Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Cyfrifon Cyhoeddus
The Public Accounts Committee

Dydd Iau, 24 Mehefin 2010
Thursday, 24 June 2010

Cynnwys
Contents

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Jeff Cuthbert	Llafur Labour
Irene James	Llafur Labour
Bethan Jenkins	Plaid Cymru The Party of Wales
Ann Jones	Llafur (yn dirprwyo ar ran Alun Davies) Labour (substitute for Alun Davies)
Sandy Mewies	Llafur Labour
Jonathan Morgan	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Chair of the Committee)
Nick Ramsay	Ceidwadwyr Cymreig Welsh Conservatives
Jenny Randerson	Democratiaid Rhyddfrydol Cymreig Welsh Liberal Democrats
Janet Ryder	Plaid Cymru The Party of Wales

Eraill yn bresennol
Others in attendance

Gillian Body	Archwilydd Cyffredinol Cymru Auditor General for Wales
Chris Burdett	Dirprwy Gyfarwyddwr, Is-Adran Cymorth i Ddysgwyr, Llywodraeth Cynulliad Cymru Deputy Director, Support for Learners Division, Welsh Assembly Government
Simon Dean	Cyfarwyddwr Strategaeth a Chynllunio, Cyfarwyddiaeth Gyffredinol Iechyd a Gwasanaethau Cymdeithasol, Llywodraeth Cynulliad Cymru Director of Strategy and Planning, Health and Social Services Directorate General, Welsh Assembly Government
Chris Hurst	Cyfarwyddwr Cyllid, Cyfarwyddiaeth Gyffredinol Iechyd a Gwasanaethau Cymdeithasol, Llywodraeth Cynulliad Cymru Finance Director, Health and Social Services Directorate General, Welsh Assembly Government
Andrew Lewis	Cyfarwyddwr Gwella ac Arloesi, Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro Director of Improvement and Innovation, Cardiff and Vale University Local Health Board
Dr David Williams	Cynghorydd Arbenigol i Lywodraeth Cymru ar Wasanaethau Iechyd Meddwl Plant a'r Glasoed Expert Adviser to the Welsh Government on Child and Adolescent Mental Health Services
Jan Williams	Prif Weithredwr, Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro Chief Executive, Cardiff and Vale University Local Health Board
Paul Williams	Prif Weithredwr GIG Cymru a Chyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol, Llywodraeth Cynulliad Cymru

Chief Executive of NHS Wales and Director General of Health and Social Services, Welsh Assembly Government

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

Alun Davidson	Clerc Clerk
Andrew Minnis	Dirprwy Glerc Deputy Clerk

Dechreuodd y cyfarfod am 8.59 a.m.
The meeting began at 8.59 a.m.

Ymddiheuriadau a Dirprwyon
Apologies and Substitutions

[1] **Jonathan Morgan:** Good morning. I welcome everyone to the National Assembly's Public Accounts Committee. To deal with the housekeeping arrangements first, I remind Members to switch off mobile phones, BlackBerrys and pagers, and I remind our guests, as well as Members, that participants are welcome to speak in Welsh or English and that headsets are available to hear the translation on channel 1 and to hear the amplified audio on channel 0. If the fire alarms sound, please follow the advice of the ushers. I have received apologies from Alun Davies and Lorraine Barrett. However, Ann Jones is due to join us this morning as a substitute for Alun Davies for the remainder of this term. I welcome our witnesses this morning. We will move on to the first main item on the committee's agenda.

9.00 a.m.

Ymateb i'r Her o Gyllido'r Sector Cyhoeddus yng Nghymru: Tystiolaeth gan y GIG yng Nghymru
Meeting the Challenge in Welsh Public Sector Finance: Evidence from NHS Wales

[2] **Jonathan Morgan:** We will now be taking evidence from NHS Wales. Starting with Mr Williams, I ask the witnesses to identify themselves for the record.

[3] **Mr Williams:** I am Paul Williams, director general for health and social services and the chief executive of NHS Wales.

[4] **Mr Hurst:** I am Chris Hurst, the director of finance for NHS Wales.

[5] **Ms Williams:** I am Jan Williams, the chief executive for Cardiff and Vale University Local Health Board.

[6] **Mr Lewis:** I am Andrew Lewis, the director of innovation and improvement for Cardiff and Vale University Local Health Board.

[7] **Jonathan Morgan:** I welcome our witnesses here this morning. You will be aware of the background to this review. We are taking into account the auditor general's report, 'A Picture of Public Services', and we are also incorporating our response to a number of other reports published by the Wales Audit Office. That is to allow the committee to assess how public services are responding to the scale of the financial challenge that we face and to examine what plans are being put in place to allow public services to respond. My opening

question is to Mr Williams. The report, 'A Picture of Public Services', says that there will be a significant reduction in overall spending. It estimates that the Welsh block grant will reduce by £0.5 billion a year for three years but that the impact will vary across different parts of the public sector. What is the current outlook for future NHS capital and revenue budgets? What level of savings are NHS bodies already having to identify? How are they going about developing the savings plans?

[8] **Mr Williams:** On the overall outlook, we will not have certainty until the comprehensive spending review in the autumn. In common with most of the public sector, we have been using some broad-brush assumptions that emanated from the Treasury, namely that revenue could decline by something like 3 per cent per annum for the next three years or so and that capital could decline by about 10 per cent per annum. These are just planning assumptions, but we felt that it was appropriate to start doing some modelling on best-case and worst-case scenarios, because, obviously, if things get even tighter than we have imagined, we will have to accelerate plans. So, I must emphasise that, for the moment, these are just planning assumptions.

[9] On savings, looking at the track record of the NHS, going back to around 2006 until last year, year on year, the NHS had saved around £850 million. We were running cost improvement programmes, averaging between 2 and 3 per cent. Last year, as the growth level reduced, we had to up our game, and a cost improvement programme of around 5 per cent was set. That meant that the savings targets were increased to more than £200 million. NHS Wales broke even in the last financial year. Looking to this year, the growth level has declined even further, and we are looking at a cost improvement programme of around £400 million, which is moving to around 7 or 8 per cent. So, you will see that it is significant, but you will no doubt want to explore how we are tackling that. However, that is the broad answer to your question, sir.

[10] **Jonathan Morgan:** Thank you for that. I am very grateful.

[11] **Sandy Mewies:** Good morning. We are in a very fast-moving situation, and you have outlined how you are reacting to that, although there is no certainty at this stage about what is going on. I think that you have already hinted at the answer to this, but are you already having to revisit plans and assumptions across the NHS capital investment programme in light of the expected reduction in capital funding over coming years?

[12] **Mr Williams:** Yes. As we anticipate a 30 per cent reduction in capital over the three to four-year planning period, we are revising our assumptions on schemes. First and foremost, capital schemes need to be affordable. You are probably familiar with the term 'revenue consequences of capital schemes'. We must be very careful that we are not building buildings that we cannot afford. We need to ensure that we are accelerating the pace of service modernisation and that investment is driving forward new technologies and our approach so that it is much more balanced in our care. It is also placing a greater emphasis on community and primary care services and on day-case surgery. We are also looking at where there are opportunities to invest in revenue savings schemes, particularly around IT systems as one example. So, in the longer term, if you look over the various decades, you will see that capital has ebbed and flowed with the economic upturns and downturns. It is possible to flex the programme, so we are not talking about schemes being taken out of it, but about their starts possibly being delayed, or we might introduce schemes with a different emphasis, but there is enough flexibility in the programme to do that.

[13] **Jeff Cuthbert:** I have a supplementary question for Jan and Andrew. I appreciate that your responsibilities are limited to Cardiff and Vale University Local Health Board, nevertheless, as representatives of an individual health body, do you feel that your plans, although they have to be in outline stage at this point, accord with what Paul has said about

potential overall reductions? Do you feel that, in terms of capital expenditure, you are likely to secure sufficient funding, from whatever the source might be, to meet your plans?

[14] **Ms Williams:** We work within the framework set by the Health and Social Services Directorate-General and we are currently working within the five-year framework that the department has just issued. That gives us an opportunity to look again at how many sites we have and their disposition and functional content. It also gives us the opportunity to look carefully at the models of care that are appropriate for the next decade. One thing that we are looking to do, through our five-year planning process, is to be clear about what we need in terms of physical sites. We need to consider how we can work with local government and third sector partners on sharing accommodation, for example. More particularly and more importantly, we need to consider what we will be working on with our communities in terms of health and wellbeing, promoting independence and delivering more care in community settings, primary care settings and outside what have been traditional hospital buildings.

[15] So, we are looking to see what, over the next five years, we would do differently now that there is a strategic requirement on us. We are making good progress in doing that. So, I am confident that our plans reflect the strategic circumstances within which we find ourselves. Our five-year framework in outline is going to our board at its 6 July meeting and it demonstrates to us that within our current estate, we have opportunities to deliver our service change. We have been very fortunate to date in securing significant capital development that will also assist us when we take our five-year framework forward. However, the key to all of this is that we must move away from the concept of buildings being the most important thing for health services or for health and social care services. We are looking at different models.

[16] **Mr Williams:** In terms of making our capital work harder for us, I have written to the strategic capital investment panel, asking its experts to meet me to see what I can learn from that panel in terms of the fact that, traditionally, hospitals have been built to a standard of 30 years to 60 years. I wonder whether we are building too much long-term investment into our standards. I would like to know whether we can learn from other sectors in that you can have standards that invest less in the long term and then you have greater short-term flexibility and you build quicker and have more flexibility. We have also had a very successful programme of using framework contracts and the capital schemes that we have been using with the framework have been coming in on time and on budget. Nevertheless, it is a question of whether there are still lessons to be learnt, and ways in which we can sharpen up the procurement processes around capital, particularly as the market gets tighter, as it were, and where we may have greater leverage.

9.10 a.m.

[17] To touch on Jan's point, by bundling schemes together across organisations, it is a question of whether there are other opportunities where we can have greater synergies. We are also stepping up our disposals to release assets, which can then be reinvested in capital.

[18] **Jeff Cuthbert:** Did you say 'bundling' schemes rather than 'bungling'?

[19] **Mr Williams:** Yes; I said 'bundling'. It is a colloquialism for bringing—

[20] **Jeff Cuthbert:** I know what you mean; I just wanted to be sure that I heard you correctly.

[21] On Jan's point, I agree with you absolutely. There is sometimes a confusion created where people think of the service as the building—an old hospital or whatever. However, that is not the service. Of course, you need adequate premises for whatever you are going to

deliver. I was very interested to hear you specifically mentioning the sharing of facilities with local government. Could you give us one or two examples of the sorts of things that you are looking at? Moving back to Paul, so far, I am pleased with what I have heard from Cardiff and Vale University Local Health Board, but do you think that that sort of foresight is typical of NHS bodies across the rest of Wales?

