Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Cyfrifon Cyhoeddus
The Public Accounts Committee

Dydd Mercher, 13 Ionawr 2010
Wednesday, 13 January 2010

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Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Lorraine Barrett	Llafur Labour
Alun Davies	Llafur Labour
Michael German	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Bethan Jenkins	Plaid Cymru The Party of Wales
Sandy Mewies	Llafur Labour
Jonathan Morgan	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Chair of the Committee)
Nick Ramsay	Ceidwadwyr Cymreig Welsh Conservatives
Janet Ryder	Plaid Cymru The Party of Wales

Eraill yn bresennol
Others in attendance

Jeremy Colman	Archwilydd Cyffredinol Cymru Auditor General for Wales
Paul Dimblebee	Partner Ymgysylltu, Swyddfa Archwilio Cymru Engagement Partner, Wales Audit Office
Matthew Hockridge	Swyddog Ymchwil Polisi, Swyddfa Archwilio Cymru Policy Research Officer, Wales Audit Office
Keith Ingham	Pennaeth Iechyd a Gwasanaethau Cymdeithasol Plant Head of Children's Health and Social Services
Rob Pickford	Cyfarwyddwr Gwasanaethau Cymdeithasol Cymru Director of Social Services Wales
Rob Powell	Cyfarwyddwr Astudiaethau Arloesol, Swyddfa Archwilio Cymru Director of Innovative Studies, Wales Audit Office
Paul Williams	Prif Weithredwr, Gwasanaeth Iechyd Gwladol Cymru, Llywodraeth Cynulliad Cymru Chief Executive, National Health Service Wales, Welsh Assembly Government
Yr Athro/Professor Richard Williams	Cynghorydd Gwasanaeth Iechyd Plant a Meddyliol Children and Mental Health Service Adviser

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

Alun Davidson	Clerc Clerk
Joanest Jackson	Cynghorydd Cyfreithiol Legal Adviser
Andrew Minnis	Dirprwy Glerc Deputy Clerk

Dechreuodd y cyfarfod am 9.13 a.m.
The meeting began at 9.13 a.m.

Ymddiheuriadau a Dirprwyon
Apologies and Substitutions

[1] **Jonathan Morgan:** Good morning. I welcome Members to the first meeting of 2010 of the Public Accounts Committee. Before I go through the usual housekeeping arrangements, I welcome three new Members who have been appointed to the committee—Sandy Mewies, Jeff Cuthbert and Alun Davies. They replace Janice Gregory, Lesley Griffiths and Huw Lewis, who have all joined the Government. I would like to place on record my thanks to Huw, Lesley and Janice for the work that they put into this committee over recent months and years. Their contributions were extremely valuable and I know that they worked hard on the inquiries that we undertook. I look forward to the contributions of Sandy, Jeff and Alun over the months and years ahead. A very warm welcome to you as new members of this committee.

[2] I remind Members as usual that housekeeping arrangements apply. Please switch off mobile phones, BlackBerrys and pagers. The Assembly operates bilingually; headsets are available for translation and amplification. I have not been informed of a fire drill this morning, therefore, if a fire alarm sounds, please follow the ushers' advice. That covers the housekeeping arrangements for this morning.

[3] We have two apologies for absence. Sadly, Jeff is unable to make this first meeting; he has a meeting at the Welsh European Funding Office, or whatever it is called these days, and that was unavoidable. Irene James is also unable to attend. Therefore, we are two Members short this morning. However, I understand that Alun Davies and Nick Ramsay are due to join us at some point this morning.

9.14 a.m.

Ymgynghoriad Swyddfa Archwilio Cymru ar Arferion Archwilio
Wales Audit Office Consultation on Audit Practice

[4] **Jonathan Morgan:** The Auditor General for Wales is consulting on audit practice and has provided the committee with an update on the consultation and is seeking the committee's views. The auditor general is supported by Matthew Hockridge, a policy research officer at the Wales Audit Office, this morning. I ask the auditor general to outline the consultation and its main themes and then I will ask Members to respond, as appropriate.

[5] **Mr Colman:** The origin of this document is the regime that applies to the audit of local government bodies. Local government bodies in Wales are audited by auditors appointed by the auditor general. The auditor general does not audit local government bodies directly, but through this process of appointment. For many years, that regime and its predecessor have provided for the auditor general to issue a code of guidance to the auditors of local government bodies. The basic idea is that those audits should be conducted in a consistent manner, although the auditors might come from a variety of sources: my staff or private firms. When I took up my appointment nearly five years ago, I decided that if it was a good idea for local government auditors to be consistent between one and another, it was just as good an idea for the auditors of other public bodies, not only local government bodies, but NHS bodies and the Assembly Government and its offshoots, to be consistent. So, I applied the code to my own work.

[6] The code that we started with in 2005 has been overtaken by events, in a number of ways, most particularly by the changing legislative background. That meant that we were required to revise the code. The draft code that is before you is strikingly different from the

original code. We have taken this opportunity to rethink our style and approach. It is a code that is based on principles, so there are no rules here, but principles that the auditors must follow. We are currently undertaking a process of consultation, and when it is concluded at the end of January, we will consider any points that have been made, particularly any point that has been made by this committee. We will amend the draft if necessary and then, in March, a Minister will lay the document formally before the Assembly for approval. Subject to that approval, the code will come into force with effect from 1 April this year and so the financial year that follows.

[7] This is not the most interesting document that it has been my pleasure to present to this committee. I will be happy to receive any comments that there may be, but the committee need not feel ashamed if it does not find that it has much to say. The draft has been extensively consulted upon already, in fact, and reflects a number of points that have been made by Assembly Government officials and the firms that I employ to do audit work. So, this is an advanced draft; I will be grateful for any comments, happy to answer any questions and I hope that you enjoyed reading it.

[8] **Jonathan Morgan:** I have a brief question before I open this up for discussion. As a code of audit practice, does this differ in any way, shape or form from other codes of audit practice elsewhere in the UK?

[9] **Mr Colman:** It does. It is much simpler. We took the decision to base it upon principles that are clearly stated and readily comprehensible. It contains much less technical detail than our previous code or the comparable code issued by the Audit Commission in England. In the consultations that we have conducted so far, we have found that this new approach has been very much welcomed. So, it is different, and we are proud that it is different.

[10] **Michael German:** May I follow that up? Are you the first regime to adopt a principles-led approach? If that is the case, can you give us some idea of where these four principles come from?

9.20 a.m.

[11] My second question relates to matters that were raised in previous meetings. Given that you have a set of principles according to which you audit other people, is there or will there be a document that contains a set of principles on how you are audited?

[12] **Mr Colman:** On the first question, although the approach in this code is new, in the sense that it is principle based rather than rules based, the principles themselves are widely accepted. They reflect the work of an important organisation that not many people have heard of—the Public Audit Forum—which brings together the public audit bodies of the United Kingdom. These principles are, therefore, consistent with the principles that are operated by my colleagues in England, Scotland and Northern Ireland, but we have chosen to present the code in a different way. It is an issue of presentation rather than content.

