in Cardiff, so we should be seeing roughly that number of people—650 people—through our service in a given year. I think it's then that we can make a proper evaluation of whether the capacity in the service meets that demand, and whether that demand is reflected in the numbers of referrals that we're getting. So, I think it's quite an important piece of work, now, to do over the next 12 months, to make sure that we're actually directing the resources in the right way. I think we've got quite an innovative team in Cardiff and Vale that are always looking to develop services, and there's a keenness, I think, to develop into primary care services as well and do some preventative work.

So, I think we need both capacity to manage the people who are at their most ill, which will be these numbers between 10 and 20 per cent, but we also need additional capacity to look at preventative models as well and health promotion models. So, I think our assessment will be based on those two factors.

[274] **Dr Smith:** Can I also just say something about that as well, in that numbers are important, of course, but it's also quality as well as just quantity and actually measuring whether the services women get are the ones they actually want? There are some—. The college has got a feedback—a link or poem—that we try to give to women so they can actually say how satisfied or not they are with the service, and we need to develop something more in-house. There is a general health board one that we do give to women, but maybe something more specific, so that it's measuring whether we're seeing the right numbers of people and that we're actually helping them in the way that they want to be helped as well.

[275] **John Griffiths:** Okay.

[276] **Mr Roberts:** We evaluated in October 2016 where our service was, and 12 months on we'll do the same again. We're willing and open to learn from colleagues in Wales and their experiences, and are quite content to look at our services and change as necessary, because that's totally appropriate, I feel.

[277] **John Griffiths:** Okay, so you're reasonably confident then that where you are at the moment in terms of timeliness and the processes and the—[Interruption.] Would you say that you are reasonably confident then that you've done the necessary work, you've got the necessary steps in place, and that all of this is going to happen in a timely fashion?

[278] **Mr Wile:** Yes.

[279] **Mr Davies:** Yes.

[280] **John Griffiths:** All of you, yes. Okay. Well, thanks for that. In terms of quality standards that should be met, what do you think they are? What are those quality standards?

[281] **Ms Rees:** We're part of the all-Wales steering group at the moment, and there's some ongoing discussion around what perinatal mental health

services in Wales should adopt as their standards for measuring quality of service, and what we should be aspiring to and achieving. I think, from our perspective at the moment, our expectation—you talked a bit about capacity and numbers, and, in terms of the number of women that are coming through the service in terms of giving us an indication about whether we're reaching people, we're quite confident that we're reaching—. We have 6,000 live births in our health board, and, in the last year, we had approximately 550 women that were seen by the service. So, I think that gives us some indication.

[282] And, in terms of quality standards, obviously, we've got the quality network, the royal college standards, for what the service should look like in terms of numbers and what we should be aiming to provide. I think there's some general consensus that across Wales that seems reasonable. But I think we're still in the development and planning stage at an all-Wales level, and I think we're looking to try and take some direction, really, around what the agreed data collection sets would be and how are we going to measure our outcomes as services, both clinically and activity capacity demand-wise.

[283] **John Griffiths**: Is there a timeframe for that work?

[284] **Ms Rees**: Well, the all-Wales piece of work is ongoing at the moment, and we're a part of that within ABMU; we're represented within the all-Wales steering group and also at the sub-group for the clinical pathway development work. In terms of a timescale, I don't think that I'm aware of a specific timescale, but I think people are moving quite quickly towards—having reached some agreements about the process and how we start to look at an all-Wales—. Certainly, what it would look like across Wales in terms of quality and measuring quality—.

[285] **Lynne Neagle**: So, we've heard this morning from Dr Sue Smith about these three levels of the quality network standards set out by the Royal College of Psychiatrists. Can you just tell us where ABMU are in meeting those three levels?

[286] **Ms Rees**: At present, ABMU isn't signed up to the review process that Sue mentioned this morning. I think, as Sue mentioned, there's only one other health board that's signed up to it. Our health board—our aim is to sign up for it. I think we've been focusing on the recruitment aspect of getting people in post so that we can then evaluate what's happening. But I think the direction for us is to join that network, so we can be formally

measured. We have used the standards to informally measure ourselves and benchmark ourselves against them, because that was the thing that was available to us. That was done at the very beginning, when I first came into post in October. I benchmarked us against those and, as we'd expected, we weren't meeting all of those standards. But I think we'd welcome an opportunity in another 12 months, and have planned in 12 months' time, to revisit that. So, that'll be in October of this year and I would anticipate that we will have moved closer to meeting more of those standards.

[287] **Lynne Neagle**: Thank you.

[288] **John Griffiths**: I've got a quick question about sharing best practice, Chair. Given that both of your health boards have set up perinatal mental health services, are there any key lessons that you could highlight this morning as to the lessons that you would share with other health boards that might be thinking of setting up similar services? What would be the key messages?

[289] **Mr Roberts**: Appoint the right people with the right skills, because obviously it's very difficult to correct an error early on in that process, and just make sure that there's no skills deficit within your teams so that you're well prepared to hit the ground—relatively well—running.

[290] **Ms Rees**: I think I'd add to that that one of the things—and I don't know if we've found a solution to it—that was a challenge for us, and other people may find it, is around the balancing of being experts and specialists, but in very small numbers and teams, and making sure that we've balanced the expert/specialist provision against skilling up as many professionals and people within healthcare and other networks to identify women who may need support throughout their pregnancy and following birth. So, trying not to fall into what we find the challenge of being a specialist-specific service and other people feel that it's not their business. I think we're trying to balance that through delivering training and awareness sessions to midwives and health visitors, and to the third sector, and trying to work collaboratively on this.

[291] **Darren Millar**: About the resources and the finance, you mentioned that—. We know that some services were in better shape than others when the Welsh Government made its announcement that it wanted to invest to improve. That meant that the gap for them to meet was smaller in some places like Cardiff, for example, where you had a more developed service,

compared to other places perhaps like ABMU, where there was a less developed service. How confident are you that the finances that are available to your teams to be able to deliver the sort of standard of services that is going to be expected are going to be there?

[292] **Mr Roberts:** I guess, based on what we know now, and the numbers that Anita just quoted, at the moment we're confident, but I guess maybe at the moment we may not know what we don't know in terms of what that might look like come the end of this calendar year, because I guess it'll be about what demand is created by the new service and perhaps what unmet demand is out there et cetera, et cetera. So, confidence at the moment, but again, when we review in the autumn, we'll have to judge and look at the demand and capacity equation.

[293] **Darren Millar:** Okay. How much did your health board receive—?

[294] **Mr Roberts:** It was £236,000.

[295] **Darren Millar:** Because it was divvied up on the population basis, wasn't it, rather than on 'Your service has got a bigger gap to close'.

[296] **Mr Roberts:** We did previously have a service in Bridgend that commenced in 2007-ish, but that was born out of a community mental health team that was already there, so people with specialist interest started to divert some of their time more specifically towards perinatal mental health.

[297] **Darren Millar:** If the Welsh Government did inject some more cash, do you think it would be fairer to inject more cash into those areas with a less developed service and less cash into those areas with a more developed service in order to get some equity across Wales? I know what the answer is from one side of the panel—[*Laughter*.] But I'm just thinking of making sure that there's no postcode lottery and that everybody across Wales can get access to a decent level of service.

[298] **Ms Rees:** I think some of the work that's ongoing—I know that I've mentioned it already—but the work that is happening in the sub-group from the all-Wales steering group may inform an answer to that question more, because at the moment, we're trying to think about, like you said, the postcode lottery and standardising the care that women get, and how that would look and what that needs to look like. And I suppose, perhaps, when

that work's completed, there might be a clearer answer.

11:30

[299] **Mr Roberts**: Lots of health boards would argue that it's swings and roundabouts around that, because there is a different prevalence of different healthcare needs across all health boards, and if you start moving away from the per capita apportionments, then it's quite perilous.