[22] **Ms Williams:** I will give you an organisational example and then a clinical service example. Cardiff and Vale University Local Health Board has two local authorities—Cardiff and the Vale of Glamorgan—and we have locality arrangements that we are putting in place to mirror the neighbourhood management arrangements that Cardiff has and that the Vale is developing. We will be co-locating our locality teams and our locality services with the Vale of Glamorgan from 2011, which will enable us to dispose of premises that we have in Penarth. That is an example where we are bringing together organisational arrangements.

[23] In terms of clinical services, I am sure that committee members will all know of the societal issues that we face in relation to dementia, particularly as younger people, unfortunately, fall prey to dementia. We are working with the Vale of Glamorgan and with third-sector partners to develop a tripartite facility that we will manage collectively, and look at a whole range of early support through to terminal care support for older and younger people who have, unfortunately, developed dementia. That is one of the projects that we are taking forward through a tripartite health and social care integration board that we have established with ourselves, the health board, Cardiff Council, and the Vale of Glamorgan Council. It is led at a political level, with our chair, vice-chair, and cabinet members, and we have had sign-up from all partners to actively promote the use of common facilities. We are looking to see what accommodation we both have in the Vale of Glamorgan.

[24] In Cardiff, through the local service board, we have had a project under way mapping all of the estate that we all have. That work will come to fruition in the autumn when we will take it back to the local service board, and there are opportunities there for us to come together. I am hopeful that we are taking active steps to manage this better.

[25] We also participate in the national assets working group, which is a sub-group of the efficiency and innovation board chaired by the Minister for Business and Budget. Again, we are looking at sharing assets there. I am confident that, as this year goes on, there will be further examples that I can quote you of where we are utilising our premises collectively.

[26] **Mr Williams:** A number of projects across Wales spring to mind, such as the Assisting Recovery in the Community project in Bridgend, which is a shared-services mental-health-services project. The county borough council found an excellent piece of land in the middle of the town centre, and the health service provided the capital to build the building. More importantly, the staff who are working seamlessly within that building are not just from a statutory organisation, but a voluntary organisation as well. It is an excellent example of services being available to all citizens. The Welsh Ambulance Services NHS Trust is developing a make-ready depot in Wrexham; the fire service has already indicated that it wants to be involved and the police have said that they would like to join that project. We are looking at a joint community project in Builth Wells, involving a community hospital, a day centre and leisure facilities—again, bundling schemes together. Merthyr health park is another example of multiple occupation on one site.

[27] As Jan said, now that we have the efficiency and innovation board and national asset management, the entire public sector is starting to work together. One of the things that we found was that it was not easy to share the asset basis. A lot of work has been done on this in Cardiff and, arguably, Cardiff is now leading on this. Soon, the entire public sector will be able to share its asset basis in a way that was not done before and that will be good in terms of the ethos of working together and ensuring that we can use our facilities as effectively as

possible.

[28] **Janet Ryder:** My apologies for being late, Chair. In relation to the Government efficiency and innovation board, what exactly is the involvement of your department, Mr Williams? You have given us some assessment of the progress made to date, but what do you really assess it as having done?

[29] **Mr Williams:** I am there to offer two things. I represent the national health service from the director general perspective, and we also have a chief executive from the NHS, Andrew Goodall, on the board. I think that it echoes the way that we are working as directors general across our portfolios. I also add to the board some past experience of partnership working. It is about recognising that the public sector has to lead by example on working together and being smarter about the use of our resources. We have a number of programmes, ranging from asset management, to systems for sharing information, to looking at workforce. So, we are looking at it strategically in a number of areas and driving forward particular opportunities and schemes. It is the beginning of a cultural change that will signal how business will be done differently in Wales following the First Minister and his public sector summit. There is a lot of work to do here, and it is early days—we are on our third meeting—but we can already see a significant shift of attitude in terms of working much more closely together, understanding each other's problems and looking at solving problems mutually.

[30] **Ms Williams:** I want to come back on that, because I do not want us to forget the university sector in the sharing of assets. In Cardiff, we are fortunate in having Cardiff University on campus with us at the University Hospital of Wales, and we have a number of shared facilities that we take forward together. One of the most exciting, as I am sure that Members will know, is the launch of our PET scanner later this year, where we will share facilities, maintenance and so on with the university. We are about to engage in a further collaboration with it on the use of healthcare facilities for a new school of nursing and midwifery. So, it is important to remember that, while the university sector is not theoretically a public service, we do a lot of work with it.

[31] If I may also mention something else, we have a flagship development in the Cardiff Royal Infirmary. While those are health premises, we are doing scoping work on including a number of other agencies in the shell of the building to provide a one-stop shop. We are engaged in discussions with the police at the moment and we are talking to enterprises such as Citizens Advice, housing support and so on. We are confident that that will be a flagship development. We are also working with the university to look at an academic GP practice coming on site. So, the work is under way, as Members will know, and that will be a flagship enterprise in terms of all public services coming together.

9.20 a.m.

[32] **Janet Ryder:** This question is to both of you. That is fine for where you have key individuals involved in and working in a group, but how do you intend to disseminate that across Wales? This cannot stay in Cardiff. How are we going to see examples of that happening in Wrexham, Bangor, and Aberystwyth, where there are other universities? How are we going to see that spread out across Wales? How will you disseminate the information and the change in culture throughout your organisations?

[33] **Mr Williams:** It is a matter of leading by example. Now that we have been given a clear signal from the First Minister, we have Ministers backing the initiative, and we have many senior people from across all the sectors, including the third sector and the trade unions, on the board. I think that the message is getting across clearly. For me, a lot of partnership working is about leadership.

[34] **Janet Ryder:** How is that message getting out?

[35] **Mr Williams:** The second public services summit will be held on 2 July. Presentations will be made on the significant steps that have been taken since the first one. We shall be sharing information, and there will be a number of workshops. Part of it will be done by people tasking themselves at the local level, and part of it will be about spreading good practice, and it will be reinforced by the structure of the innovation and efficiency board dealing with things at the higher level. It will take time. This, for me, is a classic change management programme. Ministers need to be congratulated on taking this forward.

[36] Behaviour suggests that different stages have been reached with regard to recognising the importance of partnership—that is what tends to happen, and this is a classic change programme. I think that it is therefore important for the leaders to step up and say that this is the way that things will be done. It is early days, but I am very optimistic that the change will happen. Jan and other chief executives can demonstrate how things are developing. It depends on what is on the ground, however, and one needs to address particular approaches and cultures and the fact that we are dealing with local authorities on health matters. We have to recognise that democratically elected members have different views. However, all these issues can be worked through.

[37] **Jonathan Morgan:** Before Jan Williams comes in, I will ask one question about the collaborative projects. We are always keen to hear about examples of these and it is encouraging to find a greater degree of collaboration between different statutory bodies and between statutory and non-statutory bodies. However, will that allow you to demonstrate the sort of efficiencies that are gained as a result? Collaboration is one thing when looking to deliver a better service, but we are looking to deliver services effectively for less over the next few years. What mechanism exists to allow you to test what efficiencies have been gained as a result?

[38] **Mr Williams:** In our own cost improvement programme, much of it is the province of the NHS, and the scale of the cost improvement programme is very specific. Each board has a particular figure, and I monitor that, as do they, through their board reports. When you get into what I call the partnership dividend—in other words, working across from one organisation to another—there is more work to be done on doing that collectively. However, we are also moving towards greater recognition of the importance of pooled budgets. For instance, what we now see coming out of the primary community care strategy and the NHS as an integrated organisation is the very real prospect of integrated health and social care teams being managed by a manager, who may be a social services employee or an NHS employee, but working to a pooled budget from which both organisations derive a degree of savings.

[39] There are huge opportunities here. It is starting to develop. Jan might want to say a bit more about the detail. For me, however, that is the added value in this. Organisations themselves are driving that efficiency through this partnership dividend, as I call it, from which both organisations derive significant benefits. More importantly, it will be seamless for the citizen, and that is the message that we need to send out. In the past, there might have been four or five footfalls through the door in terms of people providing different services for a particular citizen. To use Jan's phrase of a 'one-stop shop', we are now getting to a situation where services are more seamless, we are looking at the way in which we use the budget and we are also looking at ways in which we share information systems, which not only saves money but also provides a better way for the citizen to access services.

[40] **Ms Williams:** I would like to come back on that point and I wish to say a little more about academic collaboration with the NHS, as that is important. We have a really good example in the Cardiff east locality team, known as CELT, which is a multi-agency team

involving us, social care and the third sector. It is about admission avoidance, particularly for older people not going into hospital, and getting them back out of the system very quickly and rehabilitating them within their own homes. It is in award-winning team—it has won a number of national awards for its innovative approach. The way that we measure that in terms of efficiency is through admissions avoidance. So, there are ways in which we count different aspects of efficiency. For example, we are going to co-locate our locality team with the Vale of Glamorgan Council. We have made a joint appointment in the locality manager, and I will be able to take out the costs of the facilities associated with our Penarth building that we will be disposing of. That is the way in which we build up efficiencies, both in terms of cash release and productivity.

[41] On collaboration across Wales, we have a very exciting initiative under way at the moment, namely the academic health science collaborative which involves us, Swansea and Bangor universities and the NHS in looking at the application of research. It is sourced through the Wales Office of Research and Development for Health and Social Care. It is a Wales-wide approach to applying research in the interests of better patient care. My colleagues in Betsi Cadwaladr University Local Health Board and Abertawe Bro Morgannwg University Local Health Board are fully engaged in that. That is the type of way in which we try to disseminate the learning and take things forward, which is exciting for Wales.

[42] **Jonathan Morgan:** Nick, did you want to ask a supplementary question on this?

[43] **Nick Ramsay:** Yes. My question goes back to your original question to Paul Williams. I listened closely to your answer, Mr Williams. You talked about the one-stop shop, the partnership dividend and the pooled budgets, and I can see how all of these things will help to deliver greater efficiency, but were these things not in the pipeline in any case? We have had collaborative working for as long as I have been involved in politics—we had the Beecham review and the move towards all of this. So, while I understand the potential benefits from this, the whole purpose of asking you questions is to see how public services in Wales will respond to the increase in pressure over the next couple of years. Do you think that all of this will be sufficient, or are we going to be running to stand still, at the very best?

[44] **Mr Williams:** The main savings will be within each organisation. If you want to talk about the savings that we are planning and delivering in the NHS, we can do that. There is an added benefit in what I call ‘the partnership dividend’ in partnership working. I am not saying that partnership working will be the sole answer to this—what I am saying is that it is a significant area that has not been taken forward in the past with the pace that I would have expected. Before I got this job, in my particular area I felt that we were moving quite quickly in partnership, but perhaps not so in other areas. I cannot answer why that was the case, but that seemed to be the situation. We signal very powerfully in the NHS reforms that this was about integration. So, we structurally integrated the NHS, but the pace has quickened in a way that I thought would never happen in terms of the partnership working.