[13] With regard to the principles that apply to the audit of my own organisation, that is a matter for my auditors, as and when they may be appointed. I am sure that they will be applying accounting standards and the principles of public audit that apply to all public bodies, but that is their business, not mine.

[14] **Michael German:** Do we know when and how that process will take place, because that was an issue that was raised before?

[15] **Jonathan Morgan:** I intend to raise the issue of the appointment of the auditors in

the private session later on. Some work has been done on that and I will be able to update the committee on where we are and the timescale for appointing the auditors.

[16] **Sandy Mewies:** If we look at the specific code, it is variable depending on which body is going to be audited, the size of the body and the amount of money that it has. Who makes the decision for that variation to take place? Is there a sort of bar? I may have missed the answer if it has been given previously, but I do not know how the organisations are categorised.

[17] **Mr Colman:** The decision is made by the auditor, which, in the case of NHS and Assembly Government bodies, is the auditor general in legal terms. My senior staff who are responsible for those audits would take the decision on a consistent basis. For local government bodies, the appointed auditors would take that decision. There is scope for more variation in the requirements that are placed on public bodies for financial reporting. That is not wholly under my control and, indeed, it is largely not under my control. The Assembly Government specifies the accounting requirements for NHS bodies and its public bodies. In some cases, those requirements could be relaxed without any loss of assurance and there would be an economy saving there. There would be not only less audit work, but less accounting work for the bodies to undertake. The direct answer to your question is that the code is applied by the auditors and they could consult my technical staff on how to do that.

[18] **Bethan Jenkins:** May I clarify with whom you have been consulting on this particular document? You mentioned that you have been consulting widely. Were there any problems with breaking this code? Were there any questions as to whether those principles were adhered to by your office? What processes would people follow to raise any concerns?

[19] **Mr Colman:** Matthew will tell you who we have consulted, as I do not have the information at my finger tips. On your question about what happens if someone thinks there has been a breach of the code, that would be dealt with under our complaints procedure. The regime that we operate in Wales is a mixed one, in which some of the audits are carried out by appointed auditors and some are carried out directly by the auditor general. There will be slightly different mechanisms for raising any concerns about failure to follow the code. Frankly, I would be astonished if there were any departure from the code. I do not believe that there is anything controversial in it and I do not think that there is anything that any appointed auditor could for a moment be tempted to depart from.

[20] I am the regulator of the appointed auditors, and I keep their noses to the grindstone as best I can. As for my own staff, I keep their noses to the grindstone as well, but by a slightly different mechanism. Matthew will now say who we have consulted so far.

[21] **Mr Hockridge:** We have consulted most of our audited bodies in Wales—that is, unitary authorities, national parks, Assembly Government sponsored bodies, and the Cabinet of the Welsh Assembly Government. We have also gone broader than that and included the Public Audit Forum, which Jeremy referred to. We have consulted other auditors in the UK, such as the Audit Commission, Audit Scotland and the National Audit Office. In Wales, we have also consulted our fellow regulators on the heads of inspectorate forum. So, it was a very broad consultation indeed.

[22] **Jonathan Morgan:** There was one suggested amendment from the Chair. Under the section on value for money examinations and studies, paragraph 28, it talks about the discretion that the auditor general has and what he will consider when deciding what work is to be undertaken. It talks about levels of public interest, the scale of the issues, and so on. Bearing in mind the recommendations of the peer review, might it not be helpful to have a line to indicate the consultation that takes place between you and the Assembly's Public Accounts Committee?

[23] **Mr Colman:** Thank you for that suggestion; it is helpful.

[24] **Jonathan Morgan:** Are there any other points on this section? I see that there are not. Are there any other points on the rest of the document? I see that there are none. Thank you very much indeed; that was helpful.

9.27 a.m.

‘Gofal Heb ei Drefnu: Datblygu Dull o Weithredu ar Sail Systemau Cyfan’—Briff gan Archwilydd Cyffredinol Cymru
‘Unscheduled Care: Developing a Whole Systems Approach’—Briefing from the Auditor General for Wales

[25] **Jonathan Morgan:** Members will be aware that the report, ‘Unscheduled care: developing a whole systems approach’, was published on 15 December 2009. To bring our new Members up to speed, I will just explain our usual practice when dealing with these reports: a report is submitted to the Assembly, the report comes to this committee and the auditor general provides a brief on it, and then we are able to ask questions on it before deciding what to do with it. The committee can pursue a number of options at the end of the briefing and I will run through them a bit later on, once we have had a chance to go through the report. I invite the auditor general to give his briefing.

[26] **Mr Colman:** Thank you, Chair. This report summarises and pulls together the findings of various reports on ambulance services and other discrete, but interrelated reports, on a suite of studies in this important area. They include a study of NHS Direct, patient handovers at accident and emergency departments, and other work on delayed transfers of care.

[27] This is an important subject, and we decided, unusually—I do not think that it has been done before—to issue a suite of reports, culminating in this one on this important area. We did that because our original work on the ambulance inquiry in 2006 brought home to us strongly that there were systemic issues that needed to be looked at. You could not sensibly look at the ambulance trust in isolation, as it is part of a system. Some of the features of the ambulance trust that give rise to concern are driven by circumstances outside the control of the trust itself. For this reason, this has been a complicated piece of work, and it was an ambitious thing to take on board. I hope that the committee will find it helpful.

[28] As regards the findings of this particular report, my colleague, Rob Powell, will give a bit more in detail in a moment. We had some difficulty, I must say, in conveying quite what we meant to say here. The report will strike you, I think, as being critical, and it is intended that you should regard it as a critical report. The criticism is that, despite the fact that unscheduled care copes with an enormous volume of work and is, generally speaking, greatly appreciated by the patients and others who have dealings with it, the system as a whole is not very coherent. That sounds like a heavy criticism. It needs to be looked at in the context of unscheduled care generally in the NHS in Great Britain. The system is not very coherent anywhere in the UK and that is not surprising because it was never thought of, or designed, as a system. In a way, it is therefore unsurprising that we have found that the system is not coherent. That is possibly a slight excuse for the situation that we found.

9.30 a.m.

[29] What can be done about it? In recent months, there have been some extremely encouraging signs of the Assembly Government commissioning work to look at these issues

as a whole-system issue. It is far too early to say whether the answers that are emerging from that are the right ones, but as an auditor, I take great comfort from the fact that it has now been recognised that this is a whole system that needs to be looked at as such, and reformed as such. We hope that this report will draw attention to the areas where those changes are needed. Let us hope that the Assembly Government and others will be able to take the opportunity of the restructured NHS to drive improvements through in this important area of NHS business. Rob can now give you a bit more detail.

[30] **Mr Powell:** I will give you a little more detail on the work that we have done on unscheduled care. Members will recall that you have already considered reports in this series of work on ambulance services and patient handovers at accident and emergency departments, NHS Direct, and delayed transfers of care. This report pulls all of that material together at the whole-system level, as Jeremy said.