[300] **Mr Wile**: You talk about Cardiff having a slightly developed service—it was only two staff to start with, so there aren't huge differences. We didn't start off with huge differences between the health boards.

[301] **Dr Smith**: On paper, it does look as though we've got a pretty good number of staff now, and that we should be able to deliver far more than we did when it was only a few of us. It's surprising how much it's not really in proportion, because the more people you are, the more you have to manage things, the more other things you have to look at, and it doesn't necessarily mean—. So, I think with our team, we're trying to look at how we can use best the people that we've got now and move on. We would never say 'Oh, yes, we've got enough' because it's a bit bottomless really. You can always do with more.

[302] Can I just say a little bit about the quality standards as well? There is a financial implication to that because health boards have to pay in to the college to actually get that, and even in Cardiff that was a little bit of a bone of contention for a while, until we—

[303] **Lynne Neagle**: How much do they have to pay?

[304] **Dr Smith**: It's about £3,000 for a year, but if you pay for three years, you get it for £7,000. But then, in the long-term, it's seen as 'Oh, that's a bit more, though, and we can only do things in the short term', so it ends up costing more. So, I think that might be one of the advantages of having a managed clinical network rather than a community of practice, because at the community of practice and steering group, we've been saying 'We think that actually all the health boards should sign up to this', but we haven't really got any clout to insist that they do.

[305] **Lynne Neagle**: Okay. Thank you. Hefin.

[306] **Hefin David**: I've shared with you already that my wife had a pretty horrific experience with regard to undiagnosed mental health issues, particularly with regard to being unable to breastfeed. I note that the Public Health Wales consultation suggests that clear, transparent, evidence-based pathways are essential for the prevention, early identification and treatment of perinatal mental health issues, to ensure that all women are supported by those services, proportionate to their level of need. It was absolutely clear to me that that didn't happen in my case, and having shared stories with other people, and through social media, it is happening relatively often; I'm trying to get the bottom of how often. So, for patients with what you might classify as non-severe perinatal mental health problems, what is the referral process?

[307] **Ms Rees**: In ABMU, women would be identified by their GP, their midwife or their health visitor as having a need or an emerging difficulty. Those people can refer into the perinatal mental health service. We offer an advice and consultation service if people aren't—

[308] **Hefin David**: Okay. So, it's up to the midwife and the health visitor to identify where those problems can be referred. One of the issues that we found was that there was no consistent—. We didn't consistently have the same midwife. We didn't consistently have the same health visitor, and therefore when a health visitor says to you 'How are you feeling? You don't look very good, how are you feeling?' it's very difficult to say that to different people at different times. Is that a problem, and is that a problem across—?

[309] **Ms Rees**: I think, from experience, inconsistency of contact is one of the biggest themes that comes up, certainly when we hear from people with lived experience. That is one of the challenges. In ABMU, certainly where women can be identified early as having possibly predisposing risk factors, there is an aim in ABMU for them to be offered consistency of care with midwives. So, certainly, some of the women who are already known to us, who then become pregnant again, or they're known to us during their pregnancy, we can liaise with—

[310] **Hefin David**: From what you're saying, there's a clear problem at that first stage: the first time, the first pregnancy, the first time it's been identified.

[311] **Ms Rees**: I think it's a challenge identifying women, and I think there's lots of reasons for that: stigma, inconsistency sometimes in contact and service contact—

[312] **Hefin David:** And, also, not seeing consistently the same midwife and the same health visitor. Is that a resource issue, or is it just organisational?

[313] **Ms Rees:** Probably maternity for ABMU would be better—

[314] **Dr Smith:** I think working closely with midwives is something that they will identify—that they find it frustrating that they're overworked and they've got big caseloads and then they're asked to cover other people. They would accept that that was an issue as well. And I'm pretty sure that there have been moves quite often within maternity services to try to change that and to try to give that consistency. But realistically—

[315] **Hefin David:** What solves that problem? Is it organisation or money?

[316] **Dr Smith:** Yes, it's organisation—

[317] **Hefin David:** Organisation.

[318] **Dr Smith:** Yes, because we're talking about something that we can't have that much control over, apart from educating women themselves, I suppose, that if you feel like this, it's really important to talk to somebody. But the other—

[319] **Hefin David:** Okay. And for those non-severe cases, what sort of referral is appropriate? What kind of treatment is appropriate?

[320] **Dr Smith:** Sometimes it can be enough to meet someone once and hear that, actually, this is okay and this is how you do feel and not to beat yourself up about it. Sometimes something very minimal, especially very early on, can make a massive difference and prevent things later.

[321] **Hefin David:** Okay.

[322] **Ms Reed:** Certainly in our own experience—and you mentioned about the proportionate response, proportionate to somebody's need—one of the things we find is that often advice and consultation, liaison and supporting midwives, health visitors and GPs to support women helps to build that consistency of interaction. It helps to measure whether it's proportionate and then if there is a need for something in addition to the universal support that is available.

[323] **Hefin David:** Okay. Ian.

[324] **Mr Wile:** I was just going to say there are some evidence-based psychological interventions that are around for people with mild to moderate problems at that early stage, which can be done while people are being monitored. I'm not an expert on the actual psychological interventions themselves, but we do provide them in Cardiff, particularly around our primary care services, and I think there are some skills now being developed in the team around that kind of low-level psychological support.

[325] **Hefin David:** Do you recognise the same problems that I referred to—

[326] **Lynne Neagle:** Can you let Sue—? Sue wanted to come in then, didn't you?

[327] **Dr Smith:** I've lost track of what I was going to say then. But I think it's going to be slightly different about the low level when you've got a baby, and so there is definite room for increasing maybe the primary care level of education and training about those. Certainly in England, where they've got the Improving Access to Psychological Therapies service, whereas we've got primary mental health support—they do have a stream now where there is specific training for perinatal, and I think that does need to happen in the primary care here.

[328] **Hefin David:** And how, across health boards, are you enabling consistency in care pathways? How are you making sure that people have the same service?

[329] **Ms Rees:** Within our own health boards?

[330] **Hefin David:** Whether you live in Swansea or live in Cardiff or live in Caerphilly, we need consistent approaches. Is there shared practice?

[331] **Ms Rees:** Well, we have the community of practice and we meet twice a year, sharing the emerging evidence base and new practice. And also there's the stream of work I mentioned earlier ongoing around looking at a kind of unified or national best pathway—

[332] **Hefin David:** The national care pathway.

[333] **Ms Rees**: Yes, and to think about where everyone is in relation to that. This process will probably help with that.

[334] **Hefin David**: So that's something you would welcome.

[335] **Ms Rees**: Yes.

[336] **Dr Smith**: [*Inaudible.*]—community of practice is to try to share and to look where everyone is and try and get some consistency. But, as I've said a few times, there's no real clout behind that, which is where a managed clinical network might improve things.

[337] **Lynne Neagle**: So, are you able to tell us from both health boards' point of view what the waiting times are for non-severe perinatal mental health and for the more acute problems, please?

[338] **Ms Rees**: Within ABMU, people are seen within 28 days. So, for non-severe presentations, people are seen within 28 days of referral. They would be seen for an initial assessment. In terms of severe or more acute, urgent referrals, if we have a referral we'd be in touch with the referrer and the service user within the next working day. We may not always offer within the next working day face-to-face contact with the patient, but we would link in with existing pathways around crisis and home treatment teams or duty assessment services, and we would link in and try and be part of the assessment process. We're pitched at a level of primary mental health, so we don't—at the moment, the model doesn't allow us to offer an urgent, immediate, same-day response.

[339] **Lynne Neagle**: And Cardiff and the Vale?

[340] **Mr Wile**: It's pretty much the same. The routine referrals are within 28 days, but I think, understanding from the team, we probably see most people within two to three weeks within that. Again, on the urgent response times required, which, from a national point of view, standards are for mental health 48 hours, I think the problems are the same as ABMU. It can be problematic negotiating assessment.

[341] **Dr Smith**: Yes, and we have recently started having a duty system of an afternoon. There's always a member of staff who's available then to field anything that might seem more urgent and to look at the appropriate—. It may not be that we end up seeing them, but at least they can give advice as

to what the best course of action is.

[342] **Lynne Neagle**: Okay, thank you. Can you tell us what the pathway is for someone who's under 18, and how that works in relation to co-operation with CAMHS?

[343] **Ms Rees**: Yes. In ABMU, we will undertake joint assessments with CAMHS where it's identified that a young person is pregnant. On our referral form, we ask for that information anyway, about other mental health services involved and social services' involvement. So, we aim to know whether they're involved with CAMHS already at the point of being referred to us. But if somebody is under the age of 18, we would endeavour to seek that information out: are they already known to CAMHS, and, if not, for us, with permission from the family, to seek a joint assessment with CAMHS? I think, in ABMU, we're in a fortunate position that there is some clinical experience of CAMHS working in our perinatal mental health team. So, I think there's maybe a confidence and some links already existing there.

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

[345] **Dr Smith**: It's pretty much the same in Cardiff.

[346] **Lynne Neagle**: The same. Okay, lovely. We're going to move on now, then, to talk about mother and baby units. Julie's first.

[347] **Julie Morgan**: Thank you. I did ask Sue in the previous session about the history of the mother and baby unit in your health board. I don't know if you've got anything to add, really, about any particular issues that you learned from your experience of having that unit.

[348] **Dr Smith**: Well, even though we maybe didn't meet the standards—. I was thinking earlier, actually, that there are also standards—in the same way there are quality standards for community teams, there are quality standards for in-patient units as well. Even though we were a small unit, which was just run by nurses and doctors—we didn't have a multidisciplinary—we still passed the basic standards for that work. We still did a good job; we still helped quite a lot of women, even though maybe it wasn't ideal and wasn't used as much as it could have been.

[349] **Julie Morgan**: And you did feel that they should be—

[350] **Dr Smith**: I mean, at that stage, as I say, and looking back at that stage, maybe what we should have done, rather than just closing, was to actually have a good look at what we need for the whole of Wales. If this is meant to be the unit for the whole of Wales, and it's not working like that, then why not? So, actually looking at it at that stage, rather than closing, although I can completely understand the reasons why it did close as well.

[351] **Julie Morgan**: Yes. Do you have anything to add, Ian, on that point?

[352] **Mr Wile**: No, nothing to add, really. I think it's fair to say that there were some difficulties in sustaining it, because although there was a reasonable demand for the unit to stay open, there'd be periods when it was very busy and then periods where it would close because there wouldn't be any service users there. And, of course, staff had to be redeployed, we'd lose skills and there was a staff turnover. So, it was quite hard to sustain it based on the arrangements that there were at the time. I think there's certainly a demand there, but I think if there was a mother and baby unit in Wales, the way that it's commissioned is really important to get right, and having very clear pathways on what the purpose of those admissions would be for the different health boards. I think then it would be optimised, the use of a unit. As it was, five years ago, it didn't feel as safe as it could have been, although the standards of care were very good there when people were in hospital.

[353] **Julie Morgan**: Thank you. And what is your view on this?

[354] **Mr Roberts**: I'd agree with Ian. Sustainability is key, because we need to create something that is going to last and promote excellent patient care. I think, obviously, geography might be a challenge around that, because we all know how long it takes to travel from, say, Haverfordwest to Cardiff. I think the need for us to convince mothers that maybe travelling a distance in order to get the right service for them is the best outcome for them and their child. So, I think it's obviously driven by sustainability, and I gather commissioning colleagues are already looking at the options available.

11:45

[355] **Julie Morgan**: What about what happens now in your health board if an in-patient—?

[356] **Ms Rees**: In ABMU currently, if somebody needs treatment in an in-patient setting, they're admitted to acute psychiatric wards, which doesn't

always feel satisfactory. I think it's an area that we haven't had all the facts on in our health board in terms of numbers, and so the demand possibly has been hit. Certainly since we've been operational, since January, across all areas in our health board, we've had four ladies admitted with perinatal illness to acute psychiatric wards. The data prior to us being operational in January were very hard to come by. There was no specific mechanism for recording if it was a perinatal related admission in the health board. But, in terms of supporting the idea that we need something locally to Wales, three out of the four women turned us down for even enquiring about a mother and baby unit bed on the basis that it was too far for them to go to England.

[357] **Julie Morgan**: So, they remained in the community then, did they?

[358] **Ms Rees**: Well, they remained on the acute ward without their baby for the shortest amount of time possible. Some positive things did happen within that, although it wasn't an ideal situation. One mum was facilitated to continue expressing milk and went home and recommenced breastfeeding, which was her wish. Lots of work went into making the not-ideal situation as good as it could be.

[359] **Lynne Neagle**: Do you have any information on the four women that were admitted as to whether they would have preferred to go to a mother and baby unit, or was that not available?

[360] **Ms Rees**: The information I have is that when they were—they were women known to our team, so that is why we had the information. When, as always, the mother and baby unit is discussed if it seems appropriate, and, in these cases, it was discussed, and three of the four women automatically ruled it out, because, as soon as it was introduced that it was outside of Wales, travelling and family—. Two of them had other children at home and didn't want to be so far that they couldn't come and visit them, and I think it's a shared—. I don't think we're the only health board experiencing those unsatisfactory experiences for women.

[361] **Julie Morgan**: So, there's a case for somewhere in south Wales, basically, isn't there?

[362] **Lynne Neagle**: Sue.

[363] **Dr Smith**: Another thing about mother and baby units that links with what you've been asking about training and stuff over the morning is that it

is really good for training as well, in terms of staff coming through, student nurses coming through, medical students, student doctors. At the moment, I'm the only medic in the team in Cardiff, and it's quite difficult to then give that time to train some of the junior doctors, as much as I'd like to, because that is quite difficult. Although primarily, obviously, the unit is for the women, I think the expertise that it develops around it then is something that also has to be considered as a bonus to it.

[364] **Lynne Neagle**: Darren, on this, then Michelle.

[365] **Darren Millar**: I was just conscious of the fact that those three mums ruled out going to a mother and baby unit because of the distance—the very long distances. But to what extent is that then hiding the true level of demand? You mentioned the figure earlier on, Sue, that there were probably 10 women last year who you felt should've been admitted to a mother and baby unit. Only five of them actually ended up, I think—

[366] **Dr Smith**: No, they didn't go in. I think I made five referrals altogether, but there were at least another five that I thought that this would be really beneficial to them. But it's hard to argue for the funding to actually go miles away when we just about manage, here.

[367] **Darren Millar**: We're told that the level of incidence of serious, poor perinatal mental health would suggest that about 60 to 80 mums across Wales would need a mother and baby unit provision. Do you recognise those figures?

[368] **Dr Smith**: Yes.

[369] **Darren Millar**: That would be about right.

[370] **Dr Smith**: Yes.

[371] **Darren Millar**: What sort of size of mother and baby unit do you think that would suggest is required? How many beds, because, obviously, the length of stay is going to be different for different mums, isn't it?

[372] **Dr Smith**: A minimum of six in the south.

[373] **Darren Millar**: Across Wales.

[374] **Dr Smith**: Well, eight across Wales, but, logistically ,that would be really hard to do so you'd probably have to have a different model in north Wales to south Wales, with a minimum of six.

[375] **Lynne Neagle**: Michelle.

[376] **Michelle Brown**: Thank you. If we can just develop—. You said six mother and baby units across—

[377] **Dr Smith**: No, six beds on one unit.

[378] **Michelle Brown**: Six beds, sorry.

[379] **Dr Smith**: It just wouldn't work like that.

[380] **Michelle Brown**: Where would you like to see the mother and baby units located?