[45] For example, in Bridgend, a locality manager has been jointly appointed between the county borough council and Abertawe Bro Morgannwg University Local Health Board, who is totally responsible for managing health and social care services in Bridgend. That is happening elsewhere. Hywel Dda Local Health Board has stepped up the pace at county level, as it has made a joint appointment with Pembrokeshire County Council.

9.30 a.m.

[46] Pembrokeshire County Council’s director of social services has now been seconded to Hywel Dda Local Health Board in order to give the governance issues to the health board, which is now managing health and social services across the county. We are looking at what might happen in Powys, where there is a different model again. So, we are making a

significant move from the rhetoric to the reality and pooled budgets. It is early days, but this is now accelerating at a pace that, for one reason or another, did not happen in the past under 'Making the Connections'. However, it is certainly happening now, and that is transforming the landscape and behaviour. There is lots of learning to be done and there are many development issues.

[47] Going back to Janet Ryder's question about the role of the efficiency and innovation board, there are some difficult issues about whether pooled budgets constitute different terms and conditions for staff. That is where I think the strategic work of the innovation board will help. Perhaps nationally we can start to think about the process, if we need a generic worker for example. In the past, someone might have been in health or social services, but things have merged to create a different sort of job with different terms and conditions, so we need to look at how we manage that in terms of transferring people across and so on. So, there are difficult issues, but I sense that they are now being grasped in a way that has not happened hitherto. I know that that was a very long answer, Chair, but I think that it gives you an insight into what is happening.

[48] **Jonathan Morgan:** Sure. Thank you.

[49] **Jenny Randerson:** Jan referred to the admissions avoidance measures that are being taken. The report, 'A Picture of Public Services', states that the key issues for the NHS are that too many people are going into hospital for treatment that would be provided in a more cost-effective way in the community and that, when they get to hospital, they are staying too long. We have been getting those reports and messages from the auditor general for years now. So, why has the NHS not already made more progress on this? In recent years, it has had a very good budget; there was a considerable uplift in its budget in Wales. Do you think that the additional resources in the past have been used as well as they could have been?

[50] **Mr Williams:** Again, I come back to the concept of integration. In the NHS previously, there were different providers of hospital services and community services and there were perverse incentives in the system. It does not make sense if you look at it from the outside, but these levers were in operation. There were difficulties with delayed transfers of care. Sometimes, partnership working existed only at a superficial level, and no-one really felt the need to move someone on, despite the fact that someone was an individual who had been caught up in the system. Now, I think that we have a sense of urgency with regard to partnership working; I think that the penny is dropping. However, there are also some other powerful things going on, such as the work that we are now doing on chronic conditions management. We can actually show you the metrics. We can now show you results of the work that has been put into chronic disease management. Carmarthenshire is a good example: the lengths of stay in Carmarthenshire are now reducing because we have effective chronic disease management programmes in place.

[51] The challenge now is to roll that out and universalise it throughout Wales. Jan is doing work in some areas of chronic disease management in Cardiff, as are colleagues in north Wales and Carmarthenshire. We now have to rapidly accelerate that learning and best practice. I would like to be able to come back to the committee in a couple of years' time and say that we now have active case management whereby everyone who has a chronic disease is identified and given every assistance they require to avoid hospital admission. The previous system failed individuals who came into hospital, often through accident and emergency departments, and who were not processed in an appropriate way, and perhaps also had poor discharge arrangements. So, there is a great deal of work going on on this.

[52] First and foremost, the driver in this is quality, but quality saves money as well. Generally, some of these issues, for the right reasons, are turning on some of the professionals in ways in which they were turned off because they felt that the system was working against

them. Jan might want to say something else.

[53] **Ms Williams:** Yes. You make a really important point there, Jenny. We know that, in the past, there has not been the urgency to do what we can to enable people to stay well and to remain within their homes and communities, and, when they have been admitted to hospital, we have not been alert enough in the past to the arrangements that we need to make to get people back home. It is very evident, and all the research tells us, that, after an elderly person has been in hospital for two weeks or so, his or her capacity to return to independent living decreases, and it decreases markedly the longer that person is with us. So we have, as a system, been adding to the dependency of a very important part of our population.

[54] A number of things have come together now that are making us look at this differently. One, as Paul mentioned, is integration; there is no doubt that local health boards, with their responsibility through from primary, community, hospital and tertiary services, are being really positive and GPs and consultants are coming together in a way that they have not done before. The arrangements with social care are coming into play, and we have a much better, whole system approach, which starts with things at the prevention level, such as fall prevention programmes and home support. It starts then with the teams that we have in place—I have mentioned CELT. We also have the Penarth integrated care team, very sophisticated case management arrangements for all elderly people who are admitted and much more sophisticated discharge liaison arrangements. Everyone who goes in now will have a predicted day of discharge, and the discharge liaison team will be working to help people out. We are talking not just to local government, but to third sector colleagues as well. In Cardiff and Vale, a masterclass was held yesterday with all our third sector partners, and one area that we concentrated on was services for frail older people, and how third sector colleagues could help more with the maintenance of independence through home-based and community-based support. There are reforms, given the current climate, but we also need to do better and get it right first time for people. Once we get it right first time for people every time, costs drop out of the system, and we are doing a lot of work in Cardiff and Vale on what we term the ‘quality dividend’. It is a really important point and something that we, as a society, need to be cognisant of.

[55] **Jenny Randerson:** Looking at the other side of it, there is evidence from England that, sometimes, the pressure to get people through hospital as quickly as possible can be too great and lead to unnecessary readmissions and early readmissions. Do you measure that? I accept that it is possibly more difficult to measure admissions avoided, but it is easy to measure early readmissions, is it not?

[56] **Ms Williams:** We measure both, in fact. Through CELT and the Penarth integrated care team, clinicians make an assessment of how many bed days we have been able to avoid through their mechanisms. We also monitor readmissions within 30 days, and our medical director will monitor those regularly. In Cardiff and Vale, we are not an outlier in that perspective, but the board monitors that, because we recognise that it is no good trying to discharge people before they are medically fit for discharge. Our board has pinned its colours to the mast of quality and safety, and we lead on this at every board meeting. Our board will not support anything that compromises quality and safety; we are very hot on that.

[57] **Mr Williams:** We may, Chair, want to touch on the 1000 Lives campaign, which is recognised internationally now as a huge success. I had a meeting with the board this week and I raised again this issue of inappropriate discharge and readmissions for the 1000 Lives board to look at. It is a measure of quality.

9.40 a.m.

[58] However, coming back to this issue of perverse incentives, there is no reason why a

health board should discharge someone inappropriately, because it still has the responsibility for their care. The system may look good statistically, but it does no good at all for the individual or for the board if people are inappropriately discharged. In a market situation, where you have a number of different organisations, it is possible for people to get discharged and that no-one thinks about the consequence until they see it in the statistics. We are trying to get ahead of those statistics and drive it through quality. However, with regard to incentives, the system drives the health boards to find the most suitable process, rather than to just discharge and walk away, creating a problem for someone else in another agency. Our principles with regard to integration are far stronger and should fundamentally drive us in the right direction.

[59] **Jeff Cuthbert:** I am impressed with what you have said so far on the delayed transfers of care and the length of stay in hospital. Do you think that, where local government has responsibilities with regard to, for example, social services, they are fully engaged with you on this?

[60] **Ms Williams:** Yes, very much so. In Cardiff and the Vale we have set up the integrated care board at a political level, and we have very strong relationships at officer level. We have two directors who manage the whole of our business—our director of primary, community and mental health services and our director of acute hospital services—who meet regularly with their counterparts in Cardiff and Vale. For example, at our third sector masterclass yesterday, the director of social services from the Vale of Glamorgan was a key player. So, we have a common understanding and a common shared priority. For instance, I mentioned earlier the support for people with dementia, which is a growing societal issue, and the three statutory organisations are conscious of our responsibilities on that.

[61] **Sandy Mewies:** Jenny raised an important point that it is all very well getting people out of hospital quickly, but there is no point if a revolving door situation is set up. Paul, you made the point that it is in the interest of health boards to carry out serious discharge assessments—that element was missing for a long time. I know of a case, not in recent times, where an 85-year-old man was taken home by ambulance, and was left outside his home, with no food in the house and no-one to look after him. What is the point in that?

[62] **Mr Williams:** Absolutely.

[63] **Sandy Mewies:** A few questions arise from that. First, how are you measuring, across Wales, that discharge assessments are being carried out properly? How is that reported? There are obvious benefits to that. In the 1980s, I worked on turning the Griffiths report into the community care scenario in Clwyd, and there was always an issue about the definition of NHS continuing care. Has that been resolved? You have been talking about partnership dividend and value added, and I can mention a scenario where a senior officer would tell me that it was perfectly acceptable for a family to have a much-loved relative in a persistent vegetative state in a bed in the front room. That may have been okay, but you then had to put in place other things that involved social services, local authority housing and so on. Is that being achieved now? We are 20 years on from that now, so is your partnership dividend and value added with regard to joint working achieving that? It is fine for people to want to be cared for in their home and community, but there are standards that must be met.

[64] **Mr Williams:** To start at the back end of your question, we are hearing about the spread of good practice from members and how quickly they can roll it out, addressing first and foremost the issue around readmission rates. I now collect data that was not previously collected, because, in a market system, it is left to the providers and the commissioners. I have a pretty good national picture now of what is happening on lengths of stay, delayed transfers of care, readmission rates and so on. I can build up a picture.

[65] I have also put in a strong performance management system, which is backed by the Minister. That performance management system includes the Minister and me meeting with the chairs monthly, so if there are figures that we are not happy about, we have the opportunity to talk to them. Similarly, I formally meet with the chief executives on a monthly basis and, twice a year, we hold meetings between executive teams to go through the figures. I like to sense how the new management teams are operating; I can talk to the chief executive, but I also get a feel of how effectively the team is working. It is interesting to see that interplay and understand some of the nuances about partnership working.

[66] Continuing healthcare is one of the big issues confronting us as the population grows older. Over the last few years, expenditure has been growing exponentially, and I asked that we set up a team to start looking at the whole process of continuing healthcare. We recently issued a new framework on it, but there is more to do. We have a group looking at it nationally, including partners, to see whether we need to fundamentally challenge the concepts. We do not start talking about definitions, as we are talking about people here. One good example to come out of the partnership working is the Torfaen example on the frail and elderly, where Alison Ward, the chief executive, and Andrew Goodall, have personally been going through the cases. That has never happened before, so we are recognising that this really matters. The issue then is how we can make that behaviour the norm. That is the trick. There is more to do, but I can see change of behaviour and approaches that were not there previously.

[67] **Jonathan Morgan:** We need to move on to Irene James's question.