[31] I will just give some facts and figures to start with. 'Unscheduled care' is not a particularly well-understood term across the system. It really means any unplanned health or social care activity in the form of help, treatment, or advice given urgently or in an emergency situation. It has a close relationship with scheduled care, and the boundaries between the two are not too clear. Scheduled care is planned, non-urgent health or social care, but the two are interrelated.

[32] On page 5 of the report, you will see a diagram that we have used throughout this project. It has been on our website. It attempts to show the range of services that are available to citizens, with the citizen at the centre in three concentric circles. The closest to the patient are services that are available remotely, for example by telephone, such as NHS Direct or a 999 call. The second band involves services that go to the patient, involving either a GP or a health visitor calling, or an ambulance going to pick that patient up. The outer circle represents the patient going to a service, such as an emergency unit or a minor injury unit. The diagram demonstrates the complexity of the range of services that are available, and also the fact that patients may access one or several of those services in the course of a single episode. That is important to bear in mind. It is a very difficult and complex area, as Jeremy says.

[33] I will give you some of the facts and figures involved. We estimate that there were just over 2 million contacts with unscheduled care in 2008-09, with about 1 million attendances at emergency units or minor injury units at hospitals, at a cost of around £100 million for the accident and emergency departments and about £20 million for the minor injury units. There were just over 500,000 calls to GP out-of-hours services. A little over 300,000 calls were made to NHS Direct, which cost £9 million. Some 360,000 urgent or emergency calls were made to the ambulance service, at a cost of around £100 million. So, you have 2.2 million contacts as a minimum, and we estimate the minimum spend to be around £250 million annually, just on the discrete, easily identifiable components of unscheduled care. More services are available, of course, which you might define as being unscheduled care. On top of that, 2 million people a year contact their GP practice, and that can involve a mixture of urgent and non-urgent cases, depending on how easily they can get an appointment when there is an unexpected need.

[34] The policy context was first set out in February 2008 with the Assembly Government's delivering emergency care services strategy, sometimes known as DECS. That has been developed further in recent months through the emerging primary and community services strategy, which is the strategic delivery programme that covers scheduled and unscheduled care. It is designed to move away from what could be described as a 'push system', in which people are pushed into more acute forms of care and then pushed out again, to a system that pulls patients through in a more coherent manner. The diagnosis in that strategy is consistent with what we found over the course of this programme of work. So, that

is the background.

[35] I will take you through the major conclusions in more detail. We looked at whether there has been sufficient progress in the planning and delivery of unscheduled care. We concluded that the services help a large number of people with very different needs, and are highly valued by the Welsh public—there is no question about that. Over the last couple of weeks, citizens and services have experienced problems due to the appalling weather, and what we have seen shows the commitment and service that is provided at such difficult times, when people are extremely vulnerable. Having said that, there is growing momentum to change the system, but partners still face several short and longer-term challenges in making this complex system work in a more coherent fashion. Those challenges are really quite difficult.

[36] A lot of money is tied up in unscheduled care. Given the severe financial pressures that public bodies face—in the health service, local government, and the third sector—the report provides a platform for some more radical thinking about new ways to build on the strengths of the existing system, and to provide a more coherent design and model of services in order to improve the use of resources and to provide better outcomes for citizens.

[37] The report has two parts. Part 1 is the diagnosis; it starts off by talking about the wide range of services that the unscheduled care system provides at all times of day and night. People are, generally, able to get help when they need most it. There is a wide range of services—as set out in figure 1—and specialised staff, who are very well regarded by the public. We invited members of the public to provide us with comments on the system, and we drew on previous academic research. Boxes (a) and (c) on pages 19 and 22 give some examples of those positive views, from Welsh citizens, of the services provided.

[38] Nevertheless, the overall pattern of services can be quite disjointed, which can result in inefficiency, uncertainty and delays for service users. The committee has already seen some of that. For example, the patient handovers work showed the amount of ambulance capacity that is lost in Wales when ambulances are unable to turn around quickly enough when they drop patients off at the emergency unit, which has knock-on consequences throughout the system in respect of the supply of services as well as the demand. There are issues relating to getting into the accident and emergency department that result from the volume of people being transported by the ambulance service and the number of people turning up at the emergency unit, some of whom do not necessarily need that level of care. There are issues with delayed transfers of care, and the back door of the hospital is as relevant to unscheduled care as the front door. This issue is about the flow through the entire system, from people's first contact with an unscheduled care service from the discharge at the back door of the hospital. It is clear that some of the problems with discharging patients relate to problems at the front door of the hospital, that is, getting people in to the system in the first place.

[39] There can be delays in assessment and treatment, particularly in areas such as mental health and local authority services, which often have a significant impact in keeping people independent and helping them at times of crisis. If there are gaps in local authority services, that can have an impact on NHS services. It is those sorts of links that are relevant here.

[40] There are some gaps. There has been quite a lot of work to develop what are called 'patient pathways', which are standard routes through the system that bring together the different services. They are quite inconsistent, both in their development in different parts of Wales and in the understanding of patients and professionals alike of how to use and access them. An example is whether paramedics can easily access a pathway to take a patient through a different route through the system, as opposed to automatically going to the accident and emergency department, which might already be under severe pressure.

[41] In some cases, there are gaps in community-based services—in social care and NHS services—which make it more likely that patients will default to more acute settings, such as the accident and emergency department, when their needs could be met elsewhere. There are real opportunities to develop the workforce, and there are new and extended roles for nurses, paramedics, general practitioners and pharmacists in supporting patients close to their homes. However, the level of development of those roles is mixed. In particular, there has been fairly slow progress in developing more clinically driven roles in the ambulance trust to enable paramedics to see and treat patients without transporting them to hospital or to treat them and refer them on to another service. So, there are opportunities for more autonomous decision making at that level.

9.40 a.m.

[42] Chronic conditions are a key issue here as well as social care. There is scope for more upstream preventative work on unscheduled care to try to tackle problems before they become more acute. That could help to spread the demand more evenly within the system.

[43] There is quite clear evidence, set out in the first part of the report, of preventable demand or demand that presents in potentially the wrong part of the system. The Welsh Ambulance Services NHS Trust has a high proportion of category A calls relative to English trusts, which increases the pressure on it and on the number of patients going to accident and emergency departments. Until a recent change in policy from the Assembly Government, it was routinely transporting category C patients who, through clinical-desk-type services, could potentially have been supported at home or in a different way and without a blue-light ambulance response. That, again, could have helped to spread the demand more easily. There is fairly clear evidence that the public and professionals alike are not always clear about what the appropriate level of service might be for their needs and the report contains a couple of case studies from England of some quite innovative approaches to try to communicate clearly to the public the type of level of service that they should access for different types of needs.

[44] We looked at out-of-hours services and appendix 3 provides some detail on that in relation to primary and social care. The key conclusion there is that the system is particularly disjointed out of hours and, quite often, services simply try to keep people safe until routine services are available in the morning. Sometimes, that distinction between scheduled and unscheduled care can be unhelpful because it does not necessarily reflect the needs and demands of the person trying to access a service. That is part 1 of the report.

[45] Part 2 of the report covers the future: the growing momentum for change, which I mentioned earlier, and some of the shorter and longer-term challenges across the system. There is some encouraging news because, following the committee's consideration of patient handovers at accident and emergency departments, there is some evidence that compliance with recording the touch-screen data is improving and that the level of capacity lost by the ambulance trust through excessive handovers has reduced. Although I think that it is quite early to draw a really clear conclusion about that, there were some encouraging early signs.

[46] In some parts of the world, there have been some very encouraging developments in co-locating different, unscheduled care services to try to pull together a more coherent and single point of access into the system, which offers considerable potential. NHS Direct is improving its impact by helping people to look after themselves at home without necessarily accessing other parts of the system. However, there is a long way to go to clearly set out the strategic role of NHS Direct in the wider system.

[47] The challenges relate to clarifying the number of areas where greater national guidance would be helpful. There is a real tension here that Members should be aware of

between overspecifying centrally what the system should look like and providing sufficient local flexibility to design services and a model that meets local needs. However, as regards the development of paramedic and nursing professions, trying to align the health and social care workforce, trying to achieve continuity between scheduled and unscheduled care, sharing information between services and clarifying the role of NHS Direct, there is scope for some more national guidance. However, there is a need to be careful not to overspecify at the national level, particularly with seven health boards that have much more critical mass and ought to be able to develop systems more easily and learn from each other much more effectively than was the case with a larger number of organisations all trying to commission and provide.

[48] The report also highlights the scope for partner organisations to achieve a more clear joint commitment to improve the coherence of unscheduled care as a system. As part of this project, we have issued a leaflet for local service boards that might have a role locally, if aligning health and social care is a priority for them, in helping to overcome some of the barriers, but that is obviously a matter for local service boards, which set their own priorities. We have produced this document that sets out some of the implications that they might wish to consider if that is an issue for them.

[49] Clinical and managerial leadership will be critical. That is something that those providing front-line unscheduled care services will need to be centrally engaged in delivering. There is scope to gear up public engagement work to help the public to understand the system more clearly.

[50] The other key points are the fact that there is probably not sufficient understanding of demand for services within the system. Services certainly know the level of activity for different parts of the system, but very much on an episodic basis, without necessarily understanding what people needed across the various services, and whether or not that demand might have been better met through a different type of service.

[51] There is scope to improve the way that the system learns and improves. The performance management regime has some very important targets, but they are characterised by the speed of access. That is important, and those targets have helped to improve access at accident and emergency departments, for example. However, that only tells part of the story. Quality, outcomes and the overall experience for the patient in getting better are arguably as, if not more, important as the speed with which he or she might access parts of the system. The different targets may apply serially to the same person, in trying to get help in different parts of the system for the same episode of care. So, we highlight in the report the scope to provide a more balanced view, and we also highlight that the ambulance trust has set its own measures on how quickly it responds to those with chest pain or experiencing a cardiac arrest. The trust is measuring a four-minute response time for those cases, which is a clinically driven measure of success, and not a nationally set central target. That is a useful counterbalance to the important eight-minute target that it is also chasing.

[52] We have also made a number of recommendations in the report about public engagement and improving access to unscheduled care, studying the system to understand the demand and opportunities to deliver a more coherent system and better outcomes. We have also made some recommendations about the delivery of unscheduled care on the ground.

[53] That is all that I want to say, but I am happy to take any questions.

[54] **Jonathan Morgan:** Thank you, Rob; that is much appreciated. Mike German has the first questions.

[55] **Michael German:** Thank you for what is an overwhelmingly interesting report.

Having gone through a number of other steps on the way, the report brings it all together. It has been a long route—it has been something like four years since this suite of audits took place, and we are now getting to grips with the situation. One of the points that Rob made, which is fundamental to all of this, is about the balance between central direction and local action. I refer to paragraph 23 and your recommendations in paragraph 6(a) on page 15. You would think, if there was dysfunction—the fact that this committee and you have been at it for four years indicates that there must have been some dysfunction—it would be down to the central Government to give some sense of purpose, direction and shape to what is happening. I note in paragraph 23 that you say that the delivering emergency care strategy—which is the overwhelming route-map by which people should progress—has been criticised by the stakeholders, that is, the operators, for not providing enough prescription. You have talked about balance, so can you identify how far the balance needs to move to satisfy the overarching ambition of giving enough direction for people to operate, and for local circumstances to be met? That seems to be the key action for Government. I wonder whether you would agree that that is the starting point.

9.50 a.m.

[56] Secondly, as I always like to pick up on a word that is being used, and ‘growing momentum for change’ is in big, bold typeface on page 9, so it must be important. Where is that momentum coming from? Is it momentum from all of the partners, from every respect, and if there is momentum, what is the voice for that momentum to take place? In other words, where does the momentum reach its core? Where do people come together and where can they influence the change that they are all anticipating should happen?

[57] **Mr Colman:** I will try to give a broad answer to that and then Rob will give more detail and no doubt will correct me if I am wrong. It is not quite as simple as a tension between central direction and local discretion. As we both said, the crucial element that needs to be understood about this subject is that we are looking at a whole system that has not been designed as such. Therefore, it is pretty well certain to be dysfunctional; and worse than that, what appeared locally to be good ideas could make matters worse because of the effects elsewhere in the system. The first step of wanting to do anything about the situation, as one should, would be to ask what a whole system would look like. Ultimately, that is something for the Assembly Government itself to decide. It would be crazy for it to decide it in isolation; it would need to engage thoroughly with all stakeholders to work that out, but you also need, in private, some clear thinking along the lines of what the whole system looks like.

[58] We have referred in the report—as I have also done—to encouraging developments. I see it as an encouraging development that the Assembly Government commissioned work from Dr Chris Jones and the team to think about what the whole system should look like. That is an excellent first step. I believe that the principles that he and his team have developed are widely accepted as a good approach to a whole system. That is the good news.

[59] The difficult bit is that moving from where we are now to seeing this aspect of the NHS as a whole system will require considerable change, and we all know that change is difficult and painful, even if everyone recognises the need for it and why it is happening. So, that is the area that I would be most nervous about, and where I would see the greatest barriers to improvement. The degree of change needed to look at this as a whole system is quite considerable. It may be deliberate but the new structure of the NHS is very helpful. It has reduced the number of bodies concerned and integrated a large number of functions in a small number of large bodies. That is a good first step in preparing the ground for change, but the next step is to translate the thoughts about what the system should look like into what it means for institutions. That is the difficult bit.

[60] **Mr Powell:** Perhaps I could add to that. I think that the two questions are linked. The

balance of what is prescribed nationally, and this scope and space for local organisations to study the local situation to understand demand and to design the system, fits in with the growing momentum. The Assembly Government needs to do more in some areas and a bit less in other areas to try to help local organisations to have the space to develop their system. There are clear policy issues around how the paramedic and nursing professions might develop. That is an area where it makes sense to focus nationally. There are issues about how to align the health and social care workforce and perhaps encourage more pooling of budgets and use of section 33 agreements.

[61] If there is a clear local vision, that is a good idea, and there has been very little take-up, as the report says, of those sorts of health flexibilities. The role of NHS Direct is an issue where some central policy might be helpful and overall national planning and development activity through the new health boards and the new integrated planning model is another area where there is work going on and where the role of the Assembly Government would be helpful. Many of the developments of different models of service, some of which are highlighted in here, tend to be funded through grants or short-term funding, and that makes it much more difficult to fit them into the system. It is rational in many ways because rolling them out is a way of testing whether the models work, but some of those services are often focused on whether the funding is going to carry on and they never quite get integrated into the system.

[62] On the growing momentum, that has come from the Assembly Government. There has been a real focus on simple, immediate actions that can be taken to improve the functioning of the system at a local level and a lot of pressure on the NHS and social care organisations to do that. That is helpful, and as Jeremy said, the primary community services strategic delivery programme is similar in diagnosis to this report and provides a blueprint that local bodies can take forward. However, there is a need locally for organisations to understand their own system more deeply than they do at the moment and to work out the best way to meet local needs given the variety in Wales. There is certainly a need to have a less hospital-centric approach and to engage more clearly. You talked about the voice; the ambulance trust has been inconsistently engaged in the past. With seven health boards rather than 22 and the providing trusts, that should also be much more straightforward to manage. The ambulance trust is developing its strategic capacity. Primary care has been inconsistently engaged, and it is central to dealing with this issue and to the new strategy developed by Dr Chris Jones. Local government also needs to be at the table—its services are very important in this context and are often forgotten. This report attempts to bring in the work of local government, both in providing and commissioning services for vulnerable people who may have unscheduled care needs. There is a raft of issues there.

[63] **Michael German:** Just to clarify, you said, Rob, that there are areas where the Government could do more and, as you said earlier, there are areas where it should do less. Will you give us a quick resume of where the Government should do less?

[64] **Mr Powell:** The issue of grant funding or short-term funding would help organisations to design a more holistic system. There are also areas where the Assembly Government is addressing some of the things in the report to try to develop a better suite of measures in relation to the functioning of the system. Rather than just having simple targets related to access, it is working on something called the intelligent targets group to provide a better way of measuring the success of the system. That will be another area where work is ongoing.

[65] **Jonathan Morgan:** Jeremy, do you want to add anything to that?

[66] **Mr Colman:** On the subject of targets, this is an area where my point about what seems to be a good idea locally might be bad when considering the system as a whole. I did

not just mean locally in the sense of a geographical area; I meant a local intervention. So, if the Assembly Government chooses to set a target for some process in the middle of the system, that is a potentially dangerous thing to do and should not be done without careful thought as to the consequences. It is well known that targets can give rise to perverse incentives and it is a bad idea to set a target without thinking through carefully what it would mean. Hence, the intelligent targets work.

[67] In a perfect world, you would not think about intelligent targets until you had redesigned the system because until you know how the system is supposed to operate, you cannot know what targets make sense. However, it is better to have intelligent targets and an imperfect system than unintelligent targets and an imperfect system.

[68] **Lorraine Barrett:** When I think of unscheduled care, it starts with the patient. The comment that caught my eye, which is in the box on page 20, was someone talking about a point of contact that could filter their query.

10.00 a.m.

[69] I had written down the one-stop-shop idea earlier. However, listening to Jeremy talking about the fact that the Government will have to start thinking about redesigning systems, you think about the telephony and IT systems that would have to be addressed, and wonder whether we would end up with one big, cumbersome IT system. We have heard those stories from other Government departments. There is no one-size-fits-all solution either. In many respects, it starts with the patient with regard to education as well. It is difficult because, as we have discussed in this committee, you can speak to three or four different departments before you get told to go to the accident and emergency department anyway, by which time you have spent an hour using all those resources when perhaps you could have just gone to the accident and emergency department or made one telephone call and had more guidance. I do not have any pertinent questions, just those thoughts about the whole system change that might be needed. I was pleased to hear what Jeremy said about the fact that the Government is looking at this now. I presume that it is for us then, Jonathan, to decide where we take this, but it will not be easy.

[70] **Janet Ryder:** To pick up on something that Lorraine mentioned, were you able to assess the impact of altering the out-of-hours service? Anecdotally, that had a huge impact; if you talk to people in the district general hospitals in north Wales, they say that it did not just increase the workload of the out-of-hours doctor service at the hospitals, but also the emergency services. Therefore, it has led to an increase in the number of people who may inappropriately be attending at emergency services. You have looked at what is happening now, and you say that we have never planned for it, and the ideal would be to start with a nice, clean sheet of paper, which we cannot do. However, the alteration in the out-of-hours service is an example of one particular shift in service delivery having, anecdotally, a huge impact on emergency services within hospitals.

[71] **Mr Colman:** We have not looked specifically at that issue, because that would have required us to do some audit work before the change to the out-of-hours system in order to make a comparison. Just a couple of remarks: a few years ago, one of the drivers of the removal of the requirement for general practitioners to provide an out-of-hours service was a new contract that was designed to reduce the amount of work that they do while increasing the amount that they are paid for doing it. That sounds like an odd thing to want to do, but it is not odd if you are having trouble recruiting GPs, which was the perceived problem. One of the consequences of that change, however, is that the out-of-hours service is now being delivered by someone who will not generally know much about the patients they are seeing. That is in contrast to the previous arrangement whereby, more often than not, they would know something about the patient. The question of how the unscheduled care system can

know enough about the patient to be helpful is one of the issues that Dr Chris Jones has been looking at, and he has some interesting ideas about that. Going back to Lorraine's point, supposing that you were to say that a one-stop shop would be a good idea—and it might be—there is then a big question about the shop assistant, as it were. Should the shop assistant be someone who knows where services are, or someone who knows something about the patient? You could design around either approach. In other areas where systems thinking has been applied, it is often a good idea to have some expertise at the front line, rather than a post office. Whether that would work in health, no-one knows; whether it would be feasible to do it given the IT issues that Lorraine mentioned is also unknown. So this is a very difficult area.

[72] **Janet Ryder:** The report discusses the better alignment of GPs' hours with service demand. How much of that is coloured by what you have just said?

[73] **Mr Powell:** The report says that most people find it reasonably easy to gain access to their GP in-hours, but a minority have some problems. There are variations, for example, in home visits, and so on. A lot of the evidence is anecdotal. Without getting into the individual cases, it is difficult to assess. So, the report recommends a local analysis of demand for primary care; what people are presenting for; and whether people are presenting at accident and emergency departments when they should have gone to see the GP out-of-hours service. Then, by gaining a proper understanding of what is happening on the ground, we can look at ways to improve the system. That is the optimum way to tackle that particular issue because the evidence that we have is anecdotal.

[74] **Janet Ryder:** Given that, you are calling for a major public education campaign, are you not, on how to access the services, and where to access them in a way that is appropriate to your need? How fundamental is that public information campaign to making this work?

[75] **Mr Powell:** It is part of it. Case study K, which has been on our website for about 18 months, is of an initiative called Choose Well, from Knowsley, which is being piloted in north Wales. This has used quite a sophisticated communications approach using a thermometer brand with six levels of care to try to help patients to understand when and how to access the different levels of service. That has had some encouraging results and has rolled out like wild fire in England. To my surprise, I was behind a bus in Birmingham two weeks ago that had a poster advertising the Choose Well branding. So, it has also hit the west midlands now. Done well, that is important.

[76] What we also know from research is that patients generally want to access the most appropriate form of care. That is their overriding concern. It is certainly not the case that most patients are deliberately or wilfully accessing the wrong level of service within the system.

[77] **Jonathan Morgan:** Would you say that the problem we have is that we are dealing with human nature and, at the point at which you need some medical assistance—whether it is absolutely urgent and you need to be at an accident and emergency department, or you need to see a doctor, or whatever it might be, such as needing to get social services involved—people can go into a state of panic and so human emotion overtakes what should and could be an informed decision about the most appropriate way of accessing unscheduled care? Although I sympathise with the concept of better information campaigns and communication, ultimately you have that particular sticking point that is difficult to overcome.

[78] I would like to ask a quick question about timescales. This is a significant piece of work with a substantial number of recommendations. You have said that there is momentum for change and you said in part 2 of the report that there has been some progress in addressing some of the more immediate problems. However, if the Assembly Government was to respond to these recommendations, over what timescale would you expect to see some real change in moving the system towards a more coherent arrangement? I presume that you will

be keeping more than just a watching brief on this.

[79] **Mr Colman:** On that last point, you are absolutely right; I would be failing in my duty if I did not take a very close interest indeed in this aspect of the NHS. Huge amounts of money are potentially not being spent as wisely as they might be through the way the system has evolved rather than been designed. It will take a very long time indeed—it will certainly not be within my term of office as auditor general—before an audit report could say that unscheduled care is working really well in Wales. That is not a criticism of the arrangements in Wales; it would be true everywhere.

[80] What is capable of being done relatively quickly is agreement on the direction of travel and a strong drive and understanding that that is what will happen. So, for example, on the issue of educating patients, if the system were not going to change at all, you could get big improvements—subject to your point about emotion—by making sure that everyone is really well informed about where they ought to go when they have a problem. They might not get it right every time, but they will get it more right than they currently do. That would be an improvement. However, if you are changing the system at the same time, you are also changing where they will have to go. So, having educated them all, in a few years' time, you might have to re-educate them all. This illustrates that, if we could start afresh, which we obviously cannot, one's approach would be quite different from what we have to do now.

[81] Our recommendations are therefore a mix of things that can be done very soon with things that will take much longer to do. I would expect that, well within my term of office, we would be following up what is happening here. This is something in which I take a close interest. It would be really nice to see the Assembly Government committing itself to a particular direction of travel. It is not for me to tell it what it is, but it is a good step to say that it sees it as a system and wants to review it as such. Implementing those changes is a long-term exercise.

[82] **Jonathan Morgan:** Thank you. There are three brief points from Nick Ramsay, Janet Ryder and Sandy Mewies.

10.10 a.m.

[83] **Nick Ramsay:** Thank you, Chair. I have a quick question relating to paragraph 1.65 on page 40, about the section on NHS Direct Wales services. Bizarrely, it says that some people might contact NHS Direct if they want to retain their anonymity because of the lack of information sharing with other organisations. That page also refers to the question of whether greater sharing with general practitioners would assist the operation of that service. Can the auditor general tell us, if he is looking ahead to that perfect utopia of unscheduled services working well, whether he sees NHS Direct remaining as a stand-alone system, or whether he sees that there is scope and a need for it to be incorporated into the whole NHS system in general?

[84] **Mr Colman:** The merger of NHS Direct with the ambulance trust was a move in the right direction. The benefits of that merger, which have been recognised by the ambulance trust, have not all yet been captured, because it takes time—and that is not a criticism. There are things that they can do that will improve the integration of NHS Direct with the emergency ambulance services. A central point—a single telephone number—has a part to play in improving the service, but I cannot express a view on exactly how that will be done. It comes back to the issues that we were discussing a few moments ago about how much information the person who takes the call has about the patient, what is recorded and what happens to that information. They are difficult issues, but the concept that NHS Direct could play a significant role in steering people in the right direction is a sound concept. The detail of how to do it, where there are a number of choices to be made, requires quite considerable

thought.

[85] **Janet Ryder:** You mentioned that the report considered unscheduled care as a result of social care and mental health issues, not just clinical issues. So, to what extent do we need to consider the impact that local government and the services that it offers has on this issue?

[86] **Mr Colman:** It is essential as it is part of the system and needs to be considered as such.

[87] **Sandy Mewies:** Please forgive me, but I am still feeling my way around this committee. I can see that a lot of work has been done on this issue, but I am not clear on what you were saying about educating the public, because the Knowsley example, which seems to be a good, focused and quite simple way of doing things, has concentrated on one area. There is an indication that there is a need for consistency across Wales. You refer to the need for commonality in triage assessment and so on. How are you going to achieve that? You were talking about educating the public, and I, a bit like Jonathan, feel that people who have never accessed an emergency service before have no idea where to go, and, for many people, approaching social services is their very first contact with social services as an emergency service. I am unclear on whether you are saying that you can educate the bulk of the public in the bulk of the information beforehand, or whether what you must think about is the point of access and the sort of information that is accessed, and whether there is a medical input or a case of someone who is just signposting. So, the two issues that are important if you are looking for consistency are the triage and assessment systems and the information that is given out. Can you clarify that for me?

[88] **Mr Colman:** I will need some help from Rob on this issue. I will first consider what I hope will not be the case, which is that the system in Wales does not change at all. There could be an improvement, however, even in that unsatisfactory situation, if a higher proportion of patients knew what they were doing. There will always be some, because it is the first time that they access those services, who will not know what to do, and there will be some who may not get it right because they are upset and because their emotions are aroused and they do the wrong thing in a time of stress. However, we are saying that there would be benefits in a higher proportion of people getting it right. To illustrate what I mean by getting it right, I will use an English example. In certain parts of London, over many years, the local hospital has been seen as the place where you go if you have a health problem. GPs are not in it. People have a GP, but if you have a problem, you go to a hospital. That can be unhelpful, because, in many cases, that is not the right place to go and patients would be better off going to their GP, and to their out-of-hours GP, if necessary. It is that sort of issue that an education campaign can address. On triage, I must hand over to Rob.

[89] **Mr Powell:** The difficulty is that there are many different forms of triage. All of the different services tend to do their own assessment, with some people going from one service to another giving the same information many times without it being shared. That is all part of developing a more coherent model, but you are right that it links into the point about patient education, because if the model becomes more coherent, with a move towards a single point of access, the public needs to understand that point of access and when it should be contacted.

[90] **Sandy Mewies:** The point is also that even if people are educated enough to know where to go, and then they have to go to several places and get different answers, that will not help. I was just clarifying the point; there is no need to respond.

[91] **Mr Colman:** One example of where triage is an issue is what may strike one as a simple question: when you go to the accident and emergency department, who do you see first—a secretary, nurse or doctor? Depending on who you talk to, you will get different answers as to which is the best option. For example, some people believe that a doctor can do

the triage more effectively than a nurse, and, of course, far more effectively than a secretary, and will be able to send people away, saying, 'No, you're not ill. Off you go'. A nurse might hesitate to do that, and a secretary certainly would not do that; it would not be right for a secretary to do that. So, one school of thought is that you should have a doctor at the door. Another school of thought is that you should have a nurse there, while some people say that you need an administrator. So, this is an area where there is no consensus as to the right approach.

[92] **Jonathan Morgan:** I will just point out for Alun and Sandy that, when we consider these reports, there are four usual options, although we are able to revise them if we need to. The first is that we do nothing additional except write to the Government asking for a response to the auditor general's recommendations. The second is that we write to the relevant accounting officer or the Minister, seeking further information, which would be appropriate should there be issues where we wanted further information to be considered. The third is to refer the report to another Assembly committee, possibly a scrutiny committee, and the fourth option is to launch an inquiry of our own should there be significant issues that the committee wished to consider further, and then invite witnesses on the back of that. This is not the first report on unscheduled care that we have considered, because, as Mike and the audit office representatives have alluded to, other reports on unscheduled care have already come to this committee, and this draws together that work. I have a preference as to what we should do with this report, but I am keen to hear the view of other Members at this point.

[93] **Janet Ryder:** I know that the pressure on the work of this committee is great, but I think that this warrants further review, particularly the aspects to do with local government. We have reviewed the health service aspects a lot, and the response has often been that getting people through accident and emergency departments into ordinary wards is hindered because ordinary wards are full as a result of their being unable to discharge patients because the social service care is not in place. Social services can impact a lot on front-line emergency services. When social services cannot cope, people are referred to accident and emergency departments, perhaps inappropriately. We should also consider the raft of mental health emergency services, which may not be being picked up appropriately. It would be worth investigating further how health and local government services need to work much more closely together under this review.

[94] **Lorraine Barrett:** I wonder whether it would be useful to have an update from the Government in the light of what Jeremy said is already in place, so that we get an idea as to what is happening, as a first step. I am quite relaxed about it, but I would be interested to know what your thoughts are.

10.20 a.m.

[95] **Michael German:** This is the culmination of a substantial piece of work, and without fear of Jeremy becoming old and wizened, as he alleged earlier, the key questions are whether the key people who can influence this matter are on board with the direction of travel and do they have a common direction of travel? Do people see that? It means that an inquiry should be held, in my view, with that specific question in mind. Whether it is should be held by the Health, Wellbeing and Local Government Committee or another Assembly scrutiny committee is another matter, because it may be a subject in which they will be interested. Do you have any news on what their workload is like? Because this is such an important issue and it has taken so long to get at the answers, it must be a subject that merits an inquiry to assure ourselves that everyone is on board with the direction of travel. When Jeremy is grey, rather than wizened, we may reach a conclusion of the work on the whole-systems approach.

[96] **Nick Ramsay:** We will make the auditor general do this, if it is the last thing that we do. I agree with what Janet Ryder and Mike German said earlier. In many areas, this report

has raised as many questions as answers about the direction of travel. There is a multitude of different ways in which we can proceed, but it is good to have a few of those directions of travel in mind, so I support the proposal that more work should be done by this committee.

[97] **Bethan Jenkins:** I agree with Lorraine in that I do not think that we should launch a full inquiry at the moment. We should contact the Government first, because there are two elements to the report: small-scale changes which are process-driven and also larger issues around strategy. Considering the changes that are taking place in the NHS at the moment in relation to the intelligent targets, they have not yet been implemented, so we need to give time for those to bed in before we launch a full-scale inquiry. Otherwise, we may be going over ground that we are not prepared to go over at the moment, so we should be cautionary about when we start this piece of work.

[98] **Jonathan Morgan:** I have a solution that I will put to you. There has been some progress, as the report identifies, in addressing some of the more immediate concerns. The question for us as a committee is within what timescale could we see significant improvement towards a more coherent system? As the auditor general said, I suspect that I will be long retired by the time we reach that utopia. I see the value of undertaking a further piece of work, but, as a committee, we need to be careful in identifying which parts of the auditor general's report that we wish to pursue further. It is a substantial report with a large of number of recommendations, and which looks at a very complicated system of providing unscheduled care. In the first instance, my preference would be to write to the accounting officer asking for a response to the report's recommendations. It may take some time to get a full response, because the recommendations are quite substantial. The intention would be to use the response to determine how we proceed. If we decide to launch a full-scale inquiry, we could begin a significant piece of work; I am not against doing a significant piece work, because that is what this committee is here to do if it wishes. However, we need to have an idea as to some direction. The way to do that could be to get a response from the accounting officer in the first instance, which I suspect will inform us as to how we should proceed more fully. We will have to look at this in some detail, but the question for us is which parts of the report should we look at, and to what extent the detail has to take place.

[99] **Sandy Mewies:** It would seem sensible to evaluate the audits, as they have been going on for quite some time. One would hope that earlier items have been addressed to some extent by now, and your suggestion would mean that things could be evaluated in a better way, and that the way forward could be evaluated in a more accurate way.

[100] **Jonathan Morgan:** We would expect a thorough response from the accounting officer; a one-page letter saying that the Government has noted the recommendations and is working on them would not be sufficient. We would have to accept that some time would be needed for a full response, but we could then examine that and decide how to proceed. The point that Janet made about the level of interaction between health and social care is absolutely critical. Whenever you talk to those people running the acute hospitals—

[101] **Janet Ryder:** I would like to clarify something. Are we going to seek a response from the accounting officer, and will he be able to account for the interaction with local government completely?

[102] **Jonathan Morgan:** Yes.

[103] **Janet Ryder:** So, we are not going to get a response saying, 'No, that is a WLGA thing'.

[104] **Jonathan Morgan:** No.

[105] **Janet Ryder:** Fine.

[106] **Mr Colman:** Just to make an observation, and not in any way to question that proposal or decision, we have referred a couple of times to Dr Chris Jones, and I have seen a presentation that he has developed that could well be a part of any further work that this committee chooses to do, having seen the response of the accounting officer. It is a very good presentation in that it shows clearly how he is looking at this issue as a whole-systems issue. It is not my job to say that he has got it right, but I think that that presentation brings home the benefits of looking at this as a whole-systems issue.

[107] **Jonathan Morgan:** Thank you. That is very helpful. Are we happy with that?

[108] **Michael German:** That was a nod and a wink to us that we should look at that report.

[109] **Sandy Mewies:** I would like to see Chris Jones's presentation. In the past, I have spoken to him about these broader issues for reasons to do with my constituency. I would certainly like to have that presentation.

[110] **Jonathan Morgan:** If we write to the accounting officer first, we will get that response and evaluate it. We can ask for the presentation from Chris Jones and we can decide how to pursue this and whether to pursue it in its entirety, or whether there are certain parts of this that we need to pursue. It is possible that the accounting officer may come back and say, 'We are making considerably more progress now on certain aspects of what the auditor general has discovered, but we are not as far advanced in certain other parts of it.' We will need to determine from that response, and from looking at that presentation, which bits to pursue in tandem. Are you happy with that? I see that you are. Thank you. We have run over somewhat on that, but it is a substantial piece of work and we needed to set the time aside for it.

10.27 a.m.

Gwasanaethau i Blant a Phobl Ifanc ag Anghenion Emosiynol ac Iechyd Meddwl: Sesiwn Dystiolaeth y Swyddog Cyfrifyddu
Services for Children and Young People with Emotional and Mental Health Needs: Accounting Officer Evidence Session

[111] **Jonathan Morgan:** We now move on to the next item on the agenda, which is a report from the auditor general, produced with Healthcare Inspectorate Wales, on services for young people with emotional and mental health needs. We have officials with us this morning, and I will ask them to identify themselves for the record.

[112] **Mr Williams:** I am Paul Williams, director general of the Department for Health and Social Services.

[113] **Professor Williams:** I am Richard Williams, the Assembly's adviser on children's mental health.

[114] **Mr Pickford:** I am Rob Pickford, the director of Social Services Inspectorate Wales.

[115] **Mr Ingham:** I am Keith Ingham, the assistant director responsible for children's health and social services.

[116] **Jonathan Morgan:** I will start with an apology—which is not a good way to start—for keeping you waiting. The previous item overran somewhat. We are grateful to you for

being with us this morning.

[117] I will open with a brief introductory question. The report calls for a national plan to be developed within six months to address the issues that it identified in the availability and quality of services. Such an action plan should set out clear priorities and target dates for all relevant bodies. Is it your intention to develop such a plan, and, if so, will it be available by May this year?

10.30 a.m.

[118] **Mr Williams:** I am grateful for the suggestion that we need a plan to take forward the considerable work that has already taken place and to pick up the pace even further. The answer is therefore 'yes'. I have contacted the chief executives of the local health boards, I am in communication with the directors of social services and directors of education, and I work with my other director general colleagues. Regardless of whether it is a plan or a programme, it is nonetheless an issue of accelerating the priorities that we have and improving the connections between the various organisations and agencies. There is significant work to be done. I would hope that it will be completed by May. It may take a little longer, sir, but I am sure that you would agree with me that we want to do the job properly, and that is my intention.

[119] **Jonathan Morgan:** Will there be a significant delay beyond May of this year?

[120] **Mr Williams:** Until we set the task, it is difficult to say, but I would imagine that we will see significant progress. Clearly, as we have only just finished reorganising the health service and putting key people in place, I will need to take a view from my chief executive colleagues in the next couple of weeks—I am meeting them on Monday to take a view on that. We understand the urgency of the matter, and we are committed to improving these services even further.

[121] **Jonathan Morgan:** I suppose the difference between a programme and a plan could be down to the detail, but would you anticipate that, whether you call it a plan or a programme, it will have priorities, actions and target dates by which those actions should be achieved?

[122] **Mr Williams:** Yes. I would not cavil over the description; I think it is about further achievement of the key priorities.

[123] **Lorraine Barrett:** I am looking at paragraphs 1.13 to 1.17 of the report. Has there been sufficient focus on developing services targeted at those children and young people who are at risk of developing emotional and mental health problems, given that such services can reduce the problems that could develop at some future point? In those paragraphs, the report notes some concern that there is no comprehensive approach to targeting those at-risk groups. Some prevention work is needed.

[124] **Mr Williams:** I will start off, and then I will ask my colleagues to come in, as they are far more expert on this than I am. There is no doubt that we need a range of universal and targeted interventions for early intervention, particularly starting with parent programmes and engaging parents within parenting programmes. We have the work with Cymorth as one example that we need to further develop, and there is Flying Start, too. The *Western Mail* usefully covered the story yesterday of the pilot counselling schemes that will take place in primary schools in Bridgend, Cardiff, Pembroke and Wrexham. Professor Williams can add a lot more than I can on this.

Professor Williams: I have spent the past two to three years looking in particular at the

development of resilience. That is, people's ability to cope with adversity. We will all meet adversity in life, no matter how fortunate or unfortunate we are. We now know quite a lot about adversity from the science. Quite a lot of cross-governmental work has been done in this arena. We know, for instance, that attention to the school curriculum and its delivery is probably one of the most resilience-building things you can do for young people. So, part of the answer to your question lies in the domain of education services. This is a truly cross-cutting issue in other words, and not confined to healthcare. I think that we need to continue to develop preventative interventions across the full range of service sectors.

[125] **Lorraine Barrett:** Can you say something about any progress on developing the early intervention services, which would be cross-cutting services, including education? The report identifies that early intervention services for children who develop emotional and mental health problems are underdeveloped.

[126] **Mr Ingham:** Perhaps I could comment. Mr Williams mentioned Flying Start and some of the programmes under Cymorth. He has also mentioned counselling for primary school children. Equally, we have to recognise the development of counselling services more widely in schools across Wales, funded through the education portfolio. Professor Williams and I have worked closely on the development of that counselling programme to make sure that there are appropriate links to CAMHS and other services, as well as to social services. I was lucky enough to visit a secondary school in Cardiff recently that had been operating that counselling service very effectively, and I talked to the counsellors who operate there. They deal with a considerable number of young people who have a wide range of problems. Some of those children would be defined as being at risk in various ways, as they have difficult family backgrounds and circumstances. They deal very effectively with some of those at that front-line level, but they also make referrals to other services as necessary. It is important that we bring together some of these services more effectively. An objective of any plan or programme that we develop now must be to make sure that those links are not only recognised but strengthened, where necessary.

[127] I would also mention the work that has been taken forward through the Proposed Children and Families (Wales) Measure in respect of integrated family support teams. The approaches in that regard are being pioneered. We have recognised that some of the children who are most at risk—who are living in family environments where there is domestic violence, drug and alcohol misuse, and mental health problems in adults—are also at serious risk in respect of their own health, development and general wellbeing, and are more likely to develop mental health problems in later years. We have to make sure that we make the appropriate links between such programmes, and indeed between the very many programmes that the Assembly has developed and is developing, and that we see them as a broader set of services that will help young people to develop resilience and to get support where it is needed.

[128] **Jonathan Morgan:** Bethan, you had a brief supplementary question on this.

[129] **Bethan Jenkins:** I wