Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Iechyd, Lles a Llywodraeth Leol
The Health, Wellbeing and Local Government Committee

Dydd Mawrth, 10 Mehefin
Tuesday, 10 June 2010

Cynnwys
Contents

Cofnodir y trafodion hyn yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir cyfieithiad Saesneg o gyfraniadau yn y Gymraeg.

These proceedings are reported in the language in which they were spoken in the committee. In addition, an English translation of Welsh speeches is included.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Lorraine Barrett	Llafur Labour
Peter Black	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Andrew R.T. Davies	Ceidwadwyr Cymreig Welsh Conservatives
Irene James	Llafur Labour
Ann Jones	Llafur Labour
Helen Mary Jones	Plaid Cymru The Party of Wales
David Lloyd	Plaid Cymru The Party of Wales
Darren Millar	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)

Eraill yn bresennol
Others in attendance

Mandy Collins	Dirprwy Brif Weithredwr a Arolygiaeth Gofal Iechyd Cymru Deputy Chief Executive and Head of Service Review, Health Inspectorate Wales
Edwina Hart	Aelod Cynulliad, Llafur (Y Gweinidog dros Iechyd a Gwasanaethau Cymdeithasol) Assembly Member, Labour (The Minister for Health and Social Services)
Dr Peter Higson	Prif Weithredwr, Arolygiaeth Gofal Iechyd Cymru Chief Executive, Health Inspectorate Wales
Chris Hurst	Finance Director of NHS Wales Cyfarwyddwr Cyllid GIG Cymru
Julie Rogers	Cyfarwyddwr Iechyd a Gwasanaethau Cymdeithasol Plant Director of Children's Health and Social Services
Gwenda Thomas	Aelod Cynulliad, Llafur (Y Dirprwy Weinidog dros y Gwasanaethau Cymdeithasol) Assembly Member, Labour (The Deputy Minister for Social Services)
Christine Walby	Cyn Gadeirydd Plant yng Nghymru Former Chair of Children in Wales
Catrin Williams	Cyfarwyddwr Gweithredol, Gwasanaeth Cynghori a Chynorthwyo Llys i Blant a Theuluoedd Cymru Executive Director, Children and Family Court Advisory and Support Service Cymru
Catriona Williams	Prif Weithredwr, Plant yng Nghymru Chief Executive, Children in Wales
Paul Williams	Cyfarwyddwr yr Adran Iechyd a Gwasanaethau Cymdeithasol a Phrif Weithredwr GIG Cymru Director of the Department for Health and Social Services and Chief Executive of NHS Wales

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

Marc Wyn Jones	Clerc Clerk
Sarita Marshall	Dirprwy Glerc Deputy Clerk
Siân Thomas	Gwasanaeth Ymchwil yr Aelodau Members' Research Service

Dechreuodd y cyfarfod am 12.48 p.m.
The meeting began at 12.48 p.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **Darren Millar:** Good afternoon, everyone. Welcome to today's meeting of the Health, Wellbeing and Local Government Committee. I also welcome any members of the public who are to join us, and I also welcome our witnesses to the table. Headsets are available for simultaneous translation and sound amplification. If anyone has any problems with using them, help is available from the ushers. Committee members, members of the public and witnesses may wish to note that the simultaneous translation feed is available on channel 1, while the language being spoken can be heard on channel 0.

[2] I would be grateful if everyone could switch off their mobile phones, BlackBerrys or pagers in case they interfere with the broadcasting or other equipment. If it is necessary to evacuate the room, the ushers will show you to an appropriate exit. I remind our witnesses that the microphones are operated remotely, so you do not need to press any buttons. They will be turned on and off automatically.

[3] I have received one apology for absence for today's meeting from Val Lloyd. I have not received any other apologies. Are there any others?

[4] **Helen Mary Jones:** Dai Lloyd has to be in two places at once again.

[5] **Darren Millar:** Yes, I know of Dai's situation. In that case, I invite Members to make any declarations of interest under Standing Order No. 31.6. I see that there are none, so we will move on to the next item.

12.49 p.m.

Ymchwiliad i Fyrddau Lleol Diogelu Plant yng Nghymru—Tystiolaeth gan Plant yng Nghymru
Committee Inquiry into Local Safeguarding Children Boards—Evidence from Children in Wales

[6] **Darren Millar:** We continue with our inquiry into local safeguarding children boards. We are receiving evidence today from Children in Wales. I am delighted to welcome Catriona Williams, chief executive of Children in Wales. She is a regular visitor to the Assembly and we welcome her again. I also welcome Christine Walby, the former chair of Children in Wales. Welcome to you too, Christine. We have received your paper, which has been circulated to Members, so, if it is okay with you, we will go straight into some questions

on that paper.

12.50 a.m.

[7] In his oral evidence to us, the Children's Commissioner for Wales suggested that we need to inject some 'pace and momentum' in progressing the safeguarding and child protection agenda in Wales. Is sufficient progress being made by the Assembly Government in respect of these issues and specifically with regard to the effectiveness of local safeguarding children boards? Who wants to kick off on that question?

[8] **Ms Catriona Williams:** I will kick off to give Christine time to think of her response. One reason among many why I invited Christine, as a previous chair of Children in Wales, to come today was because she chaired a wide-ranging review of what was needed to improve the safeguarding of children in Wales. That was published—

[9] **Ms Walby:** I did not chair the review; I was an adviser.

[10] **Ms Catriona Williams:** Sorry, yes. She was originally a Children in Wales representative and then became an adviser and worked very much on producing that review's report. There were many issues in the review that, it is fair to say, still stand. One thing that always interested me about the content of the review and the evidence that the board received was that we have report after report and recommendation after recommendation that we need to track. The progress made on implementing that report is very slow.

[11] Children are not involved in a meaningful way in giving their views on the impact of their experiences of processes or on what they need with regard to prevention. There were some wide issues discussed in that review, and the agenda that that review specifically brought out was a continuum ranging from prevention at the lowest level of safeguarding right through to the trafficking of children and the abuse of children in care. As we said in our evidence, the safeguarding boards' very wide remit—and it really is huge—needs to be addressed.

[12] **Darren Millar:** So, you agree with the children's commissioner that there needs to be further impetus and an injection of pace into the implementation of the recommendations. Christine, did you want to add anything to that?

[13] **Ms Walby:** I am not quite sure what the children's commissioner meant by that. Could you expand on why he thought that?

[14] **Darren Millar:** He was suggesting that sufficient progress was not being made on the safeguarding and child protection agenda. He made reference to some work that had been undertaken that had not been followed up as he felt that it should have been.

[15] **Ms Walby:** The position of safeguarding boards is patchy; they tend to be as good as the people who are on them, as is the case with a lot of organisations or bodies. They have a huge remit and most of them have had to focus on the hard end, if I can describe it in that way, of child protection. Naturally, they need to be sure that they have tight and safe processes that operate when children are being abused or are suspected of being abused. In that context, the wider safeguarding agenda is quite difficult to address.

[16] I was an independent chair of a safeguarding board for a number of years, and when I was director of social services, which feels like a million years ago now, I chaired the predecessors of those boards, and I had quite a productive experience. The idea of independence is good, but there is probably a need for some independent funding as well. I will not name any local authorities, but changes do come about in the attitude of different

agencies that are members of the board when there are changes in personnel. Some people can feel quite threatened by the notion of a safeguarding board that is more independent.

[17] **Darren Millar:** We will touch on the funding and engagement issues later on. Just for clarification, the specific report that was being referred to was the 'Local Safeguarding Children Boards, Wales—Review of Regulations and Guidance'. That was the report that the children's commissioner referred to when he said that there was not sufficient progress in implementing this. Can you comment on that?

[18] **Ms Walby:** I think that that report also says that some are doing better than others. When you have the right people around the table, they make things work. So, I would say that things are patchy. I do not have the perspective of that report because I have not done that piece of work, but that would be my own observation.

[19] **Darren Millar:** Okay. We will look at some of these in a bit more detail now.

[20] **Lorraine Barrett:** In the children's commissioner's oral evidence, he suggested the possibility of an expansion of the role of the safeguarding children boards, specifically in supporting front-line practice. You have already said, Christine, that they have a wide remit, but he suggested that they should have wider responsibilities, particularly in supporting front-line practice. What are your thoughts on that?

[21] **Ms Catriona Williams:** Perhaps I could kick off. The agenda is so wide that it depends on which bit of practice you are talking about. I was previously responsible for child protection in the old Mid Glamorgan with the area child protection committees, which had a very narrow focus and not the wide safeguarding focus. Our organisation has been pushing the whole continuum, but the structures to deliver may need to be addressed now because there is definitely a need for training and support for front-line professionals working on child abuse and child protection cases. The support for the professionals out there needs to be coherent and needs to take a unified approach. There also needs to be the wherewithal to train the thousands of staff out there who are at the front line of child protection.

[22] We have talked a lot in our paper about structures because the wider focus on safeguarding has made it a challenge, to say the least, for safeguarding boards to decide which bit to prioritise. That has inevitably gone to that end, but it is difficult to get staff into the front line of practice, especially in the children's workforce, and to support them so that they are expert. There should be quality assurance of work in child protection.

[23] **Ms Walby:** There may be a confusion of issues in a way, because the safeguarding agenda is huge. If it is to be done properly, it covers road safety, play, travel to school and a whole range of other things. Then you have the core of what you might call formal child protection issues. Since safeguarding boards were set up, we have seen the development of local service boards. Catriona and I have speculated about whether that wider safeguarding agenda might not be better located in the local service boards, where you have the most senior representation from the police, local and health authorities and all those sorts of people. It would be interesting to think through whether safeguarding could be made more of a specific remit within that agenda, because the reality is that most local safeguarding children boards have to focus on the heavy end, the difficult end.

[24] **Helen Mary Jones:** Very briefly, at the risk of reading things that you have not said into what you have said, so put me right if I have misunderstood, are you suggesting that local safeguarding children boards are being asked to do too much, with the risk that sometimes they do not undertake their core function—going back to the days when we had area children protection committees—and that that is being imperilled by a lack of focus? I accept what you said about the situation being very different across Wales and that different boards are in

different positions, but are you advocating that we need to return to a tighter focus on the hard end of child protection and, possibly, for the rest of safeguarding to go somewhere else?

1.00 p.m.

[25] **Ms Walby:** The main focus is mostly on the hard end of safeguarding. However, I am not sure whether that group is the best group to look at the wider preventative and safeguarding issues. I was in favour of it, because it should be possible theoretically, but in practice you inevitably get service managers and people such as that on the board who are very concerned about ensuring that their statutory obligations are met—quite rightly; that is what they should be focusing on. However, there is a wider remit for local authorities and health authorities, namely promotion, prevention and so on. I do not know. We have not really had a chance to think that through, and I am not sure that it is our function to think it through anyway, because that would be presumptuous. However, it is a line of thought that may be worth exploring.

[26] **Ms Catriona Williams:** The great minds that sat around the table on the previous report when safeguarding boards were coming into being said that they thought that there would be a need for clarity about local strategic relationships and for an agreed definition of activities and responsibilities. Guidance has come out, but we have a wide agenda, which is great, but it needs to find a home and someone needs to be responsible. In addition, on the level of seniority, historically, local safeguarding children boards have attracted senior people, whereas perhaps children and young people's partnerships have been more varied, and then the local service boards have the chief executives. It is about looking at the whole shape and at who has responsibility for the wide agenda and who has responsibility for the child protection part of the safeguarding agenda, and making it manageable and having feedback from staff who are trying to implement it on some of these issues is important.

[27] **Ms Walby:** There are also the community safety partnerships.

[28] **Peter Black:** To take Helen's question from the opposite point of view, local service boards have a broad agenda to develop partnerships across the whole range of public services, not just local authority services. Is there a danger that by placing the wider child safeguarding agenda into its hands that you would dilute that agenda?

[29] **Ms Catriona Williams:** To respond initially, yes, when you place it with the chief executives of every organisation, there is a danger of dissipation, but there must be ownership. We are just talking about devolved matters here, but non-devolved matters come into the agenda through the police and so on. However, on devolved matters, if the chief executive of the health board has to deliver on NHS targets and child protection and safeguarding is not clearly identified in them, core agencies' drive to deliver may not be geared towards multi-agency working on child protection. The children and young people's partnerships and the children's plans also have to be central to this agenda. We are advocating that we have to have a strong, tight accountable structure that looks after child protection.

[30] **Peter Black:** Are you saying that the local safeguarding children boards have failed to take ownership of this agenda?

[31] **Ms Walby:** I do not think that they have failed to recognise or to try to own the agenda, but it has been difficult for them to get to grips with it. That is partly because of the magnitude of the child protection task and getting that right, and partly because I am not sure that the right people are there. I take your point about the LSBs, but through their representatives on the various partnerships—I stress the community safety partnerships again, because they are important, as well as the children and young people's partnerships—those chief executives can be in a better position to move forward that wider safeguarding agenda

through the various partnerships, including their relationship with the local safeguarding board.

[32] **Darren Millar:** We move on to the role of the chair now. Irene has the next question.

[33] **Irene James:** Good afternoon to you both, and thank you for your written evidence. You have already started to mention the independence of the chair of the safeguarding children boards. In your written evidence you say that the independence of the chair should be considered and funded appropriately, with guidance to underpin the authority of the role to ensure that agencies comply. How would an independent chair make a specific difference to the effectiveness of the safeguarding children boards, and is it realistic to source an independent chair given the skills and experience required for that role?

[34] **Ms Walby:** It would be realistic to source an independent chair. There are people around with those skills. Sorry, what was the first bit of your question?

[35] **Irene James:** The first bit was about something that you mentioned in your written evidence and started to talk about earlier, which is funding, and the question of how an independent chair would make a specific difference.

[36] **Ms Walby:** It is a difficult issue. I do not have any simple answers to that.

[37] **Irene James:** We take the difficult answers as well as the easy ones. [*Laughter*.]

[38] **Ms Walby:** I am not sure that I have the difficult answers either, I suppose. It is fundamentally important to have a strong element of independence in the chair, because, with the best will in the world—and I have been a director of social services—you come to the board with your own particular agenda, agency priorities, and so on. You cannot help that; it is in your DNA. Some people would say that an independent chair would also come from some sort of background, but if they are further back from it and are not actually running services and they have the skills, then you can get a more open and flexible approach. There is still the issue of making things happen, because however good an independent chair is, and however much he or she might take a majority of the board along with him or her, if certain individual agencies decide not to co-operate, then they will not co-operate. There is no simple answer to that.

[39] **Ms Catriona Williams:** I have just one rider: the concept of an independent chair came in with safeguarding boards. Prior to that—and this is very historical—some of the former area child protection committees used to rotate the chair. Sometimes you would have the health representative in the chair, and sometimes the social services representative, to try to balance the direction of the work so that it was not according to the vested interest of one particular agency.

[40] **Irene James:** That is wonderful; thank you.

[41] **Ann Jones:** Moving on to roles and representation, the Wales Probation Trust has questioned the wisdom of having local safeguarding children boards in every authority, and we know that Gwynedd and Ynys Môn work jointly, as do Denbighshire and Conwy. You yourself have said in your written evidence that it may be an opportune moment to consider reducing the overall number of boards, and you talked about whether they should be in with the local service boards, and whether we have the right calibre of person. It is the person who has the budget head that you really need to talk to in my view. Would it ease pressure on membership and representation on all the partnerships that people have to go to if we were to look at having fewer of them?

[42] **Ms Walby:** It is extremely tough on police and probation and some of the health boards and so on to try to ensure proper representation and a proper input to a number of LSCBs. I do not see why it could not be done. There is a collaboration agenda going on already in local government and this could well be a suitable candidate for that. You still have the issue of differential standards and different investment in different local authorities and other agencies, but you would then get the calibre and the quality of representation. Even with the best will in the world, if agencies that cover a number of local authority areas have to spread themselves that thinly, you cannot necessarily have the key person at each LSCB, and you do not—that happens.

1.10 p.m.

[43] **Darren Millar:** Do you think that having a reduced number of LSCBs would free up resources to pay for independent chairs?

[44] **Ms Walby:** I think that it could well do so.

[45] **Andrew R.T. Davies:** Thank you for your evidence, particularly your written evidence, which has informed the questions today. I would like to ask you about third sector representation on local safeguarding children boards. In your evidence, you state that you think that there is a deficiency in such representation. You talk in particular about respect for young carers and disabled children. Could you think of a way of ensuring better third sector representation on the boards? You have noted that, currently, there ends up being representation from one organisation in many instances rather than from a broad spectrum of them.

[46] **Ms Catriona Williams:** It is the age-old chestnut of how many people you have at a meeting. There are many voluntary and third sector organisations. We in Children in Wales know that the demand in the third sector for training, awareness raising, and all the activities to do with safeguarding has a high priority—it has the specialist knowledge of refugee children, disabled children, and the sorts of issues that arise for them. I think that it is more to do with engagement and the capacity of a safeguarding board to design and deliver training, to have meaningful contact with a range of voluntary organisations, and a systematic, two-way flow of information between it and the grass roots. One of the downsides of having larger safeguarding children boards would be losing connection with those on the ground.

[47] **Andrew R.T. Davies:** So, a better way to get that representation would be via the county voluntary councils, for example, which will have been specified as the point of contact or the organisation that would best determine what would be a good make-up or balance in the locality for the third sector.

[48] **Ms Catriona Williams:** That, too, is very variable, because some CVCs have dedicated children's workers and others do not. An umbrella body such as ours has a total focus on children across Wales. We have seen variability across Wales in how much engagement with the children's third sector there is. I think that there is a process to identify the best engagement for a particular local safeguarding children board area. It does vary.

[49] NSPCC has a statutory right to be involved in safeguarding issues and, on other safeguarding boards, some of the big providers, such as Barnardo's and Action for Children. The connection, particularly on the implementation side, needs to be looked at, to identify locally how to do it. I do not think that that is being done at the moment.

[50] **Ms Walby:** I think that there is heavy engagement with the children and young people's partnerships in the third sector. In terms of the delivery of appropriate training, if you have the link-up with the LSCB, which is in a position to prescribe, for want of a better

word, the sort of training that is required in the third sector, and you have the views of the voluntary organisations themselves, then the partnership is probably in a better position to deliver.

[51] **David Lloyd:** Moving seamlessly on, as we like to say in partnership speak, to talk about partnerships, you mentioned in your paper the timing to consider the structure of partnership working between local safeguarding children boards and children and young people's partnerships. You say that that particular link is sometimes there and works very well, sometimes it is variable and sometimes it is not there at all. To simple uninitiated physicians like me, there is a potentially bewildering array of partnerships, as everyone is potentially in partnership with everybody else. However, to zone in on the issue under discussion, how can we make the link between local safeguarding children boards and children and young people's partnerships better and more flexible, and not variable or absent?

[52] **Ms Catriona Williams:** A few years ago, we raised the question of how this would work. Because of the public profile of child protection, the senior people have gravitated to local safeguarding boards. It varies, but the structure of the partnerships is still developing. It probably just needs a review and consultation, because I would not like to give a quick answer. It needs to be looked at, because it needs to be decided which is the superior partnership.

[53] **Lorraine Barrett:** They are all equal in a partnership. [*Laughter*.] In looking at the comments of CSSIW—I cannot think what it stands for.

[54] **Peter Black:** It is the Care and Social Services Inspectorate Wales.

[55] **Lorraine Barrett:** In its report published in October, it said that front-line practitioners and team managers were often unaware of the role of the local safeguarding children board in co-ordinating policy and practice. What evidence are you aware of that social workers working in large and small third sector organisations have a sufficient knowledge of the role and remit of LSCBs?

[56] **Ms Catriona Williams:** There have been a huge number of requests for basic awareness training, so it is very far removed from the work of the safeguarding board. It wants to raise awareness and develop child protection and safeguarding policies. I do not have evidence that says that they do not know about the role of the safeguarding board, because it will vary between agencies.

[57] **Lorraine Barrett:** Do social workers receive adequate and timely information about decisions made by LSCBs? Do you have any evidence on that?

[58] **Ms Walby:** The decisions of LCSBs vary because they are mostly broader policy decisions; they are not decisions about the sort of things in which individual social workers would be particularly interested. I do not mean that in a disparaging way, but more in terms of the work with which they are engaged. Social workers will be aware of the procedures, and so on. There are sub-committees of LCSBs, some of which look at serious case reviews. There is quite a lot of connection between those and front-line workers, who would attend such sub-groups. That seems appropriate to me.

[59] **Lorraine Barrett:** I am not sure whether I made it clear, but the social workers in whom we are interested in the context of this particular question are those working in the third sector, rather than those working for local authorities. How would those big policy decisions be fed through to those working in the voluntary sector?

[60] **Ms Catriona Williams:** Chris has rightly pointed to the procedures. As an all-Wales

activity, that has been welcomed. If agencies that are developing their own policies are using the safeguarding procedures for the area in which they operate, that will have come through in a hidden way to the procedures. Some organisations, such as the bigger ones, would have an internal rolling training programme for their staff. Many training requests from the third sector may not be from just children's organisations but also from organisations working with adults and children. So, they may have less of a connection.

1.20 p.m.

[61] The field, particularly the third sector, welcomes coherence and similarity between different geographical areas. It is difficult if the organisation straddles several safeguarding boards, as they have to think of different approaches; some may access training, others may not. There is a need for that. It is about capacity in the third sector, because there are such a large number of professionals that we want to reach.

[62] **Ms Walby:** Their own management has to take responsibility for ensuring that they know about the procedures. However, if they are involved in cases, they should be drawn into case conferences, and they mostly are, in my experience. They have a role to play and information and advice to give.

[63] **Helen Mary Jones:** Looking at the capacity of the boards to protect the most vulnerable groups of children, you say that it varies considerably across Wales, and you cite particular concerns in respect of disabled children, sexually exploited and trafficked children and refugee and asylum-seeking children. Why is there such a variation in the effectiveness of the different boards in protecting those groups? It may be difficult for you to comment on that. In particular, what is needed to achieve a more consistent approach? Bear in mind that we are talking about very small numbers of children in some areas.

[64] **Ms Catriona Williams:** This is where an all-Wales approach could be useful. The asylum-seeking refugee children are geographically focused in Newport, Cardiff and Wrexham. That issue might well not be discussed in a safeguarding board in west Wales to the same level of priority. There is an opportunity for all-Wales work. There used to be regular two-day all-Wales events, run by WAG, for people on the former area child protection committees. That was an opportunity to share practice across Wales. We had thought about whether we had a role to support that now, but people would have to pay and there are issues regarding how you share information. Disabled children, for example, often tend to be focused on after a serious case review, if something has been brought out in that respect, and then a safeguarding board has to prioritise.

[65] **Ms Walby:** I am currently a county councillor in Monmouthshire, and I have seen a situation that troubled me greatly, although not from a Monmouthshire perspective. It caused me to wonder who the UK Border Agency is accountable to in terms of child protection. I still do not know the answer. I know that it is not accountable to the National Assembly for Wales, but as far as I can see, it is not party to child protection procedures. This is a question that I have been trying to pursue—and I am sorry to bring it down to a local level. The county council has done everything that it can, but there were great difficulties in the beginning. In this case, the children were whisked off to Ystrad Mynach, they were taken out of a container lorry in Chepstow or somewhere and there was a lack of clarity about how old they were and who was related to whom. The adults went one way and the children went another and the border agency was involved. Some of those children are now doing well in foster homes in Monmouthshire, but I do not know what will happen in the long term.

[66] After the trauma of being carted by lorry across Europe—I think some of them were from Afghanistan and some were from eastern Europe—there was then the trauma of being found and taken somewhere else. I do not know whether it has people who are skilled in

interviewing children. I am asking questions rather than giving you answers, but I do not know whether you have explored that kind of issue.

[67] **Darren Millar:** I think that we are opening a can of worms there.

[68] **Ms Walby:** I was not directly involved with it but I was deeply troubled, and asked questions, and others were also troubled by it. I am clear about what happened to those particular youngsters, but it is wrong to add to the trauma, whatever the circumstances, and whoever has put them in that situation. If they are minors, they need to be treated as such.

[69] **Ann Jones:** On that point, could we write to the UK Border Agency and ask what involvement it has and what training it gives to staff who find young people? The way that it is operating sounds barbaric. We could find out how its staff are trained to deal with finding children, in particular.

[70] **Darren Millar:** Perhaps we could write to ask about its engagement with local safeguarding children boards. We will do so, if everyone is content. Thank you for raising that with us.

[71] I have one final question, before we bring this part of the meeting to an end, regarding the engagement of young people in LSCBs. You refer to the engagement of young people as being patchy: in some areas it works well and not so well in others. Do you think that LSCBs should prioritise raising their game in relation to the engagement of children who have been involved in the child protection system, in particular, and if so how do you think that can be achieved?

[72] **Ms Walby:** That is a difficult one.

[73] **Ms Catriona Williams:** There is a plethora of ways of making improvements to the system through feedback from children and young people who have been through the system—not necessarily as they are going through the system, but having come through it, considering things that would have worked better for them. It seems to me that it has been the last form of children's work that has meaningfully sought children and young people's views. If we are talking about the sorts of situations that Chris has mentioned—trafficked children, children who are going through very severe safeguarding issues—a lot of skilled work is needed to find out what is really happening. With the sexual exploitation of children, we know that researchers find it incredibly difficult to ascertain what is going on in massage parlours and so on. It is difficult at the very sharp end, but perhaps a little easier at the basic process end of how LCSB processes are working, or not working, or how they could be improved. For example, courts are beginning to look at how children who have been through the courts system view the services. You could use existing structures. Children who have had experience of case conferences could share their experience, and methods that are well-established in other fields could be used.

[74] **Ms Walby:** Again, I would give a plug to the children and young people's partnerships. It is extremely difficult to hit on the right time to engage with children and young people who are going through the system. In a way, it is too late. I recently saw an exercise whereby a children and young people's partnership was asked by a scrutiny committee to engage with a range of children and young people, taking the questions that were used in the safeguarding vulnerable children review. An exercise was set up by that review, which was chaired by Gwenda Thomas.

1.30 p.m.

[75] It used that as a model, and took on board a number of the sorts of questions that were

used. It then fed that back into the scrutiny committee. The same thing could be done with the LSCB. Rather than having many different parts of organisations trying to engage, doing that in a more co-ordinated way is better for the young people, and you would get a better range of answers.

[76] **Darren Millar:** Thank you for that evidence. I am afraid that the clock has beaten us. I am sure that we could have asked you many more questions, but if there are any other pieces of information that you would like to make available to the committee and to bring to its attention as part of the inquiry, we would appreciate receiving that in written form.

[77] **Ms Catriona Williams:** Thank you for inviting us.

1.31 p.m.

Ymchwiliad i Fyrddau Lleol Diogelu Plant yng Nghymru—Tystiolaeth gan CAFCASS Cymru ac Arolygiaeth Gofal Iechyd Cymru
Committee Inquiry into Local Safeguarding Children Boards—Evidence from CAFCASS Cymru and Healthcare Inspectorate Wales

[78] **Darren Millar:** I am pleased to welcome Catrin Williams, who is the executive director of the Children and Family Court Advisory and Support Service Cymru, Dr Peter Higson, the chief executive of Healthcare Inspectorate Wales, and Mandy Collins, the deputy chief executive and head of service review. Thank you for the evidence that you have submitted to the committee. If you are content, as time is tight, we will move straight to questions on that evidence.

[79] We have spoken to several witnesses during the course of our inquiry, one of whom was from the Wales Probation Trust, who expressed concerns about the number of local safeguarding children boards across Wales. The witness suggested that it might be appropriate to reduce the number, perhaps on a regional or joint-board basis. What impact would that have on your work? What would be the benefits and drawbacks? Dr Higson, would you like to start?

[80] **Dr Higson:** It is a matter for the policy side of the Assembly Government to look at. In relation to inspection and the approach of an inspectorate, there are possibly questions about the capacity of a large number of smallish boards to deliver the same level of service. As far as inspection is concerned, it would not make any difference to us in the sense that we will inspect one or 10. That could be achieved by working in consortia; it does not necessarily mean that there would have to be a reduction in the number. There is certainly some evidence of capacity issues across the piece.

[81] **Darren Millar:** Where there are joint boards, such as the ones in north Wales, for example, in Gwynedd, Ynys Môn, Conwy and Denbighshire, they are still statutorily separate, but they are working together collaboratively. Has that had an impact on your inspection regime in that respect?

[82] **Dr Higson:** No, not really. Under the previous regime of 22 local health boards, many worked together in consortia on certain treatment or health areas, but, again, we can inspect them separately or thematically.

[83] **Darren Millar:** What does CAFCASS think about that?

[84] **Ms Catrin Williams:** CAFCASS Cymru is a service delivery organisation in the Welsh Assembly Government. We have 10 operational branches across Wales, and provide

membership to all LSCBs. Obviously, policy issues are a matter for our policy colleagues in the Welsh Assembly Government, but in terms of our capacity, the greater the number of LSCBs that exist, the greater the demand on our directors to attend and to contribute. We put a great deal of emphasis in the organisation on CAFCASS Cymru senior managers contributing actively to area child protection committees, so we give it a high priority organisationally. It is interesting that the developments in north Wales have reduced the number of LSCBs that we can attend and to which we can contribute. That means that our contribution can be more effective, and better resourced.

[85] **Darren Millar:** Do you think that there is a risk associated with a reduced number of LSCBs, or would you be comfortable that that was not putting children at risk?

[86] **Dr Higson:** No risks come to mind in particular, as long as one is clear about the respective statutory roles and responsibilities. However, working in collaboration and consortia should not be a risk if the governance arrangements are well thought through and worked out.

[87] **Darren Millar:** Thank you, that is very useful. I think that the next part of the question has been dealt with, Lorraine.

[88] **Lorraine Barrett:** It has really, but I just wonder whether it is realistic in the long term to maintain the level of representation that you have on the different boards.

[89] **Darren Millar:** Do you mean the capacity?

[90] **Ann Jones:** There is a high-pitch buzzing noise in the room at the moment.

[91] **Darren Millar:** I cannot hear it, Ann. I am too young.

[92] **Ann Jones:** You will hear it one day. [*Laughter*.]

[93] **Lorraine Barrett:** Was it when my microphone was on?

[94] **Darren Millar:** It is like one of those anti-social behaviour things for controlling people, which makes a noise like a mosquito.

[95] **Ann Jones:** Are you trying to insinuate that I need to be controlled?

[96] **Darren Millar:** Not at all.

[97] **Lorraine Barrett:** I just wanted to ask—

[98] **Dr Higson:** You were talking about capacity issues.

[99] **Lorraine Barrett:** Yes. Further to what you said, I was just asking whether it is realistic to maintain that level of representation in the longer term.

[100] **Ms Catrin Williams:** As an organisation, we have got to be realistic that demand is exceeding capacity at the moment. Therefore, we will always have to take those issues into account. However, that does not negate our commitment to all the local safeguarding children boards as they currently exist.

[101] **Irene James:** In your experience, is there a lack of clarity about where the balance should be struck between the role of local safeguarding children boards and that of individual agencies in respect of safeguarding?

[102] **Ms Collins:** Yes. From our reviews, we have found that there is confusion about the roles of local safeguarding children boards and the statutory bodies. There is confusion about where the boundaries are and what role the LSCBs can play. They tend to be very reactive; rather than taking a preventive role, they tend to look at things that have happened. To me, that indicates some confusion as to what role they can play and how they can influence the role of each of the agencies around that table.

[103] **Andrew R.T. Davies:** Thank you for your evidence. The children's commissioner suggested the possibility of expanding the role of local safeguarding children boards when he came before the committee a couple of weeks ago. Would it be a helpful approach to expand this role, particularly with regard to information sharing? One of the things that we hear time and again is that a piece of information that is critical to safeguarding a child's welfare will sit with one aspect of the team that is looking at it and, for some very perverse reason, not reach the other agencies involved. At the end of it, we all look back and say, 'We knew that that information was there'. So, would it be useful to expand the role of local safeguarding children boards?

[104] **Dr Higson:** I think that one could achieve that end without necessarily strengthening their current role. The issue that we have picked up on concerns the clarity of information sharing. There is a great deal of policy and guidance, but it is about practice, not just practice on the ground, where clinicians and other professionals share information of concern, but practice between agencies that should be sharing and pooling information in a meaningful way, and which should also be looking at it and interrogating it.

[105] **Andrew R.T. Davies:** Could you give us a taste of the type of practice that you are alluding to? You say that there is no need to expand the role of the LSCBs, but that the practices that you understand are operating to date should be looked at. Can you give the committee a taste of the type of practice that you would identify as failing?

[106] **Dr Higson:** It is a mixed picture. It is not all failing. There are some good examples. An example would be information being held by one part of a service that may not necessarily be shared even with another part of the same service. It is about knowing what the concerns are, what the thresholds are and then being able to identify a clear repository for that information if there is an interagency approach. With regard to the role of the LSCBs, it is about being clear on whether they have a role to broker that information, look at it and act on it. That is where the individual agency's responsibilities and the corporate responsibility of the LSCB could be clarified. There are examples where concerns have been raised and passed on, but to what end? Do people know what is going to be done with that information?

1.40 p.m.

[107] There is a mixed picture. On the ground, that could be clarified without necessarily needing to regulate for any stronger role for the LSCB. It might help if that was the case, but it is not necessary. I think that it is about clarity. We think that there is a mixed picture; there is confusion in some services.

[108] **Andrew R.T. Davies:** Therefore, you would seek clarity regarding the systems that are already in place. There is no need to radically change what is in place. The example that you gave was that information just sits there in the organisations themselves and is not passed on to other desks, let alone to partner organisations. Would the local safeguarding children boards, as you highlighted there, not be a good way of making sure that the train is followed with that information? Again, if you have the organisation working well, there is no certainty that the information will move into other organisations. There does not seem to be some sort of corporate overview.

[109] **Dr Higson:** It would very helpful for the LSCB to be the hub, and for that to be clear to the other agencies and to all agencies. There also needs to be some clarity about what it is that they are sharing, what the levels of concern are, what types of information there are, and then what the respective roles are because there are statutes that govern individual agencies and practitioners. Then there is the LSCB. If you get all of that clear, there could be a very valuable hub in terms of handling information, making sure that it is acted upon, and closing the loop. Quite often, with some of the cases where things have gone wrong, it is where information may have been shared, but no-one has actually followed it through to a conclusion to ensure that the right actions have been taken.

[110] **Andrew R.T. Davies:** Therefore, it quite neatly falls into training and making sure that there is almost corporate training so that everyone understands their responsibilities.

[111] **Ms Collins:** One of the issues that we have identified is the need to give people the confidence and the capability to make decisions around information sharing. There is nothing to say that they should not share information. They are just very nervous about sharing it. The emphasis of our written evidence was on information sharing and adult services in particular, whether they are mental health or substance misuse services, where the client is seen as the adult. The stigma attached to those services means that people are concerned about sharing information. So, for example, you may have a number of children in a family where you have a substance misuse user who is on methadone, and perhaps the risk assessment of the situation of the children in that family has not been properly undertaken. As you have said, I think that the local safeguarding children boards could be leading by example in terms of encouraging and making sure that those people are confident as well as capable of sharing that information.

[112] **Darren Millar:** I understand that the UK Government has today instigated an independent review of child protection procedures and the relationship between social workers and the police, in particular, in terms of information sharing. Do you think that a similar review should be conducted in Wales? What is your opinion on that?

[113] **Dr Higson:** It is clear that it is rather a confused landscape sometimes in terms of statutory responsibilities. Having just heard the news report about that, the emphasis is on ensuring that there is more time for practitioners to practise and less emphasis on the administration of the system. Child protection is a complicated system. That does not help because one has layers of different types of guidance and responsibilities. There are professional bodies that issue guidance to their professional members and there are organisations and agencies. There are also different laws at different times, which are slightly different.

[114] **Darren Millar:** Would there be any merit in undertaking a separate review in Wales or do you think that we would probably be able to learn lessons from the review that is taking place in England?

[115] **Dr Higson:** I have not seen the details of what the review will cover, but from the news report, it sounded as if one could learn a lot just from keeping on top of that.

[116] **Peter Black:** In its report of October 2009, the Care and Social Services Inspectorate Wales stated that,

[117] ‘Frontline practitioners and team managers were often unaware of the LSCB’s role in coordinating policy and practice.’

[118] How significant an issue is this in the experience of your agencies?

[119] **Ms Collins:** I think that it is relatively significant. Part of HIW's role is to look at the corporate level, to see what policies and procedures there are and how they are being communicated and embedded within organisations. Quite often, we find a mismatch in terms of those working at grass-roots level and their understanding of the policies and procedures that they should be following. That is not malicious intent; it is just that people are very busy in their day jobs and we need to look at how we can better embed some of these as a matter of routine. A lot of it is not about training. Many of the people we spoke to have done the training, but the training has not been translated into practical application or been related to how it would affect them personally. Many people go to the training and listen to the bits that are about them and the job that they do, so we need to be careful how we take training forward, to make it real to people so that it can be easily translated into their daily work.

[120] **Ms Catrin Williams:** The challenge is slightly different for CAFCASS Cymru in that we are a specialist children's organisation. We recruit only experienced and qualified social workers, and it is an expectation in our recruitment and selection processes that our family court advisers have a minimum of three years' experience of working within the statutory safeguarding and child protection setting. So, there is a minimum expectation of the skills base of the practitioners coming into the organisation.

[121] Maintaining skills and awareness is the challenge for CAFCASS Cymru, and we do that through training. Our learning and development annual training plan constantly has the safeguarding theme running through it. We have recently strengthened our induction programme for new practitioners coming into the organisation, including the development of a post-qualifying module in collaboration with Prifysgol Glyndŵr. That also includes an emphasis on safeguarding and raising awareness not only of child protection procedures and our practitioners' responsibilities within those, but also of other organisations more widely, because, particularly in public law, we have an overview, given our role as children's guardians in proceedings, so there are key safeguarding issues in the majority of cases.

[122] **Darren Millar:** The next area of questioning has been covered.

[123] **Ann Jones:** I have one other point to make. I find it strange that people are still not sharing information. That fact comes out in every review, from the Maria Colwell case in the 1970s up to the latest ones. Whose responsibility is it to ensure that people share information?

[124] **Dr Higson:** There is a responsibility at every level: the organisation, the practitioners, the supervisors and the managers. Unfortunately, you are right in that the same issues come through in every inquiry. You ask what the barrier or the block is. I think that it is a complicated system, as I said earlier, and it is not clear whether it is safe for some people to share information professionally, because they may fear that it compromises their position. There is also sometimes a lack of understanding. Training must be constantly refreshed to ensure that people understand what can and must be shared in the public interest and so on. I do not think that one can put a finger on one big block, but the responsibility goes from the very top all the way down, to ensure and test that it is happening, and not just to assume that it is.

[125] **Ann Jones:** The issue of information sharing came out clearly 40 years ago in the Maria Colwell case, but here we are in the same situation with the latest case. You talk of the training, but a generation of people has gone through the training since then. Are you telling me that people have not been trained properly or have not paid attention to the fact that they should be sharing information? If I had neglected my duty in a former job, I would have been kicked out. I could not afford to neglect my duty and not share information. So, are we saying that it is acceptable that these people have decided not to share that information?

[126] **Dr Higson:** It is certainly not acceptable, no.

[127] **Ann Jones:** What should we do about it then? We obviously have not done anything about it, given that a point that was made 40 years ago is still being raised today.

1.50 p.m.

[128] **Dr Higson:** The picture is not all bad. There is a lot of good practice and sharing of information between and within agencies. From the serious case reviews—and we know that there are issues with regard to how useful they are at leading to better practice—some simple truths emerge, in the same way as simple truths emerge from most failures. They are often about not talking to the right people and not sharing the right information. The ways in which one can improve that is to keep on and make it a part of the mainstream management of the service. It already is, but we need to give it a higher profile and make it a higher priority. We also need to ensure that people understand that it is safe to share information. Technology nowadays means that we are in a different age, and we know of anecdotal evidence of some GPs—not in Wales necessarily, but we have picked this up in England—who, having shared concerns about the nature of child protection and who have then become the target themselves, because of information spreading quickly and people having the ability to target them.

[129] **David Lloyd:** Before I ask my next question, I should declare, in passing, that I remain a GP these days. You state in your paper that the input of GPs into local safeguarding children boards is seen as minimal and that you will follow that up as part of your future work plan for this year and the next. What are the barriers to GP engagement? I might have my own theories on that, but I am asking the questions this afternoon. [*Laughter.*]

[130] **Ms Collins:** There are a number of barriers. It is not a consistent picture. In some areas, there is excellent practice and engagement, but there are other areas, particularly where you have GPs working single-handedly, in which there is the matter of workload and of time not being set aside for such involvement. It again comes back to some single-handed GPs not having the confidence to get engaged in these events or become involved at the right point of the process. As Peter said, GPs live within the communities and, if they make a wrong decision about a safeguarding issue, there will be consequences for them. We have to ensure that they are properly supported to be engaged in the process.

[131] **Helen Mary Jones:** This is another question for the inspectorate rather than for CAFCASS. You say in your evidence that

[132] 'A number of partner organisations and national child protection charities have stressed to HIW that the healthcare sector plays a crucial role in providing advice and support to the multi-agency safeguarding work that the LSCBs undertake.'

[133] Do you have any evidence yet of how the new local health boards are fulfilling these functions, and have there been challenges for the NHS in having representation on the boards as a result of the recent reforms?

[134] **Ms Collins:** I know that the committee is aware of the work of Professor Mansel Aylward in this area. Certainly, each year, we do many things in relation to safeguarding. Every review that we undertake has a safeguarding element to it, both for children and for vulnerable adults, because we think that it is so fundamentally important. Furthermore, each year, we undertake a piece of work on the healthcare standards for Wales, which have now become the standards for healthcare services in Wales.

[135] Each year, we look at and plot the trends of the improvements made in safeguarding

arrangements. Certainly, as you said, last year, when we did this work, there was great concern about moving away from the 22 local health boards, as people felt that they had a local position and a local view of safeguarding issues that would be lost when we moved to the larger health board arrangements.

[136] Our work is to ensure that safeguarding is on the agenda of the organisations, and that, as a result of the restructuring, we do not have only one designated doctor and one designated nurse per organisation, but a team of people to cover the wider area. We have linked up with Professor Aylward and his team to feed in our findings, and, at the beginning of May, we received self-assessments back from every organisation in Wales looking at the healthcare standards. Standard 17 was on safeguarding and, as part of that, we are going through a process of looking again at the arrangements and testing them to ensure that they are fit for purpose.

[137] **Dr Higson:** Since we published that report at the end of last year, we are aware that the new local health boards took that responsibility very seriously as part of the transfer to the new arrangements. On the back of our report, the Minister made a request to Professor Aylward to look at the arrangements, just to ensure that that is the case. So, I think that, between us, we will follow that up and ensure that the child protection arrangements are robust and are working within the new health structures.

[138] **Lorraine Barrett:** This is a question for Catrin. CAFCASS outlines how its role involves safeguarding specific groups of vulnerable children, such as children in public law cases who have been subjected to abuse and neglect, and children in private law cases in which allegations of a safeguarding nature have been made. Are you satisfied that all the LSCBs across Wales are addressing the needs of the specific groups of children who are the primary focus of your agency?

[139] **Ms Catrin Williams:** There are clear policy issues in relation to that, which are matters for my policy colleagues. We are a service deliverer. One advantage of having representation from CAFCASS Cymru on LSCBs is that we can raise the profile of the children who are involved in private law proceedings, who are often not known to local authority agencies or other safeguarding agencies. We put a lot of emphasis in our work on identifying safeguarding issues early on in cases. We are currently preparing for the implementation of the president of the family division's revised private law programme, which means that we will undertake safeguarding checks in every case where an application is made to the court in private law proceedings. That will include undertaking safeguarding identification interviews via telephone with the parties to those proceedings. Although that creates another demand on the organisation, as against our capacity to deliver, it is a welcome development, because it will raise the profile of children for whom safeguarding in its wider form is relevant, such as those who are involved in entrenched interparental conflict and the impact of that on them.

[140] **Darren Millar:** We have one final question before we bring this part of our meeting to an end. This committee inquiry is all about reviewing LSCBs to ensure that they are effective and that there is consistency in the quality of their work across Wales. If there was one priority that your agency felt needed to be addressed in the work of LSCBs in Wales, what would it be?

[141] **Dr Higson:** For my part, it would be to make it a statutory requirement to regulate this area to ensure that all the partners fully participate in the LSCBs—and also fully contribute resources.

[142] **Darren Millar:** So, that would be a recommendation on the funding formula.

[143] **Ms Catrin Williams:** I may have touched on it already, but mine would be to raise the profile of all children who might be involved in private and public law proceedings where safeguarding is an issue.

[144] **Darren Millar:** Do you want to add anything?

[145] **Ms Collins:** No.

[146] **Darren Millar:** If Members have no further questions, that takes us to the end of this particular part of the meeting. We will take a few minutes' break before we commence the next part of our meeting.

Gohiriwyd y cyfarfod rhwng 1.58 p.m. a 2.02 p.m.
The meeting adjourned between 1.58 p.m. and 2.02 p.m.

Ymchwiliad i Fyrddau Lleol Diogelu Plant yng Nghymru—Tystiolaeth gan Lywodraeth Cymru
Committee Inquiry into Local Safeguarding Children Boards—Evidence from the Welsh Government

[147] **Darren Millar:** Welcome back, everyone. We now move on to evidence from the Welsh Government on our inquiry into local safeguarding children boards. I am delighted to welcome the Deputy Minister for Social Services, Gwenda Thomas, to our committee today, along with Julie Rogers, who I believe is the director of children's health and social services for the Welsh Assembly Government. Welcome to you both. We appreciate the paper that you have provided, which has been circulated to Members. If you are content, we will go straight into questions.

[148] I will start. In May 2008, a decision report was published regarding your approval of the recommendations of the report of the review into local safeguarding children boards—this is the review of regulations and guidance. I note that, in your written evidence, you suggest that the recommendations in the report are noted, and yet the decision statement states that you accept in full all of the recommendations and will move to implement them. We have heard from a number of witnesses that many of those recommendations have still not been implemented. We are now two years down the line, so what is the situation? Could you give us an update on the implementation of those recommendations, and where that is at currently? What are the plans to implement those that are outstanding?

[149] **Gwenda Thomas:** Really, we have moved on, but I will explain the background. That was an important piece of work, and I am grateful to the working group that drew those conclusions together. They will feed into future arrangements. However, it is important to recognise that after one year of operation, it was not timely to begin to redraw either in the margins or fundamentally what was a completely new approach in both culture and practice. The boards had only been going for about a year, so to do that would not have given the arrangements time to settle and to begin to take effect, nor would it have been fair to senior managers in local agencies or front-line practitioners. Significantly, the safeguarding review of LSCBs, social care, and the NHS in Wales was set in train just a few months after that review work. It would have been inadvisable to set in motion one line of action while further evidence of a significant and substantial nature was still being gathered. Set against that context, it would have been inconceivable and imprudent to have pressed on with any of the recommendations from the review in isolation.

[150] We are now in a far better place to assess the sorts of changes that might be needed and to work on them. For example, the role of the chairman, the structural context, the future

of serious case reviews, and consolidating and updating the 'Working Together' guidance, are all now on a much firmer foundation.

[151] Significantly, we also now have the strategic context and the involvement of key agencies at the highest level in the Welsh safeguarding children forum, through which this work will now be taken forward. I believe that the strategic and policy development leadership that the forum can offer will facilitate the process of review.

[152] **Darren Millar:** I am a little confused, Deputy Minister, because many of the witnesses that have come before us, including the children's commissioner, have referred to this report, the failure to implement the recommendations, and your acceptance of the recommendations in May 2008 when you published this decision report. It is obviously not clear to the children's commissioner and those witnesses who have appeared before us that many of these recommendations may have been superseded, which is what it sounds as though you are trying to tell us. Why has there been no communication with people such as the children's commissioner about the fact that you have, effectively, dropped the recommendations in that report, or put them to one side, because you have some other work going on?

[153] **Gwenda Thomas:** We have consulted widely on the work that followed the decision to review this subsequently.

[154] **Darren Millar:** Yes, but they are still of the opinion, Minister, that those recommendations are going to be implemented or should be implemented.

[155] **Gwenda Thomas:** Well, I certainly thought that we had conveyed the message about this subsequent review quite widely. I have made two or three statements in Plenary. If we have not connected successfully with bodies that have given evidence to this committee, I would be more than pleased to write to them, explaining how we have got to where we are now. Of course, the children's commissioner—I am delighted about this—is a member of the national safeguarding forum, and he will obviously have a say in that process, which I think that we would all say is a very good thing.

[156] **Darren Millar:** I do not think that anyone is denying the commitment of the Assembly Government to the safeguarding children agenda. However, it came as a surprise to me, certainly, and, I am sure, to other committee members, that many of the recommendations are going to be put to one side because they have been superseded by this other work. I suspect that that will also come as a surprise to many of the witnesses, given the information that we have received from them so far. Did you want to add anything, Ms Rogers?

[157] **Ms Rogers:** Yes. I do not think that it is true to say that they have been put to one side. I think that what has happened is that subsequent pieces of work have come together with those recommendations and they are now being looked at through the forum. Certainly, it is not our intention to say that it was a good review and then just park it. Several pieces of work, such as the recommendations on the funding model, the funding formula, and the issues around money, are being picked up and are in the work programme of the safeguarding forum. The work is carrying on in a continuum, but we have also since had such things as the CSSIW report and the HIW report last October, which have also influenced thinking in the area.

[158] As the Deputy Minister has said, the children's commissioner is a member of the forum, and so he is involved in the work that we are taking forward.

[159] **Darren Millar:** It is not just the children's commissioner that has raised concerns.

[160] **Ms Rogers:** I know that one of the other bodies that you have seen—the care standards inspectorate—gave evidence to the effect that it felt that the recommendations were being taken forward in a different way, not that they had been parked or ignored.

[161] **Gwenda Thomas:** I had also better share a very recent decision of mine, which is that I thought that having an independent chair would further strengthen the national safeguarding forum. We have appointed an independent chair to take that work forward.

2.10 p.m.

[162] **Darren Millar:** Okay, thank you for that. You touched on the CSSIW review. Lorraine, do you want to ask about that? It is an important question.

[163] **Lorraine Barrett:** Are you satisfied that sufficient progress is being made to address the shortcomings of LSCBs identified in the CSSIW report of October 2009, which you have just started to talk about? Are there any current plans to review the existing guidance?

[164] **Gwenda Thomas:** Yes, there are plans to strengthen the 'Working Together' guidance. The CSSIW report picked up many points on the effectiveness of safeguarding. I issued statements in October and November following up on the baby Peter case; we took our own actions to look at the effectiveness of our safeguarding. There are issues with LCSBs, but they are very young bodies, and we must not lose sight of that fact; they have not been there for very long. However, there are issues around the effectiveness of joint working with other partnerships such as the children and young people partnerships, the community safety partnerships and the health and wellbeing partnerships, and we will take that work forward. There is an issue around the effectiveness of the membership and whether sufficiently senior representatives are members of the LCSBs and are attending the meetings, and whether they are able to take decisions when they do attend. There are the funding issues that have already been mentioned and whether we should have a funding model. Fundamental to all of that is that we must accept that the responsibility lies with local agencies and not just social services. The situation where social services are the fallback has to end. So, there is work to do there.

[165] The size of LCSBs does not determine their effectiveness—there are excellent examples of good practice, and some examples of things that are not so good. We need to share the good practice across Wales. I accept that there is a lack of consistency, but these are young bodies. The safeguarding agenda has moved forward. With regard to the effectiveness of LCSBs, we have issued the self-assessment improvement tool, which is a very good way of doing this. We will be looking at the results of that and the multi-agency inspection that will take place. We will learn from all of that work what the best way forward is. If you ask whether we need a local safeguarding board for each local authority area, there are examples of where boards have linked together, such as Conwy and Denbighshire, Anglesey and Gwynedd. Is that the right way forward? Is it a better way? We have to learn from that. However, fundamentally, we must impress again on people the message that the responsibility to establish that structure and to see to its initial effectiveness lies with local agencies, but that is not to say that the Welsh Assembly Government does not have a role to play, because we do.

[166] **Darren Millar:** You have touched on just about every issue that we have been looking at, Deputy Minister, and your response was very helpful. We will pick out a little more information on each of them.

[167] **Peter Black:** You have painted a direr picture of the situation than I could ever hope to do of where we are with local safeguarding children boards. Before I ask my question, I want to touch briefly on serious case reviews. You have a review under way into them. What is the timescale for that? When is the review likely to report?

[168] **Gwenda Thomas:** I have two reviews under way. I expect the review of the structure of serious case reviews to report by the end of the summer. I am aware of the time being taken and I have been concerned about this for quite a while. Although all serious cases are serious—they would not be there if they were not—I think that there are different degrees. In some cases a child dies, and we need to be able to look at which serious case reviews we need to move forward most quickly. Too much time passes between the serious case review being carried out and the results being published, but that is not to say that nothing happens in the meantime. We have not been able to get that message across. Within that process, as soon as we recognise that there are failings, work begins immediately, so that by the time the reports are published, a lot of work has been done. We often wait for criminal prosecutions to take place and that has to be right. That is the review and I am looking forward to piloting new structures, following the report that I have received.

[169] **Peter Black:** What is the second review?

[170] **Gwenda Thomas:** The second review is to look at reviews over the last two years. They run in parallel and one will inform the other. That is an important review, which will look back at serious case reviews over the last two years, to see what we can learn from those.

[171] **Darren Millar:** Before you move on, I have a quick question. A review has been announced in England today regarding the relationship between the police and social services in particular, but more generally, about the whole child protection agenda. That review is obviously not taking place in Wales. Do you intend to undertake a separate review or are you looking forward to learning from the review that they are about to embark upon?

[172] **Gwenda Thomas:** I have also picked up on that and really looked into it, but I think that we are ahead of it. Of course, we will learn from any lessons that come out of this review; I am not saying that it will not have anything to offer us. However, I know about the work of the review by Professor Eileen Munro, and have read about it. The Hackney model is not new; it is certainly not new to us. We used the principle of the Hackney model to develop our integrated family support teams, for example. We have gone a long way down that road of using specialist social services as a special resource and using them in the best way possible. Although we will learn from the results in England, the approach that we have taken in Wales is broader, in many ways, in that we have established an independent commission, the work of which is well under way and it will report in November. A task group on the social work and social care workforce will also report in November. We have taken our review forward in an even wider way.

[173] **Peter Black:** I was also going to refer to that review in England, which is looking at how to publish serious case reviews. We have not moved down that route yet, but that may be part of your review. One of the main public criticisms of the local safeguarding children boards relates to accountability, particularly the ownership of the serious case reviews. We all understand the sensitivity of publishing those, particularly if you are able to identify children from them. There are issues around ownership, particularly where somebody is identified in those reports who then has to be referred to the Care Council for Wales, who does not have access to the report to be able to answer those charges. One individual came to me the other day who was asked to pay a £10 freedom-of-information fee to find out what the charges against him were by the Care Council for Wales, which I found shocking. Are you looking at those issues as part of your review?

[174] **Gwenda Thomas:** Yes, we look at everything and I will certainly look into that £10 to get to the bottom of that. Please give me full details, so that I can help with that.

[175] **Peter Black:** I have already written to you.

[176] **Gwenda Thomas:** Okay. You are right about ownership: the local ownership of the serious case review process is very important. I am not convinced with regard to publication. There is a debate to be had and I am not saying that there is not, but I am not convinced because we need to be very careful. We know that consideration of anonymity and identification is very important, and is a legal requirement. Of course there is a debate, and we will consider the issue.

2.20 p.m.

[177] **Peter Black:** In its written evidence, the Wales Probation Trust states that it questions the wisdom of having LSCBs in each local authority, and you have already touched on that, Deputy Minister. Children in Wales also stated that it may be opportune to consider reducing the overall number of LSCBs in Wales.

[178] You have already said that you will be carrying out a range of reviews, and I think that I have lost track of the whole thing. Do you have any plans to review the number of LSCBs in Wales? Would you be looking at a regional approach in order to secure more appropriate representation and to avoid duplication of work?

[179] **Gwenda Thomas:** The line that we have taken in Wales is not to be prescriptive and to allow local decision makers to decide what best serves their area. I do not think that there is a need for all LSCBs to be doing the same piece of work. If there is a piece of work that can be done in Conwy and in Swansea or Neath Port Talbot or wherever, resources could be shared in that way and the result of that work could be shared. As we have mentioned, in Denbighshire, Conwy, Anglesey and Gwynedd, they have taken the decision to merge. We have to see whether that merger works and whether that is best for the process. However, fundamentally, we have not moved away from the importance of decision making.

[180] An example of a piece of work is the national protocol on the trafficking of children. Of course the LSCBs have to consider children who are being trafficked in their area—I am not saying that they should not—but there is no need for every LSCB to have a protocol. What I am saying is that there needs to be awareness raising of the guidance currently in existence. I have some concerns on that as there seems to be evidence that front-line social workers are not aware of the existence of the guidance that had been produced on child trafficking. We need to ensure that we do something about that awareness raising. A piece of work such as that can be shared and should be. Resources can be saved in that way.

[181] **Andrew R.T. Davies:** Thank you, Deputy Minister, for the paper that you submitted. It has informed a lot of our thinking. You have had sight of the evidence that has come before the committee to date in this inquiry. One piece of evidence that was received early in the inquiry was that of the children's commissioner about increasing the roles of local safeguarding children boards, and in particular the scope that they could encompass, such as the sharing of information and training. Training is vital in order to understand the roles that people fulfil. What are your thoughts on the ability to expand the role of local safeguarding children boards so that there is more of an onus on being corporate, as it were, and creating training models that people can sign up to, thereby bringing about the information sharing that we all aspire to have? We have heard in other evidence-gathering sessions that that does not happen. I think that the children's commissioner used the word 'creative' and said that organisations need to be prepared to be creative.

[182] **Gwenda Thomas:** I am sure that Keith Towler will be taking that view to the meetings of the national safeguarding forum. That will be looked at there. There is room to consider regional training, or even some regional support or national guidance. We have seen that being done very successfully with the autism strategy that I spoke about on Tuesday. It is

that very clear structure and infrastructure that has helped to bring about the success of that strategy.

[183] On information sharing, to me, it is crucial. We have the Wales Accord for the Sharing of Personal Information, whereby work on information sharing is being taken forward by the Welsh Assembly Government. We can give you more details on that if that would help. When you think about it, what comes to mind when we talk about information sharing is the Bichard report that followed the Soham case. The issue that arose there about information sharing showed us that we have to be very clear about what information we are sharing. We cannot be content with just sharing information that is in the public domain, such as prosecutions and convictions. In that case, there was clearly a need for information that was not in the public domain in that way. So, we need to be able to establish such a process and I think that a protocol would be a good way of moving forward in order that we have national consistency in what we share and what we do with information.

[184] That brings to mind the vetting and barring process and how that will help with information sharing. I assume that there is going to be a review of vetting and barring, because that is what was said before the election. In my view, it is crucial that we bar people who are dangerous from working with children and that we do not go too far the other way. Information sharing on that would become more effective with the establishment of the lists and the independent process that information sharing and assessment offers. We will have to see whether that helps us to develop better intelligence and better information sharing.

[185] **Andrew R.T. Davies:** Deputy Minister, you touched on training and information, and I have asked a question about expanding the role of LSCBs. I was just flicking through the 'One Wales' agreement and there is a commitment in there about the Government expanding workforce training plans for care staff and individuals to gain qualifications through in-service training. We have touched on the important role that social workers play in safeguarding children. Has much work been done on offering that in-service training to move us forward, so that we have a better understanding of the roles and responsibilities that people have?

[186] **Gwenda Thomas:** Yes. In saying that we were having a wider review, I mentioned that the workforce task group is looking at all of these issues. It will report in November, and that review is embracing the issues of training and career development. It also comes to mind that we have taken advantage of our legislative competence in the Children and Families (Wales) Measure 2010. In that—I think that it is in Part 3—we talk about the introduction of specialist social workers to support the safeguarding agenda, obviously, and vulnerable children and children in need. So, we have that competence through that LCO. We have not developed it with a proposed Measure on integrated family support teams, but it is certainly there.

[187] **Ann Jones:** On partnerships, witnesses have identified a range of difficulties arising from the overlapping relationships between a range of partnerships across local authority areas. The CSSIW report of 2009 stated that there was currently a plethora of arrangements and that there were

[188] 'important questions concerning the clarity of responsibilities between the different partnerships and how they relate to each other.'

[189] You have said that the Welsh Assembly Government does not want to be prescriptive, but should we be prescriptive in sorting out these difficulties? In what other ways could we resolve some of the issues that witnesses are identifying?

[190] **Gwenda Thomas:** Are you talking about LSCBs?

[191] **Ann Jones:** Sorry, yes.

[192] **Gwenda Thomas:** When discussing the membership of LSCB, I mentioned that it seems to me that, sometimes, it becomes an issue for the individual representing the bodies that make up the membership, rather than their bringing the whole body to the process. We need to work on that. Everyone has their statutory responsibilities—police, health, and social services. We also see some good examples of bringing in external expertise to the work of the LSCBs, and that can benefit them. However, as I said a few minutes ago, we need people to attend LSCBs regularly.

2.30 p.m.

[193] We need the expertise to be there in every meeting. We need to ensure that the bodies are represented and that those working for those bodies do not attend as individuals, as that can cause an overlap in some places. There was a suggestion in the NSPCC's evidence that we could look at legislation. Laming clearly said—and I agree with him—that we do not need any more legislation; we have got it all. We have the guidance and we have enough to work with. The difficulty is that the issues brought to LSCBs are both devolved and non-devolved responsibilities, and it is a matter of how we deal with that. There should be a commitment on funding, which would indicate a clear commitment towards safeguarding and it is necessary to ensure that decisions are clearly made at a senior level and put to individual authorities. More important than anything else, the decisions should be disseminated among social workers and others working on the front line.

[194] **Irene James:** Some witnesses have suggested the role of the chair of the local safeguarding children board should be independent and that WAG should issue guidance to this effect. What is your view on this?

[195] **Gwenda Thomas:** I still think that is a matter for LSCBs to decide. The example that comes to mind is Rhondda Cynon Taf, which appointed an independent chair at the outset. It worked for a while, but then it did not work. One of the issues is identifying people who can take up the independent role. I would not say that having an independent chair is bad, but it must be a matter of what suits the local arrangements within each local authority area. So, I do not have a firm view as to what works best, because there are examples of different means of chairing working, and to the contrary.

[196] **Irene James:** Thank you for that, but the issue that we are all highlighting is about the skills that they bring to the role, not their independence.

[197] **Gwenda Thomas:** I mentioned at the beginning that the role of the chair is part of the review that we are conducting.

[198] **Darren Millar:** It is the buy-in of the various organisations, whether there will be a take from the chair and whether the chair would be unbiased. One of the previous witnesses from Children in Wales suggested that if the number of LSCBs was reduced, it might free some finance to fund independent chairs, which may help to attract the right quality and calibre of chair in the future. Is that something that your review will consider, Deputy Minister?

[199] **Gwenda Thomas:** It will consider it, yes. However, there are also good examples of larger and smaller LSCBs working well. That also reflects social services departments. The size of authorities does not always dictate the quality of service, but it is a debate to be had.

[200] **Helen Mary Jones:** Ddirprwy **Helen Mary Jones:** Deputy Minister, you

Weinidog, yr ydych wedi cyfeirio sawl gwaith at y materion sy'n ymwneud ag ariannu'r byrddau, ac mae sawl tyst wedi tynnu ein sylw at y ffaith fod hyn yn broblem. Er enghraifft, dywedodd Cyngor Bwrdeistref Sirol Caerffili fod angen datrys y broblem yn fuan iawn. Beth yw'r cynlluniau ar y gweill i sicrhau fod arian digonol i bob bwrdd lleol? Gwn fod rhai cytundebau lleol wedi bod yn llwyddiannus, ond yr ydym wedi derbyn tystiolaeth o ardaloedd eraill lle mae'n amlwg yn broblem o hyd.

have referred numerous times to the issues around funding the boards, and many witnesses have drawn our attention to the fact that this is a problem. For instance, Caerphilly County Borough Council said that the problem needs to be solved very soon. What plans are there to ensure that there is sufficient funding for every local board? I am aware that some local agreements have been a success, but we have received evidence from other areas where it is obviously still a problem.

[201] **Gwenda Thomas:** Yr esiampl o fodel llwyddiannus sy'n dod i'm meddwl yw'r un yn Wrecsam, lle maent wedi gallu dod i gytundeb sydd wedi gweithio. Fodd bynnag, mae'n aml yn cael ei adael i wasanaethau cymdeithasol i ariannu'r byrddau, ac nid wyf yn gweld y gall hynny barhau. Byddai'n dangos ymrwymiad hollol i ddiogelu plant pe bai pob partner yn dod ag arian gyda hwy ac yn sefydlu cytundeb ar y cyd, fel y byddant yn sicrhau bod hynny'n gallu cario ymlaen. Wedi dweud hynny, mae'n rhaid i Lywodraeth y Cynulliad ddangos arweiniad, a bydd hyn yn rhan o'r arolwg y byddwn yn edrych arno.

Gwenda Thomas: The example of a successful model that comes to mind is the one in Wrexham, where they have come to an agreement that works. However, it is often left to social services to fund the boards, and I do not see that that can continue. It would show a total commitment to child protection if every partner brought funding with them, and established a joint agreement to ensure that that can continue. Having said that, the Assembly Government must also show leadership and this will be part of the review that we will be looking at.

[202] **Darren Millar:** Thank you for that answer, Minister. I think, Dai, that your next question around front-line practitioners, implementation, and the dissemination of information has been covered. We have touched on the vulnerable groups, but I think that it is important that we get a bit more evidence on the record about those.

[203] **Lorraine Barrett:** In respect of LSCB effectiveness in protecting vulnerable groups of children, witnesses have suggested that progress in this area is patchy. Children in Wales said that its impression 'is that it varies considerably across Wales'. It noted concerns in respect of disabled children, sexually exploited children, trafficked and refugee children, and so on. Is this an issue that you aware of and do you have any plans to achieve a more consistent approach for the most vulnerable groups?

[204] **Gwenda Thomas:** Yes. I will look to the national safeguarding forum to take this forward. The forum will report to me every six months, and I am expecting the first report in September. This will be ongoing work, and we have to achieve consistency. A child should be as safe in Neath as they are in north Wales or anywhere else. That consistency is important. We must not forget that there are examples of very good practice out there. I gave the example of having developed a national protocol for trafficked children and that is a good way forward. We had guidance there with regard to the trafficking of children, but it became evident that front-line workers were not aware of that in some places. There is a crucial role there for LSCBs as well, to ensure that that is available. We are also developing, and I think that you are just about to consult on, a protocol regarding the sexual abuse of children and the wider we can consult, then the better the guidance we end up with and the more awareness we raise. The raising of awareness is an issue.

[205] **Darren Millar:** Thank you for that answer, Deputy Minister. I have the final

question, which relates to the participation of children and young people in the work of LSCBs. Some witnesses have suggested that there is good participation in some parts of Wales and yet in others there seems to be little or no participation. There is a concern, particularly for children who have been involved in child protection issues. What work are you doing with your officials to ensure that children and young people, particularly those who have been involved in child protection issues, participate with LSCBs in the future?

[206] **Gwenda Thomas:** This is something that the forum is looking at. We know that a child or a young person has the right to be involved in decisions taken about them, and the work of most LSCBs is underpinned by the United Nations Convention on the Rights of the Child. If we adhere to that convention, and LSCBs work towards the principle of the convention, then there will not be a question that children and young people are included and that they participate in the work. However, this is part of the review. I want to know exactly how this happens and if it does happen. I think that this will be part of the first report.

[207] **Ms Rogers:** Yes, it will.

[208] **Darren Millar:** Will you be open to issuing guidance on involvement in order to get some level of consistency across Wales?

[209] **Gwenda Thomas:** I would not hesitate if I thought that there was a need to do that.

2.40 p.m.

[210] **Darren Millar:** Excellent. Okay. Are there any further questions from Members? I see that there are not. Thank you, Deputy Minister for your attendance today, we appreciate it.

[211] **Gwenda Thomas:** I had intended to thank you at the beginning of the session, but I will do so now. It is useful that the committee is undertaking this review and I look forward to your report to see what you have to say.

2.41 p.m.

Sesiwn Graffu Gyffredinol gyda'r Gweinidog dros Iechyd a Gwasanaethau Cymdeithasol
General Scrutiny Session with the Minister for Health and Social Services

[212] **Darren Millar:** Minister, I am delighted to welcome you back to the committee for a scrutiny session. I am also delighted to welcome again Paul Williams, the director general for health and social services, and Chris Hurst who, I believe, is the director of resources. Welcome to you both, gentlemen. If the Minister is content, we will move straight to some questions. We have all had a copy of your update note, Minister, which we appreciated. I call on Andrew R.T. Davies to ask the first question.

[213] **Andrew R.T. Davies:** Thank you, Minister, for coming along this afternoon. It is much appreciated. Thank you, also, for your paper because it gives us a very concise overview of what is happening in the Government at the moment. I will touch on a couple of points in the paper, particularly the delivery of some of the 'One Wales' commitments. I wish to discuss the school nurse strategy, on which you made an announcement last week, and ask for some clarity over the position of school nursing. Is the aspiration to have a school nurse in every school, or is it the aspiration to have a named nurse for several schools so that that nursing provision would not be specific for just one school?

[214] **The Minister for Health and Social Services (Edwina Hart):** The commitment in 'One Wales' was quite clear in terms of the provision of school nurses within the secondary

school areas, which we are able to deliver by 2011. However, this is only the start of the school nursing project. I had reason recently to commission work to do with the interface between health and education, and the involvement of public health, immunisation, all of the various strategies that we have had on nutrition and so on, and I have seen the key role that the school nurse has in delivering a range of Government policies. As far as we are concerned, we will have the implementation of the school nurse in place by the end of this term in the secondary school setting. I will then look at what further work can be done to bring the whole concept together—of not just being a school nurse, but a school nurse whose role extends into the population, and how you have that relationship with the primary sector. It is an ongoing piece of work. Therefore, the commitment has been met.

[215] The local health boards are quite enthusiastically looking at how they can manage the recruitment. There is currently a shortfall of around 70 or 80 in the system, but we know that these will be available and in place. The LHBs are embedding this quite clearly into their future work programmes, and we are content that this is deliverable.

[216] I had the pleasure of launching the school nurse project, and I had the opportunity to meet school nurses. However, more importantly, I met pupils. When we spoke to the pupils, it was delightful to see that they had confidence in the school nurse as someone that they could talk to, not only about matters relating to health, but other issues. It is rather like the discussion that we have had on spirituality, guidance, the national service frameworks and chaplains; there is almost a role for the school nurse so that they can discuss issues that they do not necessarily want to discuss with their peers or parents, such as issues about growing up and so on. It was a real pleasure to see the confidence that they had in the school nurse system.

[217] I had a meeting with the Royal College of Nursing earlier, and it is exceptionally pleased about the delivery of school nurses. I also think that there are some envious looks across the border about the delivery of school nurses. The RCN was saying that it is about time that we started to celebrate some of our achievements in this area, such as school nurses, the community nursing strategy, and the development of many areas. Therefore, the first commitment related to secondary schools, but this is ongoing work. It is preventative work; it is about changing the health agenda from the secondary focus into the preventative and community agendas.

[218] **Lorraine Barrett:** I very much welcome everything that you have said and I just want to put something on the table with regard to what the expansion of the role of the school nurse can do. For instance, due to some extra funding, a nurse was based at the Penarth youth project, which is a youth information shop, for a few years. That was useful because she ran all sorts of advice clinics, condom clinics and that sort of thing. So, it may have been difficult for some young people to speak to a school nurse, or they may not have been in mainstream education, but they were able to speak to her. So, I ask you to look at how the nursing service can support other community groups, such as youth clubs.

[219] **Edwina Hart:** That is a very good point, Lorraine. We need to see the extension of preventative health work and discussions about sexual health, pregnancy and so on in a wider setting. You are correct in that people may not want to make those points to the school nurse in school, but they may want to say something when they are out and about doing other activities. The chief nursing officer is very keen to develop this policy in the community, over and above having a named nurse for every secondary school and for everyone in the secondary school to have access. So, depending on finance in the next few years, that may be something that we can do. Health boards will have to sustain these new posts that we are currently putting in place, so we will have to look at future work. This is a start of the process, not the end.

[220] Even in these difficult financial times, this is a key part of the preventative agenda on a wide range of issues, so that young people have access. We do not want to undervalue the role of the school nurse with regard to immunisation programmes and other things that are undertaken. This is good value for money, so we need to see how they can be looked at.

[221] **Mr Williams:** Work has not just been done with regard to school nurses; for instance, the department has undertaken work with regard to investment in schools on 'Our Healthy Future' agenda, on sexual health and dental health. So, it has not just been about school nurses; there is huge investment in issues regarding children.

[222] **Edwina Hart:** The committee may be interested in a paper of that nature for information, because it would be interesting to see the engagement that the health service has with the education service, and to show that we are taking a rounded approach to the health agenda. I would be delighted to provide that information to the committee.

[223] **Darren Millar:** We would be delighted to receive that information.

[224] **David Lloyd:** On the same point, I have had representations from GP colleagues who are piloting research into teenage pregnancies, and they very much favour the idea of the school nurse providing sex education in schools. There is plenty of evidence to suggest that sex education is being done very badly at present; teachers are not the most motivated at times and they may get embarrassed. My Biology teacher used to get embarrassed when he was taking about sexual reproduction in plants, so who knows what would have happened at Lampeter school if we had got as far as human beings on the same subject all those years ago. [*Laughter.*] There is plenty of evidence to suggest that that sort of reticence among the teaching staff still pertains, so GP and nursing colleagues are very enthusiastic about the prospect of school nurses being given a pivotal role in delivering sexual health education. That could link into primary care as regards the provision of condoms and so on, as appropriate. The school nurse is now seen as being central to that.

[225] **Edwina Hart:** That is a useful dialogue that should be had about delivering that service. I am very concerned about teenage pregnancy rates, as I am sure we all are. We only have to look at the future prospects of some of these children, their lifestyles and the health issues that are also attached to this. So, anything that we can do on that particular agenda must be warmly welcomed. There is a whole range of issues, such as unwanted pregnancies and the link with abortion rates, so, if we could get some of these discussions right in our schools, as well as in families, we could make some obvious progress in some of these areas.

2.50 p.m.

[226] **Andrew R.T. Davies:** We all share your sentiments about increasing the awareness of public health. The 'One Wales' agreement mentions every secondary school, but the picture that you painted was that there would be a far greater link with the primary sector too and that that nurse would not necessarily be dedicated to the school, but would also link with the primary sector and perhaps have other roles as well as their role in that dedicated school. That is how I perceived it in 'One Wales'—so, that link has enlarged.

[227] **Edwina Hart:** I think that it has enlarged and it will be up to local health boards to decide how they deal with some of these issues, because they have to fund the post. However, of course, there will be nurses in secondary schools. We would expect to see nurses in the majority of secondary schools, as many secondary schools already have designated nurses, as you know. However, the detail of this framework is being worked through by the local health boards.

[228] **Andrew R.T. Davies:** That enlargement creates the need for training and there is a

real issue in the NHS in Wales, as with the NHS everywhere, with staff's ability to have protected time for training. If you look at the figures from 2007, it has gone down from 6.8 days of training to 5.6 days in 2009. Fewer than 46 per cent of nurses receive statutory training, in particular, in Welsh LHBs. Those are quite abysmal figures and, if we are to improve the outcomes and the understanding of community nursing in particular, we need to get those training levels up. Are you minded to make these issues performance targets for local health boards, so that they put protected time in place for nurses to have that training on the ground in order to improve outcomes?

[229] **Edwina Hart:** This morning, I met with a group of students from nursing and allied professions and one question raised with me was about concerns raised by their colleagues who work full time in the NHS about the difficulties that they sometimes have in accessing the training that they require and in getting the necessary time off, which is the very point that you raised. I seem to recall that I wrote some time ago to chief executives—it might have been me or Paul—indicating that it was important to release staff for training, because this is about their professional development and, at the end of the day, it is about the enhancement of skills that will benefit patients.

[230] However, I take your point exceptionally seriously. On school nurses, there is a specialist community public health school nurse qualification that we encourage people to go for, but you can also use registered nurses as school nurses. However, the point that you raise on training is quite interesting and is something that the chief executive will be more than happy to take up with other chief executives in their regular meetings. That is important, even in difficult times when there are issues around cash; you have to keep up the standard of staff training so that they remain motivated in their profession and have the best practice, which means that they then deliver the best value for patients in terms of safety and patient outcomes. I do not think that I can be more specific at this time, unless Paul wants to add something, but it is certainly a matter that we understand.

[231] **Mr Williams:** First, I support what the Minister said in that training is absolutely essential. Statutory training has to be delivered. However, we need to be smarter in that it does not necessarily mean time off or time out. We can use computer packages and get greater coverage and better monitoring of where the training has been undertaken. The principle is one that we would underline and, in my former trust, that was one of my performance targets, to ensure that everyone had statutory training because it is an Achilles' heel—

[232] **Andrew R.T. Davies:** You would not be minded to support protected time as a performance target for LHBs; the Minister said that she had already written to chief executives.

[233] **Mr Williams:** I do not want to engage in banter on this; I do not want operational reasons to be given for not allowing people to take time off as opposed to insisting that training takes place. That training can sometimes take place in the workplace, using computer modules. The important point is to ensure that they have the strategy or the updated training in continuing professional development.

[234] **Edwina Hart:** GPs have done quite a lot of training models and things have been developed across the piece and have proved eminently successful in a wide range of areas.

[235] **Irene James:** We all take the verbal and physical abuse of NHS staff very seriously, which you have stated on a number of occasions, but can you give us an update on what is being done to stop such attacks?

[236] **Edwina Hart:** I saw the article in the *Western Mail* this week. I am still concerned

that not enough cases are going forward for prosecution and that staff are not recording incidents of verbal abuse enough. We are starting to get things right on physical abuse, but we do not have the desired outcomes in how staff deal with aggressive verbal behaviour. We are now collating violence and aggression data and we are looking at some of these areas, particularly in the new local health boards. They are now recording any violent and abusive incident. Hywel Dda Local Health Board, for instance, has recorded 1,600 violent and abusive incidents, 830 against staff and 466 incidents of physical assault. So, we are talking about high numbers being reported. There has been an increased effort to report since we have made a concerted effort—not only the Government and the service, but, I would suggest, the Assembly in the good cross-party approach towards the issues of violence and aggression against NHS staff. They are under scrutiny by us at a national level and at the local level.

[237] There is an issue with prosecution rates. I have been discussing how prosecution rates are being dealt with with David Francis, who is taking the lead as the chair of the Cardiff and Vale University Local Health Board and who is an ex-deputy chief constable. They reflect the different stages of implementation, apparently, in terms of the case management role. I have also discussed with him the support that should be given as part of this policy to staff who are complaining. We have to recognise that it can be traumatic for staff to put in a complaint and that it is an added trauma if it becomes a police matter. So, it is important that we look at that. However, the level of gratuitous violence is relatively small, which we should be thankful for, although I would regard any incident as unacceptable. We are currently putting in funding of £1.8 million for lone workers, of which there are about 8,000, and we are now looking at online reports, which means that you do not have to wait to report it to someone and for someone to come to ask you questions that take you through it.

[238] I am grateful for the support that I have had in the Assembly on this and it is important that we keep what we expect in terms of behaviour high on the agenda. That is not only an issue for the NHS, but, increasingly, for people providing services in the public sector. If you look at other areas, your will sometimes see that people's behaviour is a sign of the times.

[239] **Darren Millar:** Do you want to come in on that, Ann?

[240] **Ann Jones:** Yes, I do. We recently had an issue in Glan Clwyd Hospital, but there was a police presence that was part funded—[*Interruption.*]

[241] **Darren Millar:** Perhaps it is better if we come back to you once you have recovered your voice.

[242] **Peter Black:** I want to ask something completely different, so perhaps it is better to wait for Ann to recover.

[243] **Andrew R.T. Davies:** I will carry on then.

[244] **Ann Jones:** No, I am fine now. [*Laughter.*]

[245] **Darren Millar:** That was a miraculous recovery.

[246] **Edwina Hart:** Could we patent that medicine?

[247] **Ann Jones:** In Glan Clwyd Hospital, there was a police presence but it was a jointly funded effort and it almost became a mini-police station. Are there difficulties with that or is that something that we should look to do? A coroner's constable could also be there.

[248] **Mr Williams:** I have seen different approaches at work through the local

partnerships. Some hospitals employ their own security officers, because they cannot guarantee a police presence all the time. However, the important thing now, as we have closed circuit television and a higher awareness, is that we have zero tolerance. I hope that the general public is getting the message. In the early days, all sorts of initiatives were taken, but the NHS is now clear; we have drawn a line and there is zero tolerance. If it happens, you will probably be on tape and you will be prosecuted. That is a powerful message and it is out there now. In addition, importantly, the staff feel supported. If organisations want to put in further measures, that is up to them.

[249] **Ann Jones:** May I follow that up? I was pleased to hear you say that you will be looking at prosecutions. The famous case was that of a nurse being thumped by a patient in one hospital, the person was arrested, went before the Crown court and was given a custodial sentence; exactly the same thing happened in another hospital but the case was not prosecuted. What the public wants to see is a common approach.

[250] **Mr Williams:** Again, we have been working with the chief constables and the Crown Prosecution Service to ensure that we have a more coherent approach across the piece on this.

3.00 p.m.

[251] **Edwina Hart:** May I come in on Ann's point about the police? There has been a police presence at Morriston Hospital's accident and emergency department, and that was particularly successful in dealing with some of the issues, particularly during difficult holiday periods, such as at Christmas, and after rugby internationals and various events, when there is an increase in problems. It is something that I think David Francis will continue to look at, because he is the lead chair on this, with regard to the development of this work. There is an issue about the standard of training for security staff, particularly in accident and emergency departments. There is an art to dealing with people who are on the edge, and sometimes it is not about telling them to go, but offering them a cup of tea and a chat. That training element is important, and I have discussed with David the importance of training security staff in a more imaginative way, so that they can intervene before an incident happens, almost, rather than just appearing when it is under way. So they would be walking in that area and could see who has had too much to drink and get them a cup of coffee and get them to calm down. We need a multi-faceted approach, and now that we have a clear drive from the lead chair from an LHB and everyone signed up to the agenda, with the public clearly behind all of this, we can move forward. If some of these cases went before a jury, I think that the public would take a hard line on them. We are getting an integrated approach. I would not say that the problem has been solved, given the reports that we are getting and the way that it is moving, but we have an excellent relationship with the chief constables and are working hard with the Crown Prosecution Service.

[252] **Peter Black:** I want to look at the exception report on the current economic climate. I note that the report states that:

[253] 'The planning assumptions for the next three financial years from 2011-12 will require NHS organisations to reduce their costs by 7% pa, or 19.6% over this period. This equates to a reduction of £1.1bn on the current revenue budget over the next three years'.

[254] What are the assumptions behind that requirement? Is that based on pre-election forecasts, or on the understanding of where the new UK Government is going?

[255] **Mr Hurst:** It is our most up-to-date assessment and there are two factors that we need to bear in mind. One is the impact of the constraints on, and reduction in, funding. This modelling uses the latest planning assumptions issued by the Assembly Government. The other factor is what happens to costs, and, as you will appreciate, costs in healthcare tend to

rise faster than in other public services for a number of obvious reasons: population, demography and the cost of technology. When you put the two together, you quickly find a divergence under a reduced funding scenario. So, that uses the most up-to-date assumptions that we have.

[256] **Peter Black:** Health boards are struggling to contain their costs in this financial year. What savings are starting to come through from reorganisation, and what assurances are you getting from health boards that they will be able to meet these targets?

[257] **Edwina Hart:** Chris deals with the health boards weekly, and they are expected to break even, even during this difficult time. Members will appreciate the historic issues relating to two LHBs—Powys and Hywel Dda. We want them to try to break even and to make improvements. Peter is quite right—these decisions are predicated on what I have been asked to look at now, in terms of savings in health. What I may be asked to look at in the future, within this year or future years, I do not yet know as a Minister, because those decisions have yet to be taken. However, we meet regularly and although the LHBs have only been operational since 1 October last year, up until April 2010 they had saved £7.8 million on management costs, and they plan to save a further £17.2 million during the course of 2010-11, and then a further £16.2 million over the next three years. Management costs are therefore expected to have reduced by a total of £41 million since April 2008, and this will result in a reduction in NHS management costs to 34 per cent of total costs by March 2014. So, the reorganisation is bringing through those savings. It is difficult to do a breakdown of direct management and transaction costs—that would be too complicated in many ways. Clearly, there are savings where there are no transaction costs. I do not know whether you want to add any more figures that might be helpful to the committee, Chris.

[258] **Mr Hurst:** First, it is probably worth acknowledging that you are absolutely right—the service has been feeling the strain of trying to be more and more efficient while doing things the same way, and we know that that can only be part of the solution. Broadly, there are three things that give us confidence that there is a healthy future for the NHS under a reduced resource environment. One is that the NHS is efficient, but not consistently in every area. So the first thing is for us to do everything that we can, working with the smaller NHS Team Wales, to ensure that we have best practice everywhere, and that gives good quality of care as well as cost efficiency.

[259] Secondly, we believe that there are a number of opportunities that, if pursued across Wales, will bring much greater benefit. For example, a number of patients are still being treated outside Wales, and that is not particularly convenient for the patient, or, indeed, the family, if long-term care is involved. Bringing patients back to Wales to be treated is best done in a co-ordinated way, because we need to develop our services. It makes sense financially to do that, and it certainly makes sense for the patients. So, there are a number of such programmes—we call them high-value opportunities, but, in simple terms, they are programmes—that are best co-ordinated nationally.

[260] The final tranche of opportunities, which are the most challenging, is to remodel health services in a way that we know will serve the population better, by putting a greater emphasis on primary and community care and on public health, which we have already touched on—self-care, if you like, and healthier lifestyles—with less reliance on hospital-based care, which should be the last resort for most of us. In very simple terms, that is the strategy that we have been working on with the health boards. We have an outline five-year plan for each health board, and that is starting to come to fruition now.

[261] **Darren Millar:** In your written report, you make some assumptions about reductions in revenue over the next few years. Clearly, the UK Government has given a commitment to invest in health spending—not to reduce it, but to increase it in each year. There will be no

reductions. Are you telling us that the Barnett consequential that will come to Wales will not be spent on healthcare because your Government has different priorities?

[262] **Mr Williams:** I have yet to see a definition of what 'protecting health' actually means. It is quite interesting, and we might learn more from the budget. I have witnessed discussions with health colleagues in England in which they talked about having to make £20 billion-worth of savings in the next four to five years. That equates to our figure and our assumptions. We shall have to see, because, as the Minister said, just holding budgets where they are will not be sufficient to meet the demands of demography and technology. Clearly, we hope that the cuts will not be as severe as they might be, but we think it prudent to plan ahead on the basis of best-case and worst-case scenarios, and that is what we are doing.

[263] **Edwina Hart:** We have been prudent. We have at times been attacked in the Chamber as a Government and accused of not looking at issues. In the health service, we have been looking at where we can get greater efficiencies. I was taken by comments made yesterday about what we are doing with regard to drugs. That is an area of best practice that we are looking at, to see what are drugs ordered, what drugs are wasted, and what further savings can be made. I set up a group under Chris Martin, the chair of Hywel Dda, to look at some of these issues, and he is already indicating that he can look at key savings of £50 million a year just by changing practices. All this work is starting to take place. I need to tell the committee that this work has been much easier since we have had a reduced number of boards, because you have not had to have a discussion between a trust and LHB, but have had just one organisation looking at its decisions. I therefore think that we have taken the right decision on structures for the new world that is emerging, and I think that that will help us enormously.

[264] Also in relation to best practice, local health boards' engagement with local government has been very interesting, considering the number of joint appointments that are being made. Good discussions are taking place in the main between social services and local health boards. There is an understanding of the needs of the continuing healthcare budgets in this. We are making progress in that area, and the LSBs are coming into their own in the projects that they are looking at. Take the example of the discussions that are going on at Aneurin Bevan about frailty projects and issues such as that, linked to the telemedicine developments.

3.10 p.m.

[265] In partnership with local government, we are achieving value for money. The enhancement of community nursing services and so on builds a picture of the frail and vulnerable staying in their own homes; this is what they want, it is cost effective and it mitigates the need for them ever to go into the secondary care system, which is expensive. This is all coming together. During the past few years, we have moved from partnership to working together. We are not just saying it; we are doing it in a number of key areas. Some of the most exciting developments have been in Hywel Dda Local Health Board, in places such as Ceredigion, where the development of this particular work has really started to take off. We are looking at best practice and at where we can streamline, but health is an expensive business. You only have to look at drugs bills and at what drug companies put on the market to see how much that costs the national health service. That and technology push up our costs just like that. Health inflation is a good 2 per cent above normal inflation, so we are always working within those difficult areas. We have been preparing ourselves for greater efficiency to get a greater bang for the buck, to keep staff there on the front line, because the last thing that I want to do is look at front-line staff not being available to treat patients. That is why we hope that, even in these difficult circumstances, we are managing 2010-11 effectively and efficiently. However, in future years, there will be further decisions to be made.

[266] **Darren Millar:** You have raised the issue of drugs and medicines. You have said that now that there is a reduced number of LHBs it is easier to communicate messages back and forth. However, there is some confusion still, is there not, about the decision-making processes and so on? We have the Welsh pharmaceutical committee, the medicines management programme board, the pharmacy strategic delivery group, the all-Wales medicine strategy group, and NICE. We have all these different bodies and all these different sub-groups in Wales; how do they work together to communicate messages down to the LHB level? It seems that there may be a lot of collaboration opportunities between those different groups.

[267] **Edwina Hart:** They all know each other and they all discuss matters of common interest. Our all-Wales medicine group sometimes looks at drugs in advance of NICE to give me advice. When NICE guidance comes in, because it has greater resources and it might have looked at things differently, that guidance applies. There is no difficulty now that the all-Wales medicine strategy group, under Professor Routledge, is working in conjunction with NICE. I have had my annual meeting with NICE, which confirmed the excellent arrangements between the both of us; we have helped to streamline and make some quicker decisions. I am aware that the UK Government will be looking at NICE and I have already written to the English Minister for health indicating that I will be interested in any review that is taken of it. It is an England-and-Wales issue and I would be prepared to contribute if I thought that it would bring benefits to us. As for the other groups, they have key roles and functions. You understand that pharmacists understand about drugs. Any GP—and I look towards Dr Dai Lloyd here—will tell you that they have a greater knowledge about drugs, how they are used, and patient groups, than GPs, because GPs will consult. So I think that we have the correct groups.

[268] **Darren Millar:** Is there a lot of overlap?

[269] **Mr Williams:** That is a fair point. About one fifth of the total expenditure is on drugs, but, of those groups you mentioned, NICE is dealing with the introduction of new drugs and technologies, you have the group looking at the use of drugs, a group looking at the professionals, and you have our task group, which is looking at delivery and efficiency. They talk to one another, but there are distinct functions there. They are clear to us, but they may not be so clear to you, so we could explain that further to you. There is logic in the separating out of some of those functions.

[270] **Darren Millar:** That clarity is needed. Their specific roles were certainly not clear to me.

[271] **Mr Williams:** They are not all doing the same thing.

[272] **Darren Millar:** That is what I was concerned about—whether there was some duplication of work and whether any collaboration is possible. Minister, you have mentioned the availability of new medicines and Professor Routledge and so on. You will be aware that, in Scotland, letters have been produced to chief executives and there has been clear patient guidance. This is the critical issue here; patients need to know what they can expect from the NHS in terms of new drugs and how decisions are made; it must be clear for patients to understand. You will be aware from correspondence with Assembly Members on all sides of the Chamber that it is a confusing issue for patients in Wales.

[273] When they get into the system, they are seeking a certain drug because they have heard about it somewhere, or have done some research on the internet, and they want to know why it is not available here when it may be available elsewhere. Do you have any plans to introduce patient information guidance, or simple, straightforward leaflets for patients in Wales so that they can have access, as they do in Scotland?

[274] **Edwina Hart:** Later today, I will be briefing the party spokespeople from around this table about the second stage of the implementation of the Routledege report and we will be discussing future work in this area. I intend to make a statement to Plenary next week. That is very much on my mind. The issue is that, sometimes, when a patient speaks to their clinician—I am sure that we all have had cases of this—and the clinician says that, under NICE guidance, the patient cannot have the drug because it is not cost-effective, the patient offers to pay for it. That happens even when it has been deemed by NICE to be ineffective, particularly as regards end-of-life issues. What is the role of the clinician in all of this, and should there be clarity so that the patient has confidence? What happens if the patient purchases the drug privately? Does the clinician then stop the patient's NHS treatment, because of the whole issue of co-payments? Even though this has, apparently, been clarified elsewhere, it is not the case in general terms. There is still difficulty. That is the point that I would like to get to, Chair.

[275] There are ethical issues around this to which further consideration must be given. Professor Routledge and I will be briefing party spokespeople later today on these issues and other areas of interest, and I am sure that we will return to it. I would be more than happy to prepare a paper, when I make any further decisions or give further consideration to this area, if the committee would be interested. To return to your previous point, when Chris Martin's work is finished, I would be more than happy to prepare a paper on the task and finish group and to outline the roles and responsibilities of the groups that you asked about today, Chair.

[276] **Darren Millar:** That would be very helpful, thank you.

[277] **Peter Black:** I will move on to the £400 million capital expenditure, which is also referred to in the report. You will know, Minister, that, every year, a report comes out on health and safety risks on the NHS estate. How is that capital being utilised to tackle some of the more urgent issues that are raised by those reports? When the next report comes out—in January of next year, I think—are we likely to see any progress on fire safety risks and the most urgent health and safety issues, in particular?

[278] **Edwina Hart:** Clearly, local health boards have responsibilities in this area to look at this report and to maximise what they can do about their estate. We also appreciate that there is a considerable amount of work to be done in the NHS and a considerable need for new build in the NHS to give the appropriate capacity for developments in the delivery of services. I have told LHBs to look at this. There are some premises that require an awful lot of work. The amount of repair work that they require might mean that it would be better to have a new build elsewhere. They are currently looking at their estate plans in this light, and I have taken on board the debates that have taken place in the Assembly Chamber about the issue of rickety buildings and problems with fire, and big issues like disability and access issues. We have asked them to prioritise that in real terms.

[279] The issue for me is the reduction that we might see in capital over the years. We need capital to enhance our revenue streams. Good investment in capital means a reduction in revenue costs. We are looking carefully at our capital programme and prioritising the areas that would make a significant difference to patients and to costs that are mounting within the estate. For example, there are places that have very limited use of certain hospitals, where there is a big bill to pay to get them up to standard and there are new facilities coming online. You have to look at that in a logical manner.

[280] Paul, do you want to go through any of the emerging capital projects in which the committee will have an interest, particularly those emerging in 2010, which are excellent across the piece? There is a good emphasis on adolescent mental health services, in which the committee is particularly interested and which has been a key concern for the committee and

Members for a number of years. There are significant schemes. Paul, do you want to nip through a couple of them?

3.20 p.m.

[281] **Mr Williams:** Yes, if I may, Chair. I will go back to the question. We have a huge estate. First and foremost, we allocate sums to each of the health boards as part of what we call the discretionary capital programme, as part of which they have to be responsible for the essential maintenance. However, because they have estates that have often come to the end of their lives, we somtimes have to take strategic decisions to replace the whole thing, root and branch. Some good examples of that include Ysbyty Aneurin Bevan, where £53 million was spent on a complete replacement, and Ysbyty Ystrad Fawr, where £172 million was also spent on a complete replacement. In relation to redevelopment and improvements of big infrastructure, at Ysbyty Gwynedd £18 million was spent on replacing its electrical infrastructure; at Prince Charles Hospital, £15 million was spent on ward refurbishment; and, at Bronglais Hospital, £40 million was spent on refurbishment and improvements to front of house. In addition, some £5 million was spent on the replacement of vehicles for the ambulance service. On the new services that we are developing, such as the child and adolescent mental health services, we have just completed work in Abergele, and we are now completing the £27 million development at the Princess of Wales Hospital.

[282] So, there is a mix of schemes. Some deal with improving existing estates with discretionary capital. Where they fall outside that, there is a big investment in infrastructure, which falls under the main capital programme, where, strategically, the investment aims to implement a wholesale change to an estate and to upgrade it. That has represented a significant chunk. The other part of it is bringing in new services, such as the CAMHS services. The capital programme is being looked at all the time with regard to all the variables and competing demands.

[283] **Edwina Hart:** I would like to add one point to that, which I think is relevant to Peter's question. At Cardiff Royal Infirmary, which is key in Cardiff, with a base of people who come into it individually, we have overall capital costs of £37 million, which will deal with some of the ongoing problems with the building, including some structural issues. We are looking at undertaking conservation works of £8 million as part of that project, in order to ensure that we can maintain and conserve its beauty. So, it is quite a difficult balancing act.

[284] We have talked about redeveloping sites, and Paul mentioned the project in Merthyr Tydfil. A very similar building project took place at Ysbyty Glan Clwyd. The health board is currently looking to submit a plan to us in August for a property that will have a capital cost of £80 million, in order to deal with some of the issues in that area. We need to deal with those because of how the two buildings were. In an ideal world, a bulldozer would be used and a new building put up, but we now have to have a very stage-managed approach. Redevelopment work has led to problems at Prince Charles Hospital with the timing of some of its ambulances and that of the accident and emergency department. So, this is an ongoing process. However, I feel that there is a degree of expertise in the service on the part of the people who are involved. It is also important for the health boards to look differently at their capital projects. At Bronglais Hospital, the bill was greater originally, but then we looked at what would be better structurally there. It looked at it again; it has saved money and the money that it has saved on that project is now going towards further developments in Cardigan and Aberaeron.

[285] **Mr Williams:** As the Minister mentioned, at Cardiff Royal Infirmary it is not a case of replacing a hospital with a hospital; we are rethinking the whole way in which we will provide hospital and primary services for a locality. We are providing a whole health service, with walk-in facilities, mental health facilities and so on. So, rather than replacing it like-for-

like, we are remodelling. That is in line with our philosophy of integrated care and providing services that are accessible to local communities. So, I think that that is a good example of where we are being much more imaginative than we have been in the past.

[286] **Darren Millar:** Did you want to come back on this, Peter?

[287] **Peter Black:** No, not on this issue.

[288] **Darren Millar:** Andrew, did you want to come in on this issue?

[289] **Andrew R.T. Davies:** Yes, thank you. You talked about Cardiff Royal Infirmary; I would like to nip across the city to Whitchurch Hospital, if I may, where there is what we hope will be just a pause—although it would be nice not to have a pause at all. Considerable sums of the Welsh Assembly Government's money have been given to the local health board. Can you inform the committee about what is going on with the Whitchurch site? There are serious reservations about what is going on, the long-term implications and getting this project back on track. People want to have confidence about what is going on at the site.

[290] **Edwina Hart:** The development at Whitchurch Hospital was talked about for so long that clinicians have moved on in respect of what they want for Whitchurch and how they want to see mental health services in the area develop. Clinicians have taken the lead with the local health board, asking us to look at what types of developments should occur at Whitchurch. They have been talking to their patients. They decided that, to be frank, they wanted to move away from institutional approaches. Obviously, there will be something on the Whitchurch site. They want to look at where they can use other resources within the city. That discussion has not yet finished within the local health board. However, I assure you that this has been clinician-led, and not led by us in terms of cash, because, as you know, we had already agreed in principle that that scheme would go ahead. This has been a fundamental rethink by clinicians about how they want to deliver services. The original discussions on this took place 10 years or even longer ago. I am always hearing that it is us or bureaucrats taking the lead. It is not. We are asking clinicians to take the lead in these areas, and they are the ones who said, 'Hang on a second; this is what we might require in Whitchurch'. The Whitchurch site is a particularly well used site, because the George Thomas Hospice is there. It is an integral site, and it is useful for us for other services to be developed there. It is a health site. However, all of this is with the LHB, and it is the clinicians who have asked it to look at it.

[291] **Andrew R.T. Davies:** So, it is clinician-led.

[292] **Edwina Hart:** Yes, it is clinician-word. I can absolutely assure you of that. I have visited Whitchurch Hospital to have a look. There have been some improvements with regard to how the rooms look, and staff and patients are very pleased with the improvements that have been made, but clinicians said that we need to have a look at this. We need to think about what we want in Cardiff and about what our patients require. I must say that the LHB is taking this very cautiously and carefully and talking to all the patient groups. It is quite clearly where the lead has come from. We have learnt a great deal over the past few years about clinicians taking the lead. The Cardiff Royal Infirmary is another example. Clinicians were very keen on a city-centre site and on looking at what could be put on the site and how it could be developed. Clinicians are also very keen now on having what they call hot and cold sites. The University Hospital of Wales is the hot site, and Llandough Hospital is the cold site. They are telling us what development they want in these areas. As we restructure services, we are trying to take into account the wishes of clinicians in order to deliver what they think is best for their patients. I can assure you that that is the way that this is being dealt with. Paul, perhaps you would like to confirm that, as you discuss these issues with the chief executive.

[293] **Mr Williams:** I just want to reinforce the principle of engaging clinicians. This is

what we were looking for in the reorganisation—to give clinicians an opportunity to come forward and feel that their ideas were being listened to. The new boards have more clinicians on them than has ever been the case. The new infrastructures are often managed by clinicians now. It is absolutely what we intended. This is an example of clinical advice being heard in a way that it was not previously. We have taken note of that.

[294] **Helen Mary Jones:** There are two issues on that that I would like to raise, if we have time, Chair. However, first, I would like to ask the Minister for an update on the implementation of the new eating disorders framework.

[295] **Edwina Hart:** The new eating disorders framework has been exceptionally well received within the service, and implementation is going ahead. They have been particularly good at developing the service in north Wales under Mary Burrows. There are issues that we must discuss further with GPs. I recall that Dr Lloyd raised issues about GPs and the nervousness that they sometimes feel in dealing with people with eating disorders. They felt that there should be more specialists that they could refer to. So, the service is developing quite well. I was pleased that we were able to put additional resources into it. I know that the amount does not seem substantial, but those additional resources are making a difference. It was quite clear this morning, when I was talking to clinicians in the mental health field, that they definitely welcome this. It is important to recognise that this will be a service that we will have to expand all the time, as more and more people are starting to present with eating disorders. To go back to another point, school nurses are very good at picking up when people are self-harming. There is a link between self-harm and other issues. We are trying to integrate the services well. Do you want to add anything, Paul?

[296] **Mr Williams:** We are investing £1 million recurrently from this year, and we will have two teams—one in north Wales and one in south Wales; they are coming onstream as we speak.

[297] **Lorraine Barrett:** I am interested in chronic conditions management. I am pleased to see the reduction in the numbers of emergency medical admissions. I am interested in the collaborative work going on. For example, I am aware of hospital consultants working closely with GPs in managing patients so that they do not have to keep going back to see consultants all the time or back to accident and emergency departments. I know of some very good working relationships where that approach is working well. Do you want to say anything further on that? I also want to ask about the role of pharmacists, district nurses and respiratory nurses.

3.30 p.m.

[298] There are many people in Wales suffering chronic lung disorders and there are respiratory nurses working in the community. Sometimes, it is just reassurance that the patient needs. Patient support groups can also play a big part. Do you have any thoughts on that, Minister, and on support for patient support groups which, again, are about providing information to one another? It is about learning about your own condition and how you can manage it. For example, the input of people like nutritionists can also be important. Could you say a little bit about how it is all working?

[299] **Edwina Hart:** It is working quite well. We are assessing some of the sites that we have. You will be interested to know, particularly as you are a Cardiff Assembly Member, that a generic care bundle model is being developed, which seeks to integrate generic elements of chronic conditions to be used by practice nurses to optimise how they can manage it. So, an innovative project is under way in Cardiff and consideration is being given to the way in which that can then be embedded into a chronic conditions management model. That is one group that we need to utilise more.

[300] Pharmacists have a very useful role and function because they see the drugs that are being prescribed. They are aware of people's conditions and can give immediate advice. In Carmarthenshire, there is quite a large-scale telehealth and telecare project, which provides the link between health and social care, which are key elements. They look at health and social care support workers within the current service provision, and consider how they can be better utilised. As you are aware, work is being undertaken in Carmarthen on the training for these so that they can be used in health and social care. That work is being done there.

[301] You made an interesting point about nutrition, because there are big issues about nutrition and the elderly looking after themselves. I was listening to something earlier that suggested that a local authority in England is changing its service model because people had to pay for their meals on wheels to be delivered. The number of people who wanted meals on wheels had reduced because they had to make a £500 payment. That would have a direct effect on the work of some nutritionists who work with older people. We use nutritionists within the NHS, and we want everyone involved in care to be involved in the management of chronic conditions.

[302] We had a very interesting discussion with Hywel Dda Local Health Board about how there needs to be more work for GPs in the management of chronic conditions, and some of the areas that they were looking at further in terms of what can be done within practices. There is a very valuable role for practice nurses now, and there are very well rehearsed clinical pathways for diabetes and the management of it. We need to identify how those can be developed for other chronic conditions. In certain areas, you will be able to telephone if you are having a bad day—as Helen Mary knows because she was at the launch of those projects in Carmarthenshire. There are different ways of communicating to keep people out of hospital. You have hit on a very rich strain in terms of what is happening with chronic conditions management. If there is interest in the committee, I would be happy to issue a statement and provide a report on the outcome of all of these discussions.

[303] I think that Members would be very interested to see the turnaround in terms of how we are looking at it. There are enormous lessons to be learnt. There is a road map, which is also due for completion by March 2010, which was nationally agreed so that people can look at where everything is. They must also look at what they have already learnt because there is no point in doing something that is not working; we will know at a very early stage. Therefore, the demonstrator models are in place and we are looking at how that can go now into the wider primary and community services programme, which we are developing with the local health boards. The difference in balance between the local health boards, with clinicians involved, and also the voice that primary care now has in local health boards, will make a significant difference to the delivery of these services. Some of the things that were considered as secondary care matters are now quite clearly back on the primary care agenda. I think that that will make real differences, not only in terms of benefits to patients but to health expenditure.

[304] **Mr Williams:** The demonstrator sites, as you quite rightly say, are showing reduced lengths of stay. What we must do now, which will be the hallmark of success in terms of our vision for the NHS and social care over the next five years, is to have fully embedded chronic disease management in a way that provides active case management, which is about making sure that people can live as independently as possible, and where all of the agencies are on tap, if you like—not on top—not with everyone going across the same threshold, but perhaps one key worker or whatever. That is the big picture. We know that it works in the demonstrator sites, but we now need to work purposefully to roll this out. It will be a long project but we are here for the long haul to make sure that this pays dividends in terms of getting us to alter the hospital model, which is sometimes inappropriate and costly.

[305] **Peter Black:** I have a quick question on the sunbed legislation. Will it be a proposed Measure or regulations, and will you be able to get it through before the Assembly elections?

[306] **Edwina Hart:** Funnily enough, I asked officials last week to provide me with an update on sunbeds, which I hoped I would have received by today, because I am keen to move ahead on it. I am expecting advice shortly and I will share that advice with the committee. It is an important piece of legislation and I know that the committee was exceptionally concerned about it in its report and wanted us to press ahead. So, please feel free to press me on that issue.

[307] **Peter Black:** Is it going to be a proposed Measure or regulations?

[308] **Edwina Hart:** We are currently considering that, but I have not had the advice through yet.

[309] **Andrew R.T. Davies:** I want to take you back to the subject that I started with, namely the 'One Wales' commitments. I was recently corresponding with an in vitro fertilisation clinic in Swansea on the issue of its contracts being terminated because of the 'One Wales' commitment to rule out the independent sector. Realistically, how can that commitment, which is due to be met by May next year if independent operators, such as this clinic that operates at Morriston Hospital in Swansea, are currently providing IVF treatment, but the local health board has no fallback position? How far are you going to take that commitment? Are you going to take it all the way to ruling out operations such as this clinic in Swansea, where there is no alternative? Can you give a taste of how far down the road you are on this issue?

[310] **Edwina Hart:** The IVF arrangements are operational matters for the LHB. I am happy to respond to the Member if there are concerns on this particular issue.

[311] **Andrew R.T. Davies:** With respect, Minister, it was your letter that confirmed this.

[312] **Edwina Hart:** Yes, but, as far as I am aware, IVF is, and will continue to be, available in Wales. Everyone is entitled to two cycles of IVF. We obviously have a commitment in 'One Wales', which we are working towards. We have seen a reduction in use of private facilities by Welsh patients, and I wish Wales to be firmly within the NHS with regard to the delivery of services for Welsh patients.

[313] I will be more than happy, when I conduct my regular review on the 'One Wales' agreement, to update publically on these issues and identify where progress is being made or is not being made.

[314] **Andrew R.T. Davies:** So, by May next year, the independent sector will be out of the NHS in Wales?

[315] **Edwina Hart:** I do not quite know what you mean by the 'independent sector'. If you mean that I want to reduce the use of private hospitals and for operations to be carried out in NHS hospitals, then the answer is 'Yes', and we are on course to do that. So, I am not sure what you mean by that. The voluntary sector provides services.

[316] **Andrew R.T. Davies:** What about mental health services?

[317] **Edwina Hart:** I have already indicated, with regard to mental health services, that we wish to repatriate from England as many patients as possible who are generally in private facilities, hence our drive to get the proper premises in place, because we want them to be within the national health service.

[318] We have arrangements with the voluntary sector. Voluntary organisations work with us in the NHS, particularly on drug and alcohol issues, and we are perfectly happy with the not-for-profit organisations that we work with. So, as far as I am aware, we are moving towards that commitment. There have been some historic issues with regard to renal services, which were provided differently, but which we paid the bill for. However, the renal network is currently looking at a co-operative model approach to deal with those issues. We also have a reduced use of private hospitals. Paul, do you want to comment on that to give an indication of where we are going?

[319] **Darren Millar:** Could you please be brief, because we are really up against the clock and two more people want to come speak?

[320] **Mr Williams:** We have had a 16 per cent reduction in the use of private facilities by patients in Wales. So, the investment with regard to the use of the NHS is starting to feed through.

[321] **Darren Millar:** I have a quick follow-up question on IVF, Minister. In the business statement earlier this week, I raised the fact that a growing number of IVF patients are having abortions after a successful cycle of treatment. Can you include a reference to that issue in your update?

[322] **Edwina Hart:** I do not think that I will include that, to be perfectly frank. It is something that I want to discuss with medics, because they are the ones who discuss IVF treatment in detail with patients, and it is clinicians who make decisions on suitability.

3.40 p.m.

[323] I am not an expert in this area. I would like to have some private discussions with my medical director on these issues and I will then correspond with you privately on the matter in the first instance.

[324] **Darren Millar:** I would appreciate that; it is more screening-related than anything else.

[325] **Helen Mary Jones:** I am the last person to want to make cross-border comparisons, but the Minister will be aware of the publicity today about the relative performances of our ambulance service and the Scottish and English services. You could argue that, in many parts of England, it is much easier to provide such a service because those parts are highly populated and close together. However, that argument does not hold up when you have to provide services in the highlands of Scotland. Is this a bit of a storm in a teacup or does it reflect some ongoing issues with the performance of the ambulance trust? I know that there was some recent improvement, but we would all acknowledge that it has not been as fast as one would have liked.

[326] **Lorraine Barrett:** In evidence that we heard as part of the review of ambulance services, I remember a paramedic saying that he gets a bit frustrated because you can get to someone in six minutes, but not manage to save them and you can get someone in nine or 10 minutes and manage to save them, and yet it is considered a failure if you save them. I am not saying that you should not have targets on time, but could you provide us with some figures on that at some point? You do not have to answer that question now. The outcome of saving people's lives is as important as ensuring that they meet the eight-minute target or whatever it is.

[327] **Edwina Hart:** One issue that is always being raised by the ambulance service staff is

rapid-response vehicles, which enable you to meet your targets. This is only anecdotal, but we are aware that in some of the English ambulance trusts, it is rapid-response vehicles that go out and not necessarily ambulances. Therefore, the rapid-response vehicle will get to the accident, but it may not be a suitable vehicle or they may not be suitable personnel for dealing with the issues. So, that is an interesting point, but it is an aside.

[328] We undertook some analysis on this because we thought that we might be asked about it today and we have had some rough figures that Paul might like to share the details of with you, but you need to know that we are looking at some issues relating to category A calls and category B calls in response to some of the matters raised during the ambulance review.

[329] **Mr Williams:** Just after taking over, I was struggling with the performance of the ambulance service, but in the past 12 months, we have hit the target for eight months. The only reasons for not hitting the target during the other four months were swine flu—and ambulance staff are part of the population—and those two extraordinary periods of bad weather in December and January. Last month, we hit our highest target of 70 per cent. We looked at the comparators and the story that was running and, first and foremost, the Minister made the point that our response is always to send out a fully equipped vehicle.

[330] **Darren Millar:** That is not always the case because you have rapid-response vehicles on the road, particularly in north Wales.

[331] **Mr Williams:** Yes, but in the main, the gold standard that has always been adopted in the ambulance service is to try to field a vehicle. That is not the case in England, where they take a more flexible approach.

[332] On your point about like for like comparisons, we did some quick calculations on our urban cycles for this year and, in Swansea, it was 5.26 and in Cardiff it was 6.37. We are aware that we have areas of deep rurality in Wales and I think that we need to face the fact in Powys that we have not yet reached the heights of 55 or 60 per cent—in fact, we reached 60 per cent for the first time last month; I cannot guarantee that that will be the case every time. However, I think that Powys is peculiar and we need to look at that.

[333] Having seen the efficiency review, which the new Welsh ambulance service board has looked at, I recommended to the Minister that we consider whether we should use appropriate response in every case, which is not always a fully equipped vehicle. So, in other words, we should make greater use of rapid-response vehicles, which will improve not only our performance targets, but will be more comparable. In many cases, particularly in the Valleys areas where there are congested streets and so on, getting a rapid-response vehicle to a patient is the right thing to do. So, I am recommending to the Minister that we change the definition of our response, to be in line with England.

[334] **Darren Millar:** I have a final question before we wrap up, Minister, and that is on the issue of the decisions made by you and how they are implemented on the ground by the health boards. One thing that concerns me greatly—and I raised it with you this week—is that you committed to make Lucentis available on the NHS for the treatment of wet age-related macular degeneration, which everyone was supportive of, and you made cash available, yet, in north Wales, there are patients who are waiting 20 weeks for treatment when the recommendation from the Royal College of Ophthalmology is just two weeks. Two weeks was also your intention when you provided the funds to deliver that. How do you monitor issues such as that to ensure that LHBs are fulfilling the commitments that the One Wales Government has given?

[335] **Edwina Hart:** I listened to the points that were made during the Minister for business's statement. I have asked the chief executive of the NHS to look into that issue. You

have raised a broader issue of communication within the service, which was highlighted to me more in relation to the IVF issue, given all the letters that I have had from people who have gone to clinics where nurses have said to them that they do not know anything about it. I have had quite a discussion with the chairs of the LHBs, as has Paul had with the chief executives. Ordinary front-line staff are not sufficiently involved to have the decisions made by Government disseminated to them and sufficient information is not given to them for them to understand those decisions, so I have asked them to look at the communications issues in this area.

[336] I am also concerned that, sometimes, when front-line staff and others, such as medical secretaries, are asked questions by patients, they give answers that are not correct because they do not know the information. That starts off a whole ball game of writing to you as their AMs, their MPs and to me, as Minister, creating an administrative burden. If the correct answer had been given in the first place, none of us would receive a query. So, we are keenly looking at those issues.

[337] On the issue in north Wales that you raised, the chief executive is looking into it, as he is looking into the issues raised with me by Paul Davies and the concerns that he has. Both Members will be responded to accordingly.

[338] **Darren Millar:** Thank you for that, Minister. That brings us to the end of our scrutiny session and our meeting today.

Daeth y cyfarfod i ben am 3.47 p.m.
The meeting ended at 3.47 p.m.