[68] **Irene James:** I want to continue on service modernisation, innovation and efficiency. Alongside her report, the auditor general published work on lean and systems thinking, which pointed to examples where councils have been able to improve service delivery while also making significant efficiency savings. Do you think that NHS bodies are doing enough to deploy these sorts of business tools to challenge service performance and models of service provision?

[69] **Mr Williams:** Any good manager and management team need to have a set of skills, or tools, in their kit bag—lean business process reengineering, total quality management and so on. The danger is that some managers think that they have found the magic bullet and they go into a process rather than understanding what needs to be applied, how to apply it and—more importantly—how it is transferred to those people who need to see the service delivered on the ground. One thing that we have been working through with 1000 Lives is transferring some of these processes, particularly to clinicians, because most of the money that we spend is at the clinical front. If I went to a group of doctors and said that we were going to do business process reengineering, you can imagine what they would say to me. All work is a process and we need to look at ways in which we can modernise those processes. However, we have to do it in way that translates into the NHS or the public sector and is the right tool for the job. I have some pretty sophisticated chief executives who understand this, and we see this as an important element of our efficiency programme; but it is only one element. A lot of this now is driven for us through the 1000 Lives campaign, which uses a well-regarded methodology, but draws down, from time to time, some of these particular tools.

9.50 a.m.

[70] **Ms Williams:** Prior to taking up my post at Cardiff and Vale University Local Health Board, I was the chief executive of the National Leadership and Innovation Agency for Healthcare, and Andrew worked alongside me there. Among our responsibilities was to upskill clinicians and managers across NHS Wales in 'improvement science methodologies'. We did that for four and a half years. As Paul said, with clinicians, the key is to work through the process with them of how changes will benefit their patients and produce better outcomes.

There is a raft of quality-related improvements that we have made as a consequence of that. I know that you are short of time, Chair, and so would it be helpful if we submitted a supplementary paper to the committee to explain that?

[71] **Jonathan Morgan:** Certainly.

[72] **Ms Williams:** To give one very small example, however, patients in intensive care can suffer from ventilated acquired pneumonia. There is an improvement tool, called the ventilator care bundle, whereby if you follow the steps, you cut out ventilator acquired pneumonia altogether. We are now running nearly at 100 per cent across our intensive care units in Wales, and it has been hundreds of days since any VAP incidents. That is just an example of the application of an improvement methodology, but it makes sense to clinicians and it is much better for patients. I will give you a supplementary paper on that, Chair.

[73] **Jonathan Morgan:** That is very kind. Thank you very much.

[74] **Ann Jones:** The WLGA has stated that the no-redundancy policy operating in the NHS following reorganisation means that the NHS is protected from job losses—I think that we had worked that one out for ourselves—and that opportunities to secure efficiencies and economies from the process are therefore being lost. What is your view on that, Paul?

[75] **Mr Williams:** First and foremost, my management philosophy is that things are done through people, not statistics and numbers, so I think that redundancy is the last resort. A number of enlightened organisations in the private sector have just gone through the recession without reaching for the redundancy solution. During the reorganisation, we moved from 32 organisations to 10, and there were 180 executives in post previously. As soon as we knew that there was to be a reorganisation, we froze those posts, and people started to take retirement and so on, so we started the new reforms with fewer people in the system. The new organisations required 78 executives, I think. We got down from 180 to 140 using the previous mechanisms. We now have approximately 13 people working in the system who have not been appointed to full-time substantive jobs because they are still going through selection processes, so we are not talking about a large number of people. Some staff have left, others have retired, and some have gone on voluntary early release. So, I think that we have done very well, and it has been a very smooth transition.

[76] Our management costs when we started were 4.2 per cent of the budget. This year, so far, we have saved £7.8 million, but we are on track to save £25 million by the end of the year, and we are planning to save £40 million by the end of the three years, which is a saving of 20 per cent in the management costs. That will bring our total management costs down to 3.4 per cent of the budget. We also need to recognise that we must not confuse redundancy with losing headcount, which can be done in other ways. That is our point.

[77] **Ms Williams:** To go back again to my time as the NLIAH chief executive, NLIAH was responsible for commissioning all non-medical and dental training from universities, and I just want to remind committee members how much it costs to train NHS staff, from an employer's perspective. For example, it costs more than £40,000 to train a nurse or a midwife, and more than £60,000 to train a clinical scientist. So, from an employer's perspective, we cannot waste that investment. As our staff join us, they have continuing professional development, which hones their skills, and they then become an even more valuable asset. So, from an employer's perspective, redundancy must be the absolute last resort. We have done and are doing a number of creative things. In the Cardiff and Vale University Local Health Board, we have 14,500 staff and our turnover is currently running at around 9 per cent. So, we use our turnover to look at how we are using different roles, by redeploying people, developing people so that they can take on very different roles, voluntary early release, voluntary reduction in hours, and secondments to other parts of the public service as part of

our integrated approach. I just make a plea to you to remember the investment that Wales makes in its NHS professional staff and its support staff. It would be irresponsible of me, as an employer, to waste that. My responsibility is to use that to the best of my ability in the interests of the Welsh NHS.

[78] **Mr Williams:** The other point is the loss of corporate memory. When you think about it, we have had NHS reform of the like not seen in a generation. We achieved that, and the NHS, at about the same time, broke even financially and achieved its waiting times targets. We also had to deal with the swine flu outbreak. All that was going on because we did not lose our corporate memory. If we had gone for a redundancy policy, it would have cost us quite a few million pounds, we would have run the risk of losing our corporate memory, and we would probably have had to re-employ some of these people in other roles—and I have seen that happen in other reorganisations. So, there are some important points that we have reflected on as part of our risk-management approach to the reforms.

[79] **Ann Jones:** You have come down to a figure of 13 people who are still waiting to find full-time contracts. I take it that none of them is on the minimum wage, which means that there must be quite a substantial pressure on a local health board's budget. How is that being managed and how do the local health boards know that they have the right person in the right job if they are carrying these surplus people, who are being paid quite a high wage?

[80] **Mr Williams:** Whether we like it or not, people have national terms and conditions and degrees of protection depending on age, length of service, seniority and so on. So, we are working within national terms and conditions here. However, we have made sure that everyone is used purposefully. To the credit of some of those individuals, they have had to lose status, but they have taken on these jobs and, where necessary, have been referred to the NLIAH for retraining, as Jan has already mentioned. So, we have been retraining staff to ensure that they are fit for purpose for their new tasks. While they may have had their status and grade reduced, they still have a degree of protection until that runs out and, in the meantime, their salaries are marking time. I must say that that group of people is a minority and, as I said, the cash shows that we have reduced significant numbers, as we are on track to reduce our management costs by 20 per cent.

[81] **Jonathan Morgan:** We need to move on to Nick Ramsay's question.

[82] **Nick Ramsay:** In answer to the question that I asked you earlier, Mr Williams, you pretty much admitted that, while efficiency savings will be part of a solution, they will not be the entirety of it and you suggested that individual institutions and areas would share the burden of cuts in the years ahead. That was also the WLGA's view when it fed into the 'A Picture of Public Services' report. So, if efficiency alone is not the answer, which specific areas of service delivery will be affected and will have to bear the brunt of the savings to be made?

[83] **Mr Williams:** First and foremost, it will be done through modernisation. We have to increase day-case surgery rates. More than 80 per cent of our surgery could be done on a day-case basis. That is not a cut, but a change in how modern medicine should be practised. There will also be an impact on the number of in-patients going through the system.

10.00 a.m.

[84] We have talked about lengths of stay. On agency working, in the past, we lived too much on a day-to-day basis rather than planning our workforce more effectively. Many millions of pounds have yet to be saved through agency working. We have talked about a 20 per cent reduction in management costs, so that is another example.

[85] We then get on to the big areas of shifting the balance of care through integration, doing more work in the community and in primary care settings. We have responded to you on unscheduled care. There is still lots of work to do on unscheduled care, as the system demonstrates that we are reacting rather than being proactive. We have not talked much about information systems. A lot of resources could be wisely invested to save money in information systems. The 1000 Lives Campaign is about reducing harm, variation and waste, and I will demonstrate that with an example about pressure sores. We now have a methodology that started in Morriston Hospital, where one ward went for 500 days without any patients getting pressure sores. The cost of pressure sores financially, let alone in human misery terms, is enormous. We are rolling that methodology out across the whole of Wales. So, on the clinical improvement side, a lot is going on.

[86] Too many patients are still being cared for in mental health organisations outside Wales. So, we are redesigning our mental health services to bring those patients back. Nearly a fifth of all expenditure is in the areas of drug costs and medicines management. We are looking at ways of being much more effective there. We have not touched on procurement and shared services, which is another area in which we are quite effective, I think, but we could still go further. We are leading on shared services and we have done a lot on that. We have an exciting programme that has just been through a rigorous assessment, and we are starting to roll that out. We hope that other parts of the public sector will join us in taking up the opportunities offered by shared services. Those are just some examples of where we are starting to move forward and accelerate our pace, and Jan may want to mention a few others.

[87] **Ms Williams:** Our plans in Cardiff and the Vale of Glamorgan mirror that. On service modernisation, at our board in July, we will be discussing a paper on improvements to stroke services for people in Cardiff and the Vale. We will do that by focusing our acute stroke services on the University Hospital of Wales and our rehabilitative stroke services on Llandough Hospital. We will then ensure that everyone in Cardiff and the Vale who is unfortunate enough to need stroke care will get the best immediate care, because we will concentrate our specialist teams for acute hyper-stroke management in the University Hospital of Wales and give people equitable quality-based rehabilitation at Llandough Hospital. That is one example of modernisation that will assist us to provide a better quality of care and deliver a better use of resources.

[88] We are tied into a whole range of shared services. I am working with my colleagues in the Aneurin Bevan and Cwm Taf local health boards to plan a service based in the south-east for people who have low-level secure mental health needs. We will achieve an economy of scale and a better quality of service, and we will save costs by bringing people back from England. In addition, at the specialised end of our business, the tertiary services, we are working closely with our colleagues in Abertawe Bro Morgannwg University Local Health Board. We have reached an agreement this year that it will manage specialised pancreatic surgery for the people of south Wales while we manage specialised liver surgery. That is how we are marshalling our resources to give better care but managing it in an affordable way.

[89] **Jonathan Morgan:** You touched on procurement and shared services. Before Jeff Cuthbert asks his question, Sandy was meant to ask a question later on procurement and asset management, so I wonder whether she wants to pursue that now, as it has come up. It may help the meeting flow better.

[90] **Sandy Mewies:** Yes, I can do. As the Chair said, saving money through better joined-up procurement and making better use of assets are two of the potential areas of savings identified in the report. The auditor general also published a briefing earlier this month on buildings management, which identified scope for public bodies to achieve better value for money. What opportunities are there for the NHS to secure further savings by strengthening the approaches to procurement, and how is asset management being strengthened?

[91] **Mr Williams:** May I defer to Chris on this one?