[381] **Dr Smith**: I think that the difficulty with that is that someone is going to have to travel at some point, so I suppose it's just a case of looking, geographically, where the best place would be and where the best site would be. Ideally, it should be co-located with a mental health unit as well to have that back-up—ideally, with a maternity unit as well. I think that one of the standard 'threes' for in-patient units is to have both things—having an acute ward and a maternity ward on the same site—but that would be the ideal.

[382] **Lynne Neagle**: Thank you. Okay, we're going to move on to neonatal services. Hefin, briefly, please.

[383] **Hefin David**: Briefly, okay. We've had evidence that psychological support on neonatal units in Wales is woefully insufficient and requires urgent attention, and that there's a lack of trained mental health workers available across neonatal care. Can you express individually your views on that statement?

[384] **Ms Rees**: In ABMU, there isn't a specific psychological dedicated service in neonatal care at the moment, but women are able to access the perinatal pathway into our service, and we would recognise that women who have babies in neonatal care—recognise that as an added risk factor for their mental health and well-being.

[385] **Mr Wile:** It's the same position in Cardiff, as I understand it, and I'd agree with you.

[386] **Dr Smith:** I was talking to the midwife who works with our team about this yesterday. Certainly, as a trainee—this is a good number of years ago, when, I think, it was in Southampton—I went along to a neonatal unit thinking, 'I'm a trainee and I'm interested in perinatal psychiatry and I'll give them some support'. Actually, what the mums there tended to say at the time was, 'When we're here, when our babies are in here, we're actually getting really good support. The staff here are fab. It's actually when we go home that we're worried about', and that was my experience there. That was just my experience then. Since then, I know I've got a number of women, perhaps, who I've seen over the years who've had babies in a special care baby unit, and so you're supporting them as you'd support them anyway, but I think it is a good point and it is something that we should be looking at.

[387] **Hefin David:** So, you think that the focus has shifted away from neonatal services outwith that?

[388] **Dr Smith:** That was my experience of women actually saying, 'When we need it is when baby comes home rather than when we're on the unit. We seem to be getting this support because the staff are great'. That was obviously one unit, but I've heard similar things said by ladies I have looked after who've had babies on the units, saying, 'While we're in there, it's not too bad—it's when we go home that we—'.

[389] **Hefin David:** As I say, that's contrary to the evidence that we've got.

[390] **Dr Smith:** That's interesting, because what our midwife said—I wasn't aware of this—was actually that their neonatal staff do go on visits at home, then, as follow-ups, which they didn't use to do, so they're looking at that. I think it's a really good point that we should be looking at.

[391] **Hefin David:** Perhaps this is something that we should investigate further, Chair.

[392] **Lynne Neagle:** Yes, because it is meant to be one of the standards, isn't it, that's complied with on neonatal units? So, in ABMU, if somebody—. It's clear that they're getting some support in Cardiff and the Vale. If they've got to access it, is it via the perinatal team?

[393] **Ms Rees**: Yes, they can access the perinatal mental health service.

[394] **Lynne Neagle**: Is that when the baby is still in hospital?

[395] **Ms Rees**: Yes.

[396] **Lynne Neagle**: Okay, thank you. We'll move on to training. Llyr.

[397] **Llyr Gruffydd**: Thank you, yes. I'm just interested, really, in knowing how your respective health boards make sure that the professionals—the front-line healthcare professionals—within your organisations have the knowledge and the information they need to make prompt responses to perinatal health issues when they arise, and whether you provide any particular training as well, particularly, maybe, for crisis teams.

[398] **Ms Rees**: In ABMU, our focus has been on skilling up and developing the knowledge and skills of the perinatal mental health team. We're new practitioners to the area. We have been working alongside—informally, I guess, really doing joint casework and joint assessments—crisis home treatment teams, which you specifically asked about, in the hope that informal sharing of knowledge and skills gives women a better experience when coming into contact with those services. We've delivered some training and awareness sessions to the maternity services, and we're hoping to make that part of a rolling programme for midwifery services and health visiting services. I think there's been the Royal College of Psychiatrists perinatal training, which has become available. Certainly, I think the psychiatrists in our team would look to take that up moving forward.

[399] **Llyr Gruffydd**: What's the experience in Cardiff?

[400] **Dr Smith**: I said that there are two issues, really, aren't there? There's the training of the staff who are actually delivering the service, and then there's the training of other people who will come across women with potential mental health problems and making sure that they recognise it amongst all the other things they're meant to be recognising as well. So, there are both issues. A slight frustration, perhaps, because I do think that, yes, we should be delivering perinatal mental health training in Wales, but because we're all fairly new to it, having the confidence to say, 'Yes, we're setting up a training session', I think is something we need to build towards. There are lots of things already established going on in England, but I think part of the problem is that, actually, for staff—not so much medics because

they've been able to get study leave and to go places, but sometimes for other disciplines, to get funding to go across the Severn bridge into training in England has been a bit difficult in individual trusts, and that's something I've always tried to support and push for a little bit. I think, ultimately, we should be doing more in-house, but at the moment, it's a pity to miss out on the vast experience of developed services and training that is put on outside of Wales. It enhances—if you go to visit a unit somewhere else and have some training there, that just increases your own knowledge and understanding of things.

[401] **Llyr Gruffydd**: Of course. But, is the onus very much on the local health board to deliver? There aren't any national initiatives in Wales to bring people together and share that practice.

[402] **Dr Smith**: Well, there is. In community practice, one other part of that as well is sharing knowledge and we've put on a couple of conferences so far and parts of those are educational and parts of those are sharing practice as well. So, we do see that that is something we should do more of.

[403] **Llyr Gruffydd**: In terms, specifically, of the wider workforce within health services then, do you quantify in any way? Do you have any data around who has certain skills or what training they've actually done? Do you capture that in any way or is it just rather ad hoc and you sort of hope that it could—

[404] **Dr Smith**: It probably is captured somewhere.

[405] **Ms Rees**: I don't think we, as a service, capture the wider workforce's skills and knowledge, but certainly, within departments and within the bigger training department, I think there would be information available.

[406] **Llyr Gruffydd**: But who would have that information then? Because, if I wanted to know how many midwives or health visitors have had some sort of awareness-raising training or whatever, where could I go to access that?

[407] **Dr Smith**: It would have to be the individual directorates, the individual—

[408] **Mr Wile**: From a central point of view, that sort of information's not collected like mandatory training would be, for example. Because a lot of it relies on the efforts of the team to go to nursing schools, or whatever, to do

some awareness raising, I don't think that would be formally captured anywhere.

[409] **Llyr Gruffydd**: So, it's still pretty ad hoc then, isn't it?

[410] **Mr Wile**: It is ad hoc, yes.

[411] **Llyr Gruffydd**: There's not a systematic way of ensuring that there's someone in every single establishment or in every single area of expertise that has that certain awareness.

[412] **Dr Smith**: I mean, I suppose adding it to the mandatory training might help, if it was something you absolutely had to do.

[413] **Llyr Gruffydd**: But that would be one of a number of other areas, I'm sure, that people are calling for to be added to the mandatory training. Okay. Thank you.

[414] **Lynne Neagle**: Okay. Thank you very much. Hefin.

[415] **Hefin David**: During pregnancy and breastfeeding, when is the appropriate time to prescribe medication for mental health issues? Is it appropriately prescribed, do you think?

[416] **Dr Smith**: I knew you were going to look at me. I would say although I'm the doctor and maybe I'm the one who prescribes, one of the main reasons I end up prescribing, often, is because my team come to me and say, 'This lady's really struggling.' What's really nice is when I see that, a few months later, they say, 'Gosh, she's so much better since you put her back on that medication. I cannot begin to describe the difference.'

[417] **Hefin David**: Is it not something that health boards should be overseeing? Is it not something that health boards should be concerned about? I mean, you don't know whether you should answer that question or how to answer that question. Is it not something you should know?

[418] **Ms Rees**: Sorry, I don't—

[419] **Lynne Neagle**: [*Inaudible.*]—the question.

[420] **Hefin David**: When GPs are prescribing medication for mothers who

are breastfeeding and during pregnancy and have mental health issues, should the health board be aware of the extent to which this medication is being prescribed?

[421] **Ms Rees**: You mean, collating data on when and how—

[422] **Hefin David**: Should you be aware? Given the consequences it can have for bonding issues, for example.

[423] **Ms Rees**: Certainly, I can only speak for what happens in our own health board. If GPs are meeting women whom they are concerned about in relation to their mental health whilst breastfeeding postnatally, they're able to refer to us. But, even if the woman doesn't want to be referred to us for intervention or assessment, GPs can contact us for advice and consultation, and a doctor within our team will provide prescribing advice and consultation in a timely way—so, the same or next working day.

12:00

[424] **Hefin David**: So, there's access to this support and advice, if GPs need it. Okay.

[425] **Ms Rees**: Yes, and I suppose our expectation would be that we're trying to promote that at the moment as a new thing we are offering.

[426] **Hefin David**: Because we're seeing evidence that GPs are unsure about when to prescribe.

[427] **Ms Rees**: Yes. I think we see that too. We see that GPs are unsure and are seeking guidance and information from our service.

[428] **Hefin David**: But, is it the case that nobody's really sure? This is something we don't know.

[429] **Dr Smith**: I'm very honest with women about the fact that we don't know all of it, and all we can do is what's best at the time, and weigh these things up. I think, sometimes, sitting down and having a very honest discussion about that is what you need to do.

[430] **Hefin David**: So, it's such a nuanced situation, it's very difficult to issue guidelines and—

[431] **Dr Smith**: Yes, I think it is, because what's right for one might not be right for another. That's why it's difficult, sometimes, just to give phone advice. A GP might phone me up and say, 'What's the safest?', and I go, 'Well, it's this, but actually it depends on this and this and this.' So, I'll just see her because that's easier.

[432] **Hefin David**: Okay.

[433] **Lynne Neagle**: Okay, thank you. John.

[434] **John Griffiths**: We discussed earlier, Sue, didn't we, the issues around the adequate provision of services for those with a dual diagnosis, possibly addiction and maybe learning disabilities or some other mental health disorder. So, from the health board's perspective, I'd be interested again in whether the service is everything it needs to be to provide for those pregnant women with a dual diagnosis, or whether you feel improvements need to be made. And, if so, are you taking necessary steps?

[435] **Ms Rees**: I suppose, from our perspective in ABMU, in terms of particularly the dual diagnosis around substance misuse, the maternity service in ABMU are really forward thinking in terms of perinatal mental health. They have a substance misuse specialist midwife who we link in—that person covers the whole area, so that's some consistency—and we link in quite closely with the specialist midwife. There's a perinatal mental health lead for midwifery and there's a substance misuse lead for midwifery and we link in with both those people quite closely, doing some joined-up work with those people who would be invited to birth planning meetings, for example. We might undertake some joint assessment work with those people to try and improve the communication and experience of the person.

[436] **John Griffiths**: So, are you content that services as they currently exist are adequate and sufficient?

[437] **Ms Rees**: I think they are, from what we know at this moment in time, but I think we're at the beginning of the journey. I think, possibly, as we evaluate our service area in the next 12 months and look at the model, the needs we're not meeting, hopefully, will become clearer as well, and perhaps I would have a different answer then.

[438] **Mr Wile**: We're similar. The only thing I'd add to that would be that our

community addictions unit prioritises people who are pregnant. It's probably something that we need to look at a bit more closely, I think, over the next year or so, to see if people are getting the kind of service that we expect for them. So, I think there's still work to be done for that.

[439] **John Griffiths**: Okay, and could I ask, in terms of women from more deprived communities, do you have a particular approach to those women?

[440] **Ms Rees**: In terms of specific things that we identify to engage with those women, yes, one of the things we've done already is we've recognised that there is an issue around access for women who didn't have transport. The take-up for some of our group-based treatments was low, and when we followed up the reasons why, women identified childcare and transport as some of the main issues. So, one of the things we've done is relocate the venue for some of our groups to try and be more accessible to women from some of the more deprived areas of our locality, and particularly trying to link up with the Flying Start areas, because generally they operate within more deprived communities with multiple needs. So, I suppose that's what we're trying to do at the moment. But, I think it is part of reviewing our service and seeing where we are in relation to meeting those needs. We've tried to do some kinds of very immediate interim things, having identified an issue.

[441] **John Griffiths**: Yes, I see. Okay, so, again, it's work in progress.

[442] **Ms Rees**: Work in progress.

[443] **Mr Wile**: I'm quite glad ABMU are going first. [*Laughter*.]

[444] **Dr Smith**: I'd certainly mention Flying Start. Sometimes if we know a woman is in a Flying Start area, we will go, 'Oh gosh, they're going to be getting this and this anyway, that's right, so we can gear what we will need to do.' But I think, in terms of deprived areas, you probably get more referrals from certain areas, so without even realising it, you are doing more work there and understanding about the particular social catch-all issues around there. But certainly, yes, getting to groups and stuff is something we try to think imaginatively about as well.

[445] **John Griffiths**: And again, you'd be looking at how you can build on that approach and perhaps more effectively provide services to women from more deprived communities.

[446] **Mr Wile:** Yes, I think that and other hard-to-reach groups as well, where there could be potential language barriers, particularly in Cardiff south and east areas. I think that when we do a piece of work this coming year to look at demand and where that's coming from, perhaps we can have a look at some health promotion strategies and how we can get information into people's hands rather than relying on people's knowledge about accessing primary care services and their GP. So, I think that's work in progress for us as well.

[447] **Lynne Neagle:** Darren.

[448] **Darren Millar:** Obviously, in the absence of the development of these services, there have been a number of third sector organisations that might have been established or tried to pick up some of the gaps in provision. How familiar are you with the third sector services in your own areas that have been doing some work on this, and is there an opportunity there to use the third sector as something that you can refer in and out from?

[449] **Dr Smith:** I think there absolutely is and that's something that certainly, because we've got third sector representation on the community of practice, has been really helpful in increasing understanding about what's actually there and what's available.

[450] **Darren Millar:** Particularly at those lower levels—

[451] **Dr Smith:** Yes, and it's definitely something on which we need to work more closely with them and I sometimes feel that I really need to know more about what's actually going on. The Maternal Mental Health Alliance, which has mainly been in England, are going to be starting to work in Wales. There's a workshop in a couple of weeks' time and they are going to come along to look at what they can do to help with that, so that's really good and that's something that we're going to get actively involved in.

[452] **Mr Wile:** We do have examples in other areas in mental health, where we work collaboratively with the third sector around health promotion and some of the lower tiers of psychological therapies. So, we've got examples that we can mimic in mental health and apply to the mother and baby service. I think we just need to get some momentum behind that, now that the team has been built up to the point that it has.

[453] **Lynne Neagle**: Quickly from AMBU.

[454] **Ms Rees**: Yes—[*Inaudible*.]—position in terms of the fact that we're still mapping what's out there, but, yes, we do link in with a couple of specific groups in the Swansea area. So, there is something called the PANDAS Support Group, which is a third sector group, which is excellent in working with women experiencing mental health difficulties.

[455] **Lynne Neagle**: Thank you. The final question then is on managed clinical networks. What do you think the benefits are? What are the disadvantages? And for each health board, would you support the establishment of them in Wales?

[456] **Dr Smith**: I mentioned what I thought earlier.

[457] **Lynne Neagle**: So, Ian.

[458] **Mr Wile**: They can only be an advantage, those kinds of networks, if I understand what you're saying. It's just about expanding the community of practice work, is it?

[459] **Lynne Neagle**: As a formal, managed clinical network.

[460] **Mr Wile**: Yes.

[461] **Lynne Neagle**: So, it's only advantages.

[462] **Mr Wile**: I think with these royal college standards, for example, we can start taking an all-Wales approach to decisions around certain things, so that people can go back to their health boards and be supported through them, if we decide between us what the minimum standards are that we want to apply to services.

[463] **Mr Roberts**: I think that the wider you spread the net, the more informed you become, would be my view. So, I'd support Ian's words.

[464] **Ms Rees**: I think I'd support Sue's earlier comments in terms of the benefits.

[465] **Lynne Neagle**: Okay, lovely, thank you very much. Can I thank you all for attending this morning and answering our questions? You will be sent a

transcript to check for accuracy in due course, but thank you very much for your time; it's been very helpful to the committee. Thank you.

12:10

Ymchwiliad i Iechyd Meddwl Amenedigol: Sesiwn Dystiolaeth 7
Inquiry into Perinatal Mental Health: Evidence Session 7

[466] **Lynne Neagle:** Our final evidence session this morning, then, is with the Welsh Health Specialised Services Committee. I'm very pleased to welcome Carole Bell, director of nursing and quality, and Carl Shortland, who is the specialist lead for specialist mental health. Thank you very much for attending this morning, and for the paper that you provided. If you're happy, we'll go straight into questions. And I've got a question from Oscar first.

[467] **Mohammad Asghar:** Thank you very much, Chair, and good afternoon, both. My question is: if the previous mother and baby unit in Cardiff was wrongly closed, was there evidence provided to Cardiff health board that convinced them that the service was unnecessarily misleading? Could you expand on how it may have misled the health board, and what lesson can be learned from there?

[468] **Mr Shortland:** Right. The previous unit was actually—the closure of that unit was actually instigated by Cardiff health board. They wrote to WHSSC, and expressed concerns about the effectiveness and the sustainability of the unit. And some of the reasons they gave around that at the time were the significant staffing issues they were experiencing, across mental health services, particularly in nursing staff, and the fact that they didn't have any therapists in the unit. And as important was the actual use of the unit. As you probably know, it was only a three-bed unit, and they shared with us details of the activity that that unit had had. And over the previous five years, the number of admissions to the unit was running at an average of 11 patients per year. WHSSC did some further investigation with the health board, and, in the last 24 months the unit was open, there were nine of those 24 months where there were no patients in the service. And they averaged roughly 1.2 patients at any given time, over that five-year period.

[469] So, WHSSC, having received that evidence, wrote out to health boards, and got positive confirmation back from at least one health board—I think there were three south Wales health boards that responded to say that they supported the closure, given the extra investment that was going into

community perinatal services at the time, and that that should, in effect, reduce demand even further.

[470] **Lynne Neagle**: Okay, thank you. Julie.

[471] **Julie Morgan**: We've had a lot of evidence given to us that there should be a mother and baby unit for Wales, or out of Wales. Is that your view?

[472] **Mr Shortland**: I think it's a very complex question. Obviously, there has to be provision for mother and baby beds for Welsh residents. Whether that is in Wales, or it's in England, with either negotiated contracts or cost per case, is currently subject to the task and finish group piece of work that's going on at the moment. WHSSC do struggle—obviously, we try to do evidence-based commissioning, and we do struggle to get information out of health boards about the level of demand and need for these beds. The only real, hard information we get is the requests for patients to go into this service—this type of service—and, as highlighted in the paper, it has been running at really low levels. The requests for out-of-area placements sent to WHSSC varied between half a dozen and 13 over the previous three years, and the placements in actual beds running even lower than that.

[473] Now that—we recognise it isn't the real demand, because there are alternative services that have been accessed, or used, by mothers. But if we do enter into a business case discussion, we need further evidence from the health boards to support the case, to say there is the demand. You probably heard, I think, in the previous session, the epidemiology and the other suggestions are maybe 60 patients a year may benefit from this type of service, but that isn't what we're seeing coming in as requests to WHSSC.

[474] **Julie Morgan**: I don't know whether you heard the previous evidence, where one of the health boards said that, out of four women who it was felt needed to be placed in a mother and baby unit, and needed that care, three of them wouldn't consider it because it was outside Wales.

12:15

[475] **Mr Shortland**: I think that there are two issues there. From a clinical perspective, I would expect the clinicians to have those discussions about the benefits of accessing that service and to demonstrate the evidence is that mothers and babies do well if they're in a mother and baby unit.

[476] **Julie Morgan:** I think they did. We have no reason to think they didn't have those discussions, but it was the fact it was so far away, outside Wales, and, obviously, they probably had other children, and the disruption and the worry—. So, that was what's just been told to us. Those people, presumably, wouldn't have appeared on your statistics, because there wouldn't have been a request.

[477] **Ms Bell:** There wouldn't have been. What we do know is that, where we have had requests, we have found beds for those women. As part of the task and finish group work that we did, we spoke extensively to women with lived experience, and a number of those had actually accessed mother and baby beds. And whilst the travel was problematic, they said that the most important thing was the fact that they felt that they didn't want to be separated from their babies and that it was about the environment, that they felt safe, and to be able to have the best care in order for them to have a good outcome.

[478] **Julie Morgan:** Certainly, in the figures that you've given us, the number of requests for placements is greater than the number of placements granted. So, I think you've said that you could always get a place for them.

[479] **Mr Shortland:** Yes, I think the difference between the two statistics is the request for a bed placement comes in from the health boards, from the referring clinician. WHSSC work the system on a prior-approval basis, so there's no internal scrutiny of the placement at WHSSC that stops that placement going ahead. Generally, what will happen is, between the referral and the placement being found, there'll be a change in—

[480] **Ms Bell:** The clinician will come back.

[481] **Mr Shortland:** —presentation, or the individual patient may have changed their mind. But I'm not aware of any cases where WHSSC would interfere in the clinical judgment and stop that placement taking place. The other point, just going back, around the distance, as you're probably aware, there are lots of specialist services that we procure in Wales that are in England, and perinatal just happens to be one of a number of mental health placements. So, unfortunately, because of the actual—it's the skills and the expertise of staff, as much as resources. We do have to place patients in England for lots of special services—much wider than mental health as well.

[482] **Julie Morgan:** So, just to be clear, these figures for 2016-17 are 13

requests, and the number of placements: six.

[483] **Mr Shortland:** Yes.

[484] **Julie Morgan:** None of the others would have been refused a placement.

[485] **Ms Bell:** No, they wouldn't have.

[486] **Julie Morgan:** It was just that circumstances would have changed.

[487] **Ms Bell:** Absolutely, and therefore that request would have been cancelled.

[488] **Julie Morgan:** Right. So, you have always been able to get a place in an English mother and baby unit when it's needed.

[489] **Mr Shortland:** I think we have always managed to find a place. That may not have been as quickly as everyone would have liked, and it may have involved extensive trawling with providers, but we will work with the referring clinician to find the bed, wherever that is in the UK.

[490] **Ms Bell:** And I think that is becoming increasingly difficult in providing the beds. But, to date, we haven't had an example where we haven't been able to place a mother and baby in a unit.

[491] **Julie Morgan:** Over what period of time is that?

[492] **Ms Bell:** Well, I've been at WHSCC for just coming on to two years, so—

[493] **Julie Morgan:** There's no occasion when you haven't been able—

[494] **Ms Bell:** No.

[495] **Julie Morgan:** And what about delay? What is the length of delay?

[496] **Mr Shortland:** I think it varies, because, actually, the clinician who is responsible for the patient tends to take the lead on identifying the placement and then putting in the request to WHSSC. So, there are different counts we could be doing here. Once the referral comes into WHSSC, the funding is agreed virtually instantaneously, and the placement can proceed,

assuming that they've identified that bed and the placement is accepted—the referral.

[497] **Ms Bell**: I think what we have heard, though, is that that does take time. So, the clinicians who need to find the placement spend an extensive amount of time looking for and finding a placement before they come to WHSCC requesting the funding. So, it is quite an onerous task for the clinicians in order to be able to find that placement.

[498] **Julie Morgan**: Right. And what about the fact that some mothers do go into, or are transferred to, psychiatric wards without the baby? Do you have any views on that?

[499] **Ms Bell**: We don't have any input into those decisions. However, there is evidence, and significant evidence, out there, to suggest that, where possible, mothers and babies shouldn't be separated, and that's to improve the outcome for both mothers and babies in terms of long-term mental health.

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

[501] **Lynne Neagle**: Can I ask—what would you regard, then, as an appropriate time span for an emergency admission to a mother and baby unit, and to what extent are we able to meet that in Wales?

[502] **Mr Shortland**: I think it's difficult to put an actual timescale on it, because each individual case is different, and the clinician who's responsible for that patient, in effect, will determine how much of an emergency that placement is, and all efforts will be made to find a bed as soon as possible. I can't think—. I wouldn't be able to give you the exact number of days, but I would imagine, once a referral is made and is accepted, it should be within a number of days.

[503] **Ms Bell**: That turnaround is very quick, once it comes into WHSSC.

[504] **Lynne Neagle**: Okay. Darren and then Michelle.

[505] **Darren Millar**: I'm just wondering, why do they need to go through WHSSC at all, if you say 'yes' all the time. What is the point of adding this layer of bureaucracy into the process and delaying, potentially, mums getting access to the services that they need?

[506] **Ms Shortland**: I don't think it actually delays things. I think it's purely a process that the funding from all health boards flows through WHSSC, and so the referrals come in. I mean, when I say, 'We never turn a referral down', we do check to make sure it's appropriate and the relevant clinician has identified the need and identified a suitable placement, and that will include checking that the placement that has been requested is into a designated centre in England. NHS England work on a basis of designating their specialist services.

[507] **Darren Millar**: So, you're saying you're checking up on the details of the referral, so you—

[508] **Mr Shortland**: Well, we just do basic checks to make sure that—

[509] **Darren Millar**: But you've never had to turn a request down—that's what you just said.

[510] **Mr Shortland**: No, we haven't, but there is still a process. That, in effect, is done on the same day. There isn't a delay in the process.

[511] **Ms Bell**: There's no delay in terms of the turnaround.

[512] **Darren Millar**: But I'm struggling to find a reason as to why you're involved in the process at all, given that you never say 'no' to any of the requests that have come through and, clearly, the clinical judgment that is being applied by those clinicians making the requests is obviously, therefore, sound judgment.

[513] **Mr Shortland**: I agree it's not particularly about clinical judgment; it is purely the fact that all specialist services individual patient funding requests are done centrally through WHSSC. You could take the argument further and say there are actually—and I'm sure there have been—reports into IPFR previously about how health boards deal with that and whether it would make more sense for certain things to be done directly through health boards, but that is the administrative function that we work within at the moment.

[514] **Darren Millar**: And just on the prevalence of mums who may need admission into a mother and baby unit, we're told that the empirical evidence, everywhere, is that, based on the number of births in Wales, it

should be between 60 and 80. That should be around the demand. We know that, between that number—somewhere between 60 and 80 are admitted into these adult in-patient acute wards every single year without their babies, but you're suggesting that the demand isn't 60 to 80.

[515] **Mr Shortland**: I don't think we're suggesting the demand isn't 60 to 80. All we can tell you is that the number of requests we receive is at that level.

[516] **Ms Bell**: That's not to say that they aren't within the health boards being managed, either, in acute psychiatric facilities.

[517] **Darren Millar**: In inappropriate settings.

[518] **Ms Bell**: Or within the community, absolutely.

[519] **Darren Millar**: In less than ideal settings.

[520] **Mr Shortland**: When the Cardiff unit was actually opened—and I touched on the numbers earlier: 11 admissions a year. That obviously doesn't tie in with the 60, and when the Cardiff unit was opened, during the last two years it was open, we had no requests to send mother and baby patients outside of Wales. So, the total demand across Wales was in the order of 11 or 12 patients per year.

[521] **Darren Millar**: In terms of requests to you.

[522] **Mr Shortland**: No, that was what went into the Cardiff and Vale unit.

[523] **Darren Millar**: I suppose the question is: people will muddle through, won't they? Certainly, no referrals will be coming through from north Wales to Cardiff and the Vale's unit, will they?

[524] **Mr Shortland**: There is an occasional one, but very, very small numbers.

[525] **Darren Millar**: Okay, but you accept that the distance between north and south Wales would have deflated those figures and perhaps caused some latent demand for a service that was hidden from view—and the fact that the requests that you're obviously not receiving at the moment for access to mother and baby units is partially due to the distance that people might have

to travel, perhaps leaving the rest of their family behind and that causing all sorts of problems. But you're not challenging the empirical evidence that suggests that around 60 to 80 mums should be benefiting from admission into a mother and baby unit a year in Wales, roughly.

[526] **Mr Shortland**: I think we have regularly challenged the health boards to demonstrate the evidence, because—

[527] **Darren Millar**: But are you challenging the empirical evidence from around the world that this is the sort of level of women who have serious perinatal mental health issues that would probably benefit from admission into a mother and baby unit?

[528] **Mr Shortland**: I think we would be minded to take 60 as a pretty accurate figure, given we don't expect differences across the UK. But I am aware that, for example, in CAMHS services, because Wales has more developed intensive community services, the number of in-patients we send to CAMHS units is lower for Wales than the rest of the UK. I'm not aware of what intensive perinatal services are—but there could be some hidden different ways of managing patients that we use in Wales.

[529] **Darren Millar**: I don't want to have a discussion on CAMHS services because I think we'd all agree that they're far from ideal in Wales, actually, and certainly not meeting the demands of our constituents as individual Assembly Members. But in terms of this issue, you agree with the empirical evidence that around 60 people should be benefiting from a mother and baby unit admission, on average.

[530] **Ms Bell**: I can confirm that we have used those figures as part of the task and finish group work that has been done. So, yes.

[531] **Darren Millar**: Okay, thank you.

[532] **Lynne Neagle**: And in terms of what you said that you constantly challenge health boards on the data, how do you do that and what can we do to actually get better data? Because what's clear is that health boards are admitting women into acute units without their babies, and Government and you don't know about it. So, what can we do to get health boards to collect the data so we have an accurate picture?

[533] **Ms Bell**: I think it's been a historical problem, and when we've looked

back it certainly is an issue that has been raised previously as well. I do know that the community of practice is looking at how health boards can best collect data, and not only data but outcomes from different placements, whether it be within acute psychiatric settings or in mother and baby units. So, that is work that is ongoing. It is something that we have definitely highlighted as part of the task and finish group as a deficit and a gap in being able to demonstrate the evidence that we need in terms of planning future services.

[534] **Lynne Neagle**: So, you'd expect that to be addressed when this work is completed.

[535] **Ms Bell**: Yes, we would.

[536] **Lynne Neagle**: Okay. Michelle.

[537] **Michelle Brown**: Thank you. The clinical guidance that you cite in your evidence says that women who need in-patient care for a mental health problem within 12 months of childbirth should normally be admitted to a specialist mother and baby unit. Do you consider that sending mothers across the border to travel potentially very, very large distances is actually satisfying that guidance?

[538] **Ms Bell**: I guess there are two things there. The first is that we are satisfied that the placements that we have are within designated centres for mother and baby placements. So, therefore they do meet the standards required as set out by NICE and the royal colleges in terms of the standards for those mother and baby units. In terms of the distances travelled, as Carl said, whilst it's not ideal, when we did speak to some mothers who have accessed services from long distances, their priority was the fact that they had safe services and the most appropriate environment. And one of the key factors again, as we said, is that their babies were with them during those placements. So, it's about that balance. It may not be ideal, but sometimes you have to travel for specialised services in order to be able to access specialist knowledge and the most appropriate environment.

12:30

[539] **Michelle Brown**: Are you satisfied that perinatal services in England, and particularly the mother and baby units in England, can actually cater for English need and Welsh need as well? Because that seems to be what we're

currently expecting—that the English system will pick up the need for mother and baby places.

[540] **Mr Shortland:** Obviously there is evidence of growing demand for these services across the UK and both NHS England and Wales have identified an increase in resources and expansion of services over a five-year period, I think it is, in England, where they will be building new capacity in mother and baby units per se. The Welsh Government funding that came out with perinatal services in—I think it was 2015-16—clearly came out to the health boards with the message that it was all for enhanced community provision. At the time I did ask if we could consider using some of that funding to set up a mother and baby unit, but the direction from policy officials was that we needed to enhance our community support for perinatal services to get a true picture of what the demand was for a mother and baby unit.

[541] **Lynne Neagle:** Okay. And in terms of Michelle's question, you said earlier, Mr Shortland, that it's quite usual for us to commission services in England that are specialist services, but clearly there's going to be no option of any Welsh language services being delivered in England. Have you got any comment on that?

[542] **Mr Shortland:** I think all we can say on that is, in line with our arrangements for all our specialist services, Welsh translation services are available to the providers and will be funded if there's a request made. But obviously it's very difficult to ask our providers to all provide services in Welsh.

[543] **Lynne Neagle:** Do you not think there's a difference, though, with mental health services—a therapeutic service like that—being delivered in something that's not somebody's first language?

[544] **Ms Bell:** I think that would be difficult even if we did have a mother and baby unit in Wales per se, because we've already heard that the number of specialist staff out there is relatively small, and what we can't guarantee is that all of those will be Welsh speakers themselves. So, we would make the same provision even within a mother and baby unit in Wales where we would have to, as we do with lots of services, bring in interpretation services and try where we can to make the provision where we do have Welsh language staff available.

[545] **Darren Millar:** I appreciate that, on a population basis, particularly for

places like north Wales, the sustainability of a very small mother and baby unit might be difficult, actually, and might therefore require some placements over the border. Certainly I wouldn't want to see mums dragged down to a unit in Cardiff if they were in north Wales. You're quite right; we do have this relationship—a health-economic relationship—with services over the border for all sorts of different tertiary level services. But with those services, it seems to me that there is every possibility that, if discussions can take place between commissioners for the unit to be based in north Wales but serve the north-west of England as well in order to help overcome some of these language issues—. Do you accept that that is something that perhaps ought to be explored in more detail—the provision of a north Wales/north-west-type service, but to be located in north Wales in order to perhaps overcome some of these language barriers?

[546] **Mr Shortland**: Obviously, that would be an ideal situation. I think what we have experienced across a number of services is that, since specialist commissioning has become an NHS England single body representation, it has become more difficult for Wales to engage in discussions about those types of arrangements. In the past, for example, we would have been able to speak to the north-west specialist commissioners and talk about Chester, Wrexham—anywhere—and co-locating those services. But I think in the new arrangements, it becomes more difficult when NHS England tend to look at the English population as a whole. Their five-year strategic review, based on identifying a number of centres across England, was very much done in isolation, with no discussion—

[547] **Darren Millar**: There was no discussion at all.

[548] **Mr Shortland**: No.

[549] **Ms Bell**: I think they will have the majority of the numbers as well, because the numbers for north Wales are small.

[550] **Mr Shortland**: I don't believe there is a specialist unit in the north-west at the moment. I think that's one of the areas where they're looking to develop a new service.

[551] **Ms Bell**: It is. So, there are two areas that they're currently looking at: one is up there, and one is around the Devon area.

[552] **Lynne Neagle**: In terms of the task and finish group, the work that

you've referred to, are you able to outline any initial findings to the committee, in particular whether you have come up with a list of shortlisted options to be taken forward by Welsh Government?

[553] **Ms Bell**: Yes, I can confirm that we have come up with a shortened list of options. We came up with a shortlist of options through a task and finish workshop session with user involvement, and we used a set of benefits criteria to bring down a long list of options to a smaller list of options. A paper has gone to the all-Wales perinatal steering group and then to the CAMHS and ED network, which the steering group reports into. Both of those committees have endorsed that paper. Unfortunately, the joint committee was held yesterday, therefore the paper wasn't able to go into joint committee yesterday for consideration, but will go in on 25 July. So, the shortlist of options paper will go to the joint committee on 25 July where the chief executives from all the health boards will consider the shortlisted options that have been put forward within the paper.

[554] I'm not able to share the detail of those options with you, because they haven't had sight of them to date. What I am prepared to share is the fact that a mother and baby unit within Wales is one of the options that the task and finish group have put forward.

[555] **Lynne Neagle**: Thank you. In terms of the process, then, once it's been to the chief executives on 25 July, can you clarify—does it then go to the Cabinet Secretary for final decision, or is that it on 25 July?

[556] **Ms Bell**: The chief executives will debate the recommendations and the next steps, and we then will report that back into Welsh Government through the network, as they have a seat on the network.

[557] **Lynne Neagle**: And have you had any indication of when you'd then expect Welsh Government to make a decision?

[558] **Ms Bell**: I haven't, sorry.

[559] **Lynne Neagle**: Okay. Well, I think—any other questions from Members? No? Very briefly.

[560] **Mohammad Asghar**: What more can be done to ensure that mothers requiring perinatal health services do get admitted to a mother and baby unit with specialised care, as opposed to general adult facilities in hospital?

[561] **Lynne Neagle:** I think we've spent the morning, really, discussing that, and I think that we've—

[562] **Mohammad Asghar:** But this is something they have to—

[563] **Lynne Neagle:** Yes, but I think we've discussed it as far as we can in the time available—

[564] **Mohammad Asghar:** And how effective has the community perinatal service proven to be?

[565] **Lynne Neagle:** Have you got any comment, given the emphasis that's been put on the community service, on how effective that service is proving to be instead of a mother and baby unit?

[566] **Ms Bell:** I don't think we can comment on that. It very much is about the referrals coming in from the health boards, and that's a clinical decision in terms of the best placement for that mother and baby.

[567] **Mr Shortland:** The only thing I would add to that is, obviously, these new, enhanced services and teams are fairly new and have only recently, I think, completed their recruitment rounds. But what we do expect to come from that is we will have a named contact in each of the health boards to work with around collecting and improving our data collection, which, obviously, we're lacking at the moment, to help formalise and develop any business case that comes out of this process.

[568] **Lynne Neagle:** Okay. Can I thank you both for attending and answering all our questions this morning? You will be sent a transcript to check for accuracy, but thank you very much for your time.

[569] **Ms Bell:** Thank you.

[570] **Mr Shortland:** Thank you.

13:39

Papurau i'w Nodi
Papers to Note

[571] **Lynne Neagle:** Item 6, then, is papers to note. Paper to note 6 is a letter from the Minister for Lifelong Learning and the Welsh Language regarding our ALN report. Paper to note 7 is a letter from the Children's Commissioner for Wales to the First Minister on the due-regard duty. Paper to note 8 is a letter from the Chair of the Finance Committee regarding the changes to the process for scrutiny of the draft budget. Paper to note 9 is a letter from the Minister for Lifelong Learning and Welsh Language in reply to our letter on youth work. Just to inform Members, I have written to CWVYS and to Youth Cymru to seek their views on the Minister's letter, and we'll update the committee in due course.

[572] All that remains, then, is for me to remind Members that the next formal meeting is on 6 July, when we're going to continue to take evidence on our inquiry on perinatal mental health. Attending will be Powys teaching health board, Betsi Cadwaladr health board, the British Psychological Society, Perinatal Mental Health Cymru, and Action on Postpartum Psychosis, so a busy session again on that. Can I just thank Members for their attendance this morning? It's very much appreciated, thank you. Close the meeting. Thank you.

Daeth y cyfarfod i ben am 12.41.
The meeting ended at 12:41.