[92] **Mr Hurst:** It is being strengthened in a number of ways. Coming back to the point about taking a longer term view, the lead time involved in developing buildings and the like is considerable. Having a clear view of where we are going, and one that also takes advantage of other public services' plans and strategies, gives us some new opportunities, and that touches on some of the points that Paul has made about the ability to procure jointly with other public services. That is one opportunity.

[93] Framework agreements were touched on earlier. They have been a useful addition in relation to procurement. In other words, they have brought forward some of the costs associated with qualifying bidders and so on and having a number of approved suppliers in place. We only really get the value from that sort of agreement when we can be clear about our longer term requirements, because it enables our suppliers—the construction industry in this case—to come back with proposals for optimising its costs by hiring labour from neighbouring developments and by scheduling in a way that saves money. So, 'working with supply chain partners' is the phrase that is usually used. It is another opportunity where we get advantage already, but I think we can do more, particularly working across the public sector.

[94] One of the things that the new local health boards did last year was to commission some professional work to look at their estates, so that they would have an up-to-date and accurate record of them. That has proved to be very valuable, and it is a key theme that comes out of the auditor general's report, which is about having good information about the estate across public services. I think that it has to be a longer term ambition for public services as a whole, but it is one in which we are already making progress.

[95] **Sandy Mewies:** We had a discussion on asset management. If you do not yet, are you sure that you will have, in the not too distant future, a very clear picture of NHS assets?

[96] **Mr Hurst:** I think that we have now. The issue is about ensuring that it is detailed and accurate enough. I think that there were comprehensive records before, but they were not necessarily up to date in all areas with regard to the state of the estate. Jan may want to say more about Cardiff and Vale as an example.

[97] **Sandy Mewies:** You might include a strategy for what you are going to do with the ones that you are not using.

[98] **Mr Williams:** In fact, I was just checking the members, and I think that we do have good information systems. I used to take these to my former board, because assets are important, as is the way in which the estate is utilised. We can track the improvement of that asset utilisation, which has increased. I alluded earlier to the fact that we are accelerating the disposals to ensure that we are not hanging on to parts of the estate that cannot be given to other partners for developments or used to generate additional capital through sales.

[99] The other point is to do with efficiency and our contribution to the sustainability agenda. The NHS has a very good story to tell about how it has reduced its carbon footprint by about 17 per cent. It is now sourcing some 10 per cent of its energy through combined heat and power. We have reduced our waste to landfill by 7 per cent, and our water consumption has gone down. This is all part of being an efficient estate, and it makes good business sense, and on the sustainability agenda, it is driving us forward. I think that we are making a significant contribution to Wales's targets with regard to the effective management of our estate.

[100] **Jeff Cuthbert:** My main question has been dealt with already. Therefore, to avoid repetition, I will just ask a brief supplementary question to Jan and Andrew.

10.10 a.m.

[101] Given the size and scale of the new NHS bodies across Wales, how are you managing to retain a local focus?

[102] **Ms Williams:** Our board has been very determined from the outset that we would not be remote and that we would connect with the communities that we serve. I mentioned earlier that we have locality arrangements based on our two local authority areas, but we also go to six neighbourhoods in Cardiff and three in the Vale of Glamorgan. Our teams in those areas will be used a lot to make sure that what communities are saying feeds up to the board. However, our board members are also out and about frequently. For example, a number of our board members met yesterday with over 60 of our third-sector colleagues. Our board includes regular dialogue with different communities. We take our board meetings out into the community, for example; we do not hold our board meetings on our premises—we take them out to communities across Cardiff and the Vale. We have been to universities, leisure centres and so on, as a consequence of that. However, our structures are based on our neighbourhood teams being a conduit between the board, the localities and the people we serve. We are also connected to the Ask Cardiff arrangements, where there is an extensive network to seek views. We are connected to the health and social care networks across Cardiff and the Vale. We also have good connections with the council members on our board, who enable us to tap into their additional networks. Our board made it a theme that we would not be remote, and we say that the board and the front line will stay in sight of each other. That is something that our board members practice diligently.

[103] **Jonathan Morgan:** Thank you. I am conscious that we are running slightly over time, and that there were four additional questions that we wanted to put to you. For common sense purposes, I am trying to get through this item although I am conscious that we have guests waiting to join us for the next item, and that Mr Williams will be detained for a bit longer. I will write to you on three of those four questions, but Jenny has a follow-up question on oxygen therapy services to Mr Williams. We will pursue that question now.

[104] **Jenny Randerson:** It is a very specific question. You say in your written response on home oxygen that there are clear examples where LHBs are striving to make improvements on the patient assessment services, and that this would reduce costs. However, you did not provide us with any details. Can you give us some detail about the anticipated or actual level of savings in the cost of the current home oxygen contract as a direct result of the use of specialist patient assessment services? As it is four or five years on from this contract, how widespread is full implementation of the patient assessment services across Wales? How many health boards are entirely fulfilling the original criteria, and how many still have progress to make?

[105] **Mr Williams:** My officials tell me that we have saved around £44,000 on the contract. From reading the files, there is no doubt that the implementation has been much more difficult than we had imagined. That is not unique to Wales—that is also the experience in England. When I took over, the Minister asked me to draft a letter, which she sent to the new chairs of the local health boards to signal the importance of driving forward this whole initiative. It became clear to us that some of the boards had not addressed full compliance with the British Thoracic Society guidelines. The data systems and the collection of information were not as good as they should have been, and not all boards had appointed permanent leads. However, there was some good practice, some of which included establishing a clear pathway for integrating primary and secondary care, putting in place training programmes for GPs and establishing clinical information groups.

[106] On the assessment side, we felt that there is still more work to do. A further £1.6 million has been allocated to the boards this year to improve the assessment process. We followed that up with a further letter to the new boards in April, and my officials are now going through the action plans that we asked for. I might need to write with some of the detail when I have the full analysis of the action plans that we requested. Good progress has been made and we can demonstrate savings. On the detailed board-by-board information, I will have to wait until the analysis has been completed, which should be the case within a matter of weeks.

[107] **Jenny Randerson:** It would be helpful for that offer to be taken up, Chair, because this is not only a matter of financial savings but of the level and quality of patient care.

[108] **Mr Williams:** Although there is more work to do, the responses to the patient satisfaction survey have been positive. However, we should not be complacent.

[109] **Jonathan Morgan:** I thank the witnesses for being with us this morning. You are all free to leave, except for Mr Williams.

10.18 a.m.

Gwasanaethau ar gyfer Plant a Phobl Ifanc ag Anghenion Emosiynol ac Anghenion Iechyd Meddwl: Dilyniant Chwe Mis
Services for Children and Young People with Emotional and Mental Health Needs: Six-Month Follow-Up

[110] **Jonathan Morgan:** I welcome our witnesses for the next item, which is on the follow-up work that is being done by the Public Accounts Committee in looking at the progress on the delivery of child and adolescent mental health services. This is our third meeting on this matter. The first was in December of last year, when we heard from the Auditor General for Wales and Health Inspectorate Wales, who provided a briefing on their report. In January, we heard from the Director General for Health and Social Services about the actions that have been taken to address the issues in the report.

[111] I ask the witnesses to introduce themselves for the record.

[112] **Mr Williams:** I am Paul Williams, the Director General for Health and Social Services.

[113] **Mr Burdett:** I am Chris Burdett, the head of the support for learners division in the education department.

[114] **Dr Williams:** I am David Williams. I am a consultant child psychiatrist and a professional adviser to the Assembly.

[115] **Mr Dean:** I am Simon Dean, and I am the director of strategy and planning for health and social services.

[116] **Jonathan Morgan:** Thank you. I apologise for the delay in starting this item. The action plan makes specific commitments in order to address issues raised in the report, for example the provision of specialist child and adolescent mental health services for all under 18-year-olds by March 2012. However, some other issues, such as some medical staff not being willing to provide support until a child has stable home and family circumstances, do not appear to have been addressed specifically in the plan. Could you explain your thinking

behind the approach that was taken in putting the action plan together?

[117] **Mr Williams:** We were not able to satisfy the committee when I last presented to you, so I undertook to give you a detailed action plan within six months. Simon Dean chaired the group that undertook that work, and he and colleagues can probably go through the detail better than I can. There was a multi-agency and multi-organisation approach. There is still more work to be done.

10.20 a.m.

[118] I think that we have demonstrated that we have taken seriously the points that were raised, particularly those that were raised by Members at the committee, as I mentioned in my covering letter to you. Also, we are seeing this very much as a work in progress. Simon will continue to chair a group in order to drive forward work on the issues that we have identified as needing to be addressed within the action plan, or where we think that there are other issues, such as the one to which you just referred, which still need further work. Dr David Williams might want to say something about the detail of that point.

[119] **Dr Williams:** On that particular point, specialist CAMHS services should be offering support to families in those circumstances; many of the services across Wales do so, but there are discrepancies between services. One of the difficulties concerns understanding what precisely support means. Some people are requesting out-patient appointments and direct individual work, which the evidence says is not the best way to support a family, even though the person working with the family would expect that to be the way in which you should interact. It highlights the problem in the relationships between the referrers and the specialist CAMHS services, and the understanding and the expectation of what is best delivered for the family. However, within the report, and as we roll out expected standards across the whole of Wales, you would certainly expect that that circumstance would not arise.

[120] **Jonathan Morgan:** It is clear that you are taking seriously the issues that have been raised in the Wales Audit Office and Healthcare Inspectorate Wales report. However, a number of specific issues were identified in that report that are not part of the action plan. In fact, according to my calculations, around 13 separate issues have been raised with us that have not been responded to. Although we accept that you are taking this seriously, it is our job to be as picky as possible in scrutinising the difference between what was identified in the joint work between the Wales Audit Office and Healthcare Inspectorate Wales and what has transpired in the plan. We will move on to one of those issues now.

[121] **Jenny Randerson:** Following on directly from that, Chair, the national action plan does not include specific actions on many of the areas mentioned in the report, for example, the limited availability of day care and eating disorder services, the lack of child-friendly locations, and the exclusion of the voluntary sector from local strategic mechanisms. It may well be that some of these come under the high-level points in the plan, but how are you going to ensure that the local action plans address all the relevant issues?

[122] **Mr Dean:** This plan is relatively high level, as you have indicated, and it cannot possibly detail all of the specific actions that will be taken. What we have tried to do in the plan is indicate the priorities and, within that, identify how we will work at a national level to support local partnerships in developing more detailed plans to address all of the specific actions that are covered in the WAO report, and any other issues that are in their minds. The key focus will be on the local plans to deliver, with the national process being about support, performance management and quality assurance. So, the very specific issues that you have raised will be addressed through the local plans, as opposed to being articulated in a national action plan, which would have run to a significant number of pages if we had tried to address all the actions in it.

[123] **Jenny Randerson:** That is fair enough, but how are you going to ensure that local plans do that?

[124] **Mr Dean:** We will do that through our performance management processes, which we have strengthened. The national delivery group is called 'national delivery group' for a reason, so the two directors general most closely connected with this—Paul Williams and David Hawker—have charged me with chairing a group that will ensure that action plans are produced, and they will quality assure those plans. So, we will be scrutinising those rigorously so that I can report back to the directors general on the successful addressing of the issues that have been raised.

[125] **Mr Williams:** There was no doubt that, under the previous arrangements, it was very difficult to get the focused approach that we had before. I speak mainly for the NHS, but in the context of partnership working. As far as the NHS is concerned, we now have a very clear performance management system. I alluded to that in the previous session, so I do not want to go into too much detail. With regard to the requirements of this plan, we will have milestones in our performance system, whether they are monthly, quarterly or annually, at which we will be assessing the progress of the local plans. We are also expecting reports back from the group that Simon will continue to lead, which will include an annual report to my Minister. We are putting a big emphasis on reinforcing issues into the process, which was perhaps not the case before. We then have to look at how we handle it on a multi-agency basis, in terms of children and young people's partnerships and local service boards. In essence, we have to drive this through the local plans. The networks have an important part to play, but it is going to be far easier than it was previously, particularly on the NHS side, to monitor, measure and, if necessary, take corrective action.

[126] **Bethan Jenkins:** I thank you for the evidence that you have given so far, but I want to probe you further. In the past, when specific issues, such as eating disorders, were not mentioned in national plans, local health boards have not felt there to be much of a duty on them to carry out their obligations, if I can put it that way. How will you ensure, therefore, if it is not explicit in the national plans, that it will be explicit in the local plans, and for there to be an obligation to deliver those services fully? It is all well and good to say that it will be included in the local plans, but if there is no explicit mention of it in the national plans, it will often get lost in the morass of other issues that are perceived to be important.

[127] **Mr Williams:** Again, I would like Simon to start off on this, because he is the guy who pores over all these plans to ensure that he gives me the assurances that I need to give you.

[128] **Mr Dean:** I would start with the responsibilities of the local health boards, which I am sure that you have covered in earlier conversations, so I will not go into detail. The critical feature of the new boards for me is their responsibility for the entirety of the population's health, which is a responsibility that they take seriously. So, these services, which include services for eating disorders, will be firmly on their agenda. We will ensure, through the performance management planning processes, that we understand what their plans are, in this case, for services for children and young people with eating disorders or services for children and young people who are deaf. We will be picking up all of that detail.

[129] In one of the earlier versions of the action plan, we went into rather more detail and we ended up with pages of lists of specific actions. We felt that there was a danger that the detail would swamp the focus, so we have taken that detail out of this plan. However, we will be pursuing that detail with local health boards and through the national group.

[130] **Jonathan Morgan:** There are some important points here, which Jenny and Bethan

have touched on. Jenny referred, for example, to the limited availability of day care and eating disorder services. It is one thing for a local health board to tell you, 'We've secured provision of that', but it may translate as, 'We don't actually provide a day care service ourselves, but we'll send patient X to a service in England'. So, in essence, the health board is fulfilling the requirement to provide a service, in that the patient is receiving it, but it may not have delivered that service itself. Where is the emphasis on health boards providing those services locally, as opposed to merely securing the provision of that service, which could be delivered somewhere else?

[131] **Mr Williams:** I am going to ask David to start on that.

[132] **Dr Williams:** We are all aware of the works that Joy Jones has done in developing the all-Wales eating disorder plan. She works from Gwent—

[133] **Bethan Jenkins:** Yes, but that is for adults.

[134] **Dr Williams:** It is an adult-focussed plan that has come out of work that she has done in her career, working with children and adolescents. In fact, there is more of a problem in Wales with eating disorders in early adulthood. There are areas where eating disorder services are delivered locally, and areas where they are not. Part of that is related to the sustainability and the robustness of the service being delivered.

10.30 a.m.

[135] There are five specialist providers of NHS child and adolescent mental health services across Wales. Not all of those services have been able to maintain a workforce of a critical mass or of a robust nature, so they have been subject to recruitment problems and so on over the years. Therefore, there is an issue about ensuring that this plan addresses the structure of the delivery of NHS CAMHS so that services are sufficiently robust and include specialist services so that children and young people can receive the services in their local areas. At the moment, the model of services does not fit that, so it is a job of work to do.

[136] The other area of the plan that is specifically important is the service specification of CAMHS that needs to be developed, because, over the years, 'Everybody's Business' has given a wide view of the sorts of services and values of services that need to be provided, but it has not necessarily been specified in detail what sort of services need to be delivered and where. An all-Wales view of what the services should be—putting an onus on local health boards to deliver services for children with eating disorders, children with substance misuse problems, children who are deaf, and children in forensic services—is vital work. As Simon said, it was in the original draft for the body. Work has progressed at different speeds on all four of those areas in particular, but it was not included in the briefing papers. The regional network managers are a vital part of that, because they are standing in a position that is slightly aside from the provider organisations, which means that they can hold them to account, but they are also looking at a region that is big enough to enable them to have a critical mass to consider the range of services that need to be delivered.

[137] There is a balance to be had between that regional planning—over the three regions across Wales—and the original planning network that we had, with 22 organisations or partnerships trying to create services, which, in the case of services for eating disorders, for example, and other highly specialised services, is quite a difficult thing to do, because you are dealing with small chunks. That made it difficult to develop the expertise necessary to deliver those services.

[138] **Mr Williams:** It is about trying to strike the right balance, and we would welcome the committee's views on this. It is about what we are tasked to do at the national level and

the responsibilities of the local boards and partners. It is not a case of our writing a document and walking away, because we have put in place Simon's group, which will be working continually with local organisations, the boards and other partner organisations. So, it will be a case of managing their time in a way that perhaps did not happen before. That is one of the lessons that we have learned, and it is important with regard to the way we are trying to approach and tackle issues that were perhaps more theoretical in the past. We cannot lose the accountability, but nor can we manage the minutiae at the national level. So, what we are suggesting now in terms of the process will give me more comfort than in the past because, if some of these issues are still not addressed, they will be continually discussed by Simon's group.

[139] **Jonathan Morgan:** To pursue that a bit further, page 26 of the action plan sets out the arrangements for planning at the local, regional and national levels and by various organisations. It states that the planning arrangements for CAMHS should be clarified and simplified. With regard to co-ordinating that work and ensuring that those plans are integrated and comprehensive, will that be done by you, Simon, and the board that you will be working with?

[140] **Mr Dean:** Yes. The NHS is already clear that it must produce action plans to improve these services. That message has been clearly communicated by Paul through chief executives and the Minister to the chairs of health boards. The local networks are the instruments of the LHBs in doing that planning. They are fully engaged in that. They are tasked with producing action plans by the end of July, and the group that I will chair will essentially quality-assure those plans. As David indicated, the critical thing here is the service specification, which sets out the picture of the service that we wish to see provided. There is a task to do to complete that service specification and to address questions of what constitutes the right balance between in-patient and day-care-based care. That will provide a benchmark against which we can test the local plans that are coming forward. For example, as I think David may have mentioned, there was a question in the last committee evidence session about the role of community therapy teams. That is an area where there is professional debate. There is no clear, single, consensus view about how those teams should operate. We have some work to do to think through some of the key strategic issues, and need to use the group that I am chairing to maintain focus, drive and purpose, and to quality assure the plans that come forward from the NHS. If those plans are in any way insufficient, and if the group that I am chairing is unable to bring about improvement, then we are into the formal performance management processes, through Paul, for the relevant chief executives.

[141] **Mr Williams:** We have identified the key role of the clinical networks, but also whether they have sufficient resources and support. Again, that is the responsibility of the local health boards, but I have written to the chief executives to say that, because these networks are so important in the new process, I expect them to ensure that they have sufficient resources and the capacity to discharge their functions. Again, we will be watching this very carefully.

[142] **Jonathan Morgan:** I have juggled some of these questions around. I was wondering, Irene, whether you could take the next one—question 4.

[143] **Irene James:** The action plan places a lot of reliance on the three specialist CAMHS planning networks to deliver the actions, but the report raised concerns over the capacity and effectiveness of these networks. Have things moved on in this regard, and how confident are you that the networks can deliver what is expected?

[144] **Mr Williams:** I had somewhat anticipated that question, because it is connected with the last response. First and foremost, it is right that more services are managed and planned by the professionals who provide them. I think that that is correct. The Minister has confirmed

that she regards these networks as an important national asset. As I said, I have just written to the chief executives to remind them that they have total responsibility for integration, and they cannot absolve themselves of the responsibility to ensure that these networks are working across boundaries and have sufficient capacity to deliver. We are aware of their importance, but also their vulnerability if they do not have the resources required to do the job. Perhaps David could say something on this, Chair, because he has great insight into the day-to-day running of these networks.

[145] **Dr Williams:** I have been managing services in Gwent for 10 years, and the networks have made a huge improvement by having one person who is co-ordinating, from Gwent's point of view, five local plans, ensuring that they are coming together. During the preparation of the report, the three people from the networks were the ones who had the up-to-date information about what was going on, and where the areas of concern were, and who held the local health boards to account to ensure that their action plans are delivered on time and address the issues that people are concerned about.

[146] In developing the new areas of service, such as moving to the age of 18 as a cut-off point, and looking at forensic services, substance misuse services and eating disorder areas, they have been the key people in having the time to bring the relevant clinicians and bodies together. They have made a difference. It will be improved still further now, because each health board has a member responsible for young people's mental health, and across the services, through the board members and that person, supported by the national framework, there is a robust mechanism in place to ensure that decisions are taken and that the variety of health services are held to account in a way that was not possible when you had so many bodies. Many of the people who were trying to make the plans also had all sorts of other areas, such as speech and language therapy, in their work portfolio, but you could not get that work done in the same way.

[147] **Jonathan Morgan:** Simon, did you want to come back in?

[148] **Mr Dean:** If I may, briefly. I wanted to reinforce David's point that the planning networks are critical. However, it is also critical that the senior management of the LHBs is engaged fully, because this is not a job that can be delivered by the networks operating in isolation. The networks are significant resources, but that leadership from within the organisation, that commitment to deliver, and that empowerment of the network is also important.

10.40 a.m.

[149] I will speak with the executive leads about how they discharge their responsibilities, because that is the formal accountability. They are the people who can mobilise resources on the scale that may be required.

[150] **Jonathan Morgan:** We now move on to Janet's questions.

[151] **Janet Ryder:** I am slightly confused now, Chair, so can I ask for some clarification on this? The action plan places a lot of reliance on the 22 local children and young people's partnerships to drive this forward. The report obviously found that CAMHS was not prioritised significantly in those plans—there was quite a severe deficit in provision in those plans. So, you were going to come forward with action plans to guide those local plans. However, if I understand you correctly, what you have just said is that this really needs to be examined at the health board level. If I relate that to my own area in north Wales, we have one health board and at least six plans falling out of that. It would seem to me, listening to this as a lay person, that we have a great deal of duplication as well as the possibility of nothing being done, because a lot of the discussion is around what happens locally and what happens

at the health board level. Who actually drives this? How we will ensure that these services progress? Is it the local partnerships that drive this service forward? If so, how will you satisfy yourself that they are doing so efficiently?

[152] **Mr Burdett:** If I could come in on this one, the children and young people's partnerships are designed to be strategic partnerships with an overview of all services for children and young people in the area. As you probably know, they include representatives of the local authority, the health service, the voluntary sector, and other statutory partners. Their plans should therefore cover everything that is done for children and young people in the area, and the planning guidance, which we are finalising at the moment, will refer to this action plan. However, the plan cannot set out in detail every action that will be taken under every plan. It has to be supported by more detailed plans that it makes reference to, and these plans for the LHBs that we have been talking about today are just one example of those more detailed plans that sit underneath the overall children and young people's plans. In terms of ensuring that the plans are good enough, it is fair to say that the partnerships are in a transitional stage. They have to be the key local bodies for multi-agency working, but they are in transition from being planning bodies to being more delivery bodies. We have various mechanisms in place to support them, such as the partnership support unit, which we are supporting in the WLGA, and there are annual reviews of the plans by colleagues in the office to see the progress on implementation. There is also provision, if the plans really are not good enough, for the Minister to require aspects of the plan to be changed. That can be done via regulations under the Children Act 2004.

[153] **Janet Ryder:** Could I confirm that I have understood you correctly that the local children and young people's networks are changing from being planning groups to being delivery groups? You have stressed how complex this is, and you have said in previous evidence that this cannot be delivered at such a local level because of the nature of the service and the need to recruit staff. Therefore, you have to look at regional delivery. It would seem to me from your answer that there is a great deal of duplication. I would like you to convince me that these local networks have the capacity and ability to deliver these plans. If they are in a state of transition, when will we see some action?

[154] **Mr Burdett:** We certainly do not expect duplication, because the children and young people's plans are the top-level plans; they do not repeat what is set out in the other plans, although they make reference to them.

[155] **Janet Ryder:** So, each local authority plan is the top plan for that area.

[156] **Mr Burdett:** For children and young people's services, yes. They are linked to the health, social care and wellbeing plans, but, yes, that is the top-level plan for all of the services for children and young people in the area.

[157] **Janet Ryder:** So, we will have—I can only refer to north Wales, because that is the area that I know best—six plans in north Wales, each of them being the absolute driving plan for the authority. So, whose responsibility is it to marry those plans across north Wales to ensure that the one health board that we have for the area delivers those plans?

[158] **Jonathan Morgan:** It may be helpful to bring Simon in on that.

[159] **Mr Dean:** The delivery responsibility sits with individual organisations, so the local authority is responsible for delivering the service.

[160] **Janet Ryder:** Which local authority? The local health authority or the local authority itself?

[161] **Mr Dean:** Each local government authority is responsible for delivering the services that sit within its remit. Each local health board is responsible for delivering the services that sit within its remit, and there are different accountability systems for the health boards and for local government. The partnership recognises—well, it does more than that, it stresses—the importance of organisations working together to deliver, so I would expect to see a plan from each health board, because that fits with our accountability system. That plan, if it is to be successfully delivered, must be developed alongside local authority plans, otherwise it will not work. So, we must have a local children and young people's partnership that brings those plans together at the individual local authority level, and I would expect the health board plan to be the sum of those plans, as it were. So, in the case of north Wales, there would be six plans under the children and young people banner, and the health component within those would be six chapters within the health board's plan. There cannot be any dissonance; they must say the same thing. However, because of the accountability systems, we would expect to see a plan that sets out what the health service is doing. Paul's direct relationship and accountability is for what the health service delivers; the accountability for what education delivers rests elsewhere.

[162] So, there is a way of bringing all of this together, which works, makes sense and drives partnership, which will get a better result. The delivery responsibility sits with individual organisations.

[163] **Mr Williams:** I would like to add a further comment on this. You are absolutely right, this is an incredibly complicated issue, but it, for me, is the essence of the concept that this is everyone's business. If that is the ambition, we need to bring all organisations together in a focused way, with their different accountabilities, and that is difficult. We can also think of health in geographical terms, because you can start at the general practitioner or primary care level and then move on to the secondary level and then to the highly specialist tertiary level. So, in geographical terms, the boards must think: local, larger, tertiary. They cannot do that outwith their partners, many of which are under local government, and there is also the third sector and other agencies to consider.

[164] I suggested in the document that one of the things that we need to do at a Government level is to have regular reports that come back to the three major directors general, which are those for the Department for Children, Education, Lifelong Learning and Skills and the Department for Social Justice and Local Government and me. So, if these issues are not being addressed adequately at the local level and we are not getting the coherence that we require, we can, through our various accountability and performance arrangements, do what we can to ensure that there is that focus, which can be at risk in certain situations given the complexities of what we are trying to do. I do not think that anyone on our side minimises the importance of focused partnership working, but it is complex.

[165] **Mr Burdett:** In that respect, this subject is no different to any other aspect of the planning of the children and young people's partnerships. All of those aspects will be the responsibility of a particular body, but the partnerships ensure that that delivery is integrated and joined up with the work of the other partners.

[166] **Mr Williams:** I have pointed out to the health boards that I expect them to play a full part in each of the children and young people partnerships in their areas.

10.50 a.m.

[167] **Janet Ryder:** I have one more question. CAMHS also have a big impact on the education service. I can seen that one health board has a chapter on health, and that case is probably replicated across the six authorities in north Wales, with slight variation, but what happens to education? Who looks at that part of the young people's plans? There is not only

one body that looks at education across north Wales; there are six. Should the Minister look at it? Paul Williams has said that it should perhaps come to the directors here. Is that happening? If not, who is doing that work now?

[168] **Mr Burdett:** When the children and young people's plans come in, they are shared among colleagues who have the respective responsibility for policies on all the aspects that the plans cover, so that comments are received from a wide range of people. That is brought together. As you probably know, we have a Cabinet committee on children and young people. Below that is the children and young people's network, which David Hawker chairs, where all the views can be brought together and an overall view of the plans can be produced.

[169] **Jonathan Morgan:** Jeff Cuthbert has the next question.

[170] **Jeff Cuthbert:** Recommendation 7, on page 28 of your report, says that

[171] 'The Assembly Government should commission the development of information for children, young people and their parents on their rights relating to CAMHS and what they should expect from these services'.

[172] The report suggests that information may not be available currently in an appropriate form. Specific action 1 at the bottom of page 28 simply refers to the need

[173] 'to review access to these resources, with the aim of promoting awareness'.

[174] That suggests that you are not going to look at a new form of information and that, instead, you will collate what is there now and see what can be tweaked. Is that an accurate reflection?

[175] **Mr Dean:** I think that we could have drafted that slightly differently, because if, on reviewing the position, we find that the information available is inadequate, clearly we would not simply make people aware of inadequate information; we would do something about it. We are expecting the networks to review the provision of information. A key part of that is making sure that people are directed to the information that is available. Should that review identify gaps, the next task will be to plug those gaps as quickly as we can.

[176] **Ann Jones:** Another recommendation in the report says that health boards and local authorities should ensure that cases are not routinely closed because of people not showing up for appointments. The action plan identifies some actions that focus on monitoring and understanding non-attendance rates, but no action appears to have been proposed to address the inappropriate practices in many parts of Wales, namely of cases being closed as a result of non-attendance and sometimes after only one missed visit, and those cases are not always followed up with the child or the carer.

[177] **Mr Williams:** We would not condone closing any case just because someone does not attend. There could be all sorts of complex issues behind that that are telling you something very important. We do not condone that practice, and I think that Dr David Williams can give some information on his practical experience of how things have changed to make sure that vulnerable groups are given all the attention and understanding that they require.

[178] **Dr Williams:** First of all, it is a question of ensuring that the services are more accessible. So, one issue is rolling out good practice models. Secondly, an idea that we have is that child and adolescent mental health expertise should not be solely dependent on referrals; there should be greater dialogue between primary care professionals who are working with children and specialist services, so that, where possible, it can be managed.

Therefore, when there is a need for specialist input in the case of a family that may have problems attending, or in the case of a child who does not want to come, we should know about that before we start offering appointments rather than after they had missed an appointment. So, there is work to be done.

[179] On the second point, the model used is called 'the team around the child', which means that you do not pass the child from service to service, but invite other services around the child. So, if specialist CAMHS cannot access that child directly for one reason or another, the remaining professionals are aware of their responsibility to maintain the support and still have access to advice, perhaps being able to work with the family on those children who are difficult to reach. Obviously, the GP retains responsibility for health. For the majority of other children, the education service has residual responsibility, so links with it must be strengthened. Clearly, it is not as simple as offering other appointments, because if they have not come to one appointment, this would be a waste of time and it prevents other people from accessing appointments.

[180] It is about strengthening the feeling of there being a system around the child, rather than the child being passed from one professional to another, whereby, if a professional does not pick up the child, the professional who has passed the child on does not realise that he or she continues to have responsibility. So, it is about the whole model of care, and it is being addressed in the way in which services are bought up. It is also about giving time. So, in the service specification, the consultation, liaison and support services that are currently working with children are a key part of the sort of working that means we are not focusing solely on the number of children being seen in outpatient services.

[181] **Ann Jones:** That sounds very good. However, sitting here, we feel as though we are a million miles from what is happening in some communities. What action is planned to address this? It is an unsafe practice and it is happening. What you have said sounds very good, but how are you going to translate that into these communities where people need the services?

[182] **Dr Williams:** The reality is that the formation of the new health boards, where you have general practitioners and specialists managed by single chief executives, has helped us to address that and to set up a system so that there is an understanding and a shared responsibility. There is further work to be done on building links between education and specialist services and on understanding that relationship. I know that the children's commissioner has suggested that, when a child does not attend an appointment, it should be considered to be a neglect issue, because the family is failing to meet the child's needs, and that, in some cases, a referral should be made. Normally, referrals by specialist services can be made only if you already know the family, because, obviously, people have the right to attend appointments or not.

[183] There is another issue of how well families receive information about what they are being referred to. So, to come back to a previous point about available information, it is vital that people know exactly what sort of services they are being referred to. Not too long ago, we did some work on this and found that, in 30 per cent of cases, the child had not been seen by the professional who made the referral. There had been an adult-to-adult conversation, so, in those cases, it is hardly surprising that adolescents do not go to the appointments. So, it is about auditing practice, developing links and then setting out a pathway for accessing services that ensures that both services are engaged at the point of referral rather than there being a handover.

[184] **Mr Williams:** According to my information, we have an agreed protocol at the local level for identifying people who do not attend appointments. Obviously, it is an important issue, so I would be quite happy to establish whether the protocol has been applied and to

look at what we can deduce from that information for you.

[185] **Ann Jones:** That is fine, thank you.

[186] **Bethan Jenkins:** I want to comment on this, because I do not feel that the information that you have given is sufficient. I often deal with cases, particularly to do with eating disorders, where, because someone did not attend an appointment, he or she is not contacted again by the clinicians. Often, clinicians within the same department are not speaking to each other. Why is it taking so long to get a care pathway in place that can link education, GPs and specialist services to ensure that people are not lost in the system? It is all well and good to have protocols, but I see letters every day telling young people that, because they have not turned up to an appointment, they will not be seen again. That is unacceptable in this day and age.

11.00 a.m.

[187] **Dr Williams:** It is obviously unacceptable if there is different practice within a single organisation. It is a priority and a concern for people who work in the field of specialist mental health all of the time, but, in the past, to achieve such protocols, it has been a question of essentially five or six individuals across Wales trying to link with 22 local health board groups of GPs, and 22 local authority services to establish them, which has hampered progress. Therefore, I feel far more optimistic that we can do something with the new system. There is also a rising awareness that it is not acceptable. This report and other similar reports have made people realise that there is a job to be done across agencies.

[188] **Mr Dean:** When we were preparing the report, we discussed everything that was in the report of the inspector and the auditor general. The networks were very clear that this was completely unacceptable practice. I would be very interested to receive suitably anonymous examples of such cases so that I can follow them up. At a national level, the message is that there are protocols in place. There are a large number of professionals who need to deliver these protocols, and I would be very interested in having evidence that will help us to target our efforts where that is needed.

[189] **Jonathan Morgan:** I am keen to understand your thinking on the issue of collaboration and joint working. The Assembly Government's Proposed Mental Health (Wales) Measure makes a specific statutory provision for the collaboration and joint planning between local authorities and health boards to secure the provision of services for adults who need to access mental health services. If it is needed for adults, why is it not extended to children and young people?

[190] **Dr Williams:** The recommendation was that it should be extended.

[191] **Jonathan Morgan:** The Chair thought that he would try his luck on that one.

[192] **Mr Williams:** We would welcome any information that Members have on this, so that we can follow it through.

[193] **Bethan Jenkins:** Can we just have information on the projects that you are running with regard to looking into 'did not attend' rates with young people? That would interest me in terms of finding out why they are not attending if you are doing that across Wales.

[194] **Mr Williams:** I will certainly follow up on the reports that we have had about establishing the protocols. I am not sure what the data collection systems are. We can complement it with any local intelligence that you have and we might need to put in place a more systematic process to collect these numbers.

[195] **Mr Dean:** If you have a particular interest in it, Chair, perhaps a meeting outside this session might be helpful. It is an offer if you wish to take it up.

[196] **Jonathan Morgan:** That is very kind. Thank you. I now call on Sandy Mewies.

[197] **Sandy Mewies:** Are there changes planned to initial teacher training courses that will enable teachers to identify the mental health needs of young children as well as additional needs?

[198] **Mr Burdett:** This aspect is already covered in initial teacher training. The qualified teacher standards, which set out what teachers should know and be able to do as a result of their initial training, state that teachers should be able to understand how learners' emotional development affects their learning; in conjunction with more experienced colleagues as necessary, they should be able to identify and support children with emotional, behavioural and social problems; and that they should be able to work collaboratively with specialist colleagues. As with all aspects of initial teacher training, there cannot be comprehensive coverage of every single aspect, which is why it is important that teachers should continue to have professional development. As part of the revised continuum of professional standards, it is proposed that the common core of knowledge and understanding for the children and young people's workforce should be incorporated, which gives a much more rounded view of children's emotional, mental and social health. Colleagues are working on structured modules covering these aspects to be applied early in teachers' careers to build on what they learn in their initial teacher training.

[199] **Jonathan Morgan:** How many hours training do teachers get?

[200] **Mr Burdett:** I am afraid that I do not know. I will have to get back to you on that, if I may.

[201] **Janet Ryder:** [*Inaudible*.]—the balance that is put on the various courses in the initial teacher training, given that everyone is stressing increasingly the importance of training young teachers to identify special needs and mental health issues.

[202] **Jeff Cuthbert:** You mentioned continuing professional development and whether that is addressed on a more regular basis or through INSET. Could you give us information on how that is typically dealt with, not just at the initial teacher training stage but in the longer term?

[203] **Jonathan Morgan:** Okay. We will move on to Bethan's questions.

[204] **Bethan Jenkins:** At the meeting on 13 January, we also asked about the introduction of confidence and wellbeing lessons within the national curriculum in schools. I will try to pre-empt your answer, because I know that there are quite a lot of individual courses relating to mental health in different local authorities. That is all well and good, but it is important that we have a comprehensive curriculum so that young people, before they develop mental illness of any nature, can be prevented from doing so by having these types of lessons in schools. There is a wealth of information and support from specialists out there that supports this line of thinking. I know that there are time pressures on teachers and so forth, but I would urge you, along with the educational team within the Welsh Assembly Government, to consider this further.

[205] **Mr Burdett:** The key element in the curriculum is the personal and social education framework for those aged seven to 19, with which you may be familiar. It is both a part of the curriculum and an approach to be applied across the whole curriculum, and it includes a

number of themes that address this. For example, the emotional intelligence theme involves promoting the successful management of feelings and emotions. The working with others theme identifies interpersonal skills and different strategies to resolve conflict. The theme of health and emotional wellbeing talks about accepting personal responsibility for keeping mind and body safe and healthy, the factors that affect mental health and the ways in which emotional wellbeing can be fostered. To support this, the Assembly Government has provided additional advice and information on the PSE website and commissioned bilingual resources on a range of different aspects. As you may know, we are also about to issue various pieces of guidance such as a translation of 'Social and Emotional Aspects of Learning', and 'Thinking Positively', which points teachers to a range of interventions and approaches that can be taken.

[206] **Bethan Jenkins:** It also comes back to the teacher training aspect, as many teachers are not aware of the issues when they are teaching these classes. PSE classes can be very piecemeal, so the children may not get the education that they need in this area. I still think that a lot of work needs to be done, because it is not happening across Wales in the way that you described.

[207] **Mr Burdett:** There is certainly more to be done, but there are approaches in hand in that direction, which are linked to the higher prominence given to emotional health in Estyn's common inspection framework and the school effectiveness framework.

[208] **Janet Ryder:** Looking ahead to pressures on budgets, mental health expenditure by the NHS has been ring-fenced. Given the issues that departments will face and the need to address the issues with CAMHS, do you plan to retain that ring-fence or can health boards expect a cut right across?

[209] **Mr Williams:** There are no plans to remove the ring-fence. There will be a challenge to all organisations to use what they have more effectively. This strays into the subject of our previous conversation about partnership working and the benefits that we can get from that. Times are going to be tough, but this is a very important service, and we expect it to be developed accordingly.

[210] **Jenny Randerson:** Many of the actions dotted throughout the action plan are due to be implemented before the end of this year. I am interested in two things. One is how you are going to evaluate and monitor whether that has happened and the other is how effective that implementation is. It is not just a matter of whether it has happened, but whether it has worked. Do you think that you are on track throughout Wales for those things that are in the plan to be implemented by the end of 2010 to be achieved?

11.10 a.m.

[211] **Mr Williams:** I will ask Simon to respond, as he is leading on that.

[212] **Mr Dean:** I think that the answer to that is 'yes'. Significant progress has been made and we have tried to give a sense of that in the plan. There has been progress. There is more to do. There is huge commitment from the group of people that I have been working with, and if that is representative of colleagues who provide services—and I believe that to be the case—then that commitment is there. For me, the key is providing a focus and some energy and ensuring, as I indicated earlier, that the people who are providing these services are supported by the organisations that they work for to do that. So, it is about that connection between the specialist knowledge, which I tend to see through the networks, and the responsibilities of the organisations, the new LHBs, to ensure that they are providing appropriate services for this group of citizens. So the answer has to be 'yes'. We have set out an action plan, which has been developed on a multi-agency basis; it has been scrutinised by

the directors general and signed off by the Ministers. So, the challenge from where I sit is to be able to deliver the actions within the timescales that have been set.

[213] **Jenny Randerson:** How will you monitor and evaluate it?

[214] **Mr Dean:** That happens at a number of levels. At a national level, it will primarily be about outputs, but, increasingly, we need to move into outcomes. I am quite interested in working with David and professional colleagues on how we can audit effectiveness from the individual user's point of view. We tend to have a number of crude indicators only, such as the number of workers per head of population. Increasingly, we need to develop services that are valued by, accessed by, and of benefit to, service users. It brings us back a little bit to the discussion on patients who did not attend. There is no point in us simply flogging the same service approach if that does not meet the needs of a group of service users. We need to find the alternative approaches that David outlined. We need to understand whether they work and we need to continually test against the expectations of service users. For me, it is about a number of different levels, and building systems in place to evaluate that is a critical part of the next phase of work. I am sure that I will be asked by the directors general who have charged me with leading this group to answer precisely that question.

[215] **Mr Williams:** I will just complement Simon's very comprehensive remarks by saying that we have built into our annual operating framework on the NHS side a number of indicators. Those indicators are not always indicators of outcome, but they can certainly start the seeds of questions being asked and asked early. So, we have built that into our performance management framework to signal how important this service is to us and put some information pegs in the ground so that we can start to ask questions early.

[216] **Bethan Jenkins:** I am a little unclear as to whether it is a work in progress with regard to evaluation. Is there no clear definition yet of how you are going to be evaluating or monitoring? As you are working on the plan, you will be evaluating as you go along, will you?

[217] **Mr Dean:** Yes. We are evaluating current service delivery, but we are developing services; we will be changing services, and, as we do so, we will need to change our evaluation methodologies. We also—and this is a more general comment, which does not just apply to this service—need to focus increasingly on more sophisticated measures that look at outcomes, rather than at inputs or outputs. So, this is a journey. I do not think there will be a static series of things that we measure—that will change as our knowledge and our service specification changes. So, if we are developing a service specification that is focused on delivering outcomes, and it describes the approach to delivering those outcomes through a series of outputs, we need to develop our systems accordingly. Within that are the important links with the professional audit at the individual citizen level, so we need to marry together a number of different ways of looking at performance so that we can form a rounded view.

[218] **Jonathan Morgan:** Okay. I see that there are no further supplementary questions. I thank our witnesses for being with us this morning. We are very grateful to you; it has been extremely helpful. That concludes that session.

11.15 a.m.

Cynnig Trefniadol
Procedural Motion

[219] **Jonathan Morgan:** I ask for the committee's approval to move into private session. I move that

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order No. 10.37.

[220] **Jonathan Morgan:** I see that the committee is in agreement.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 11.15 a.m.
The public part of the meeting ended at 11.15 a.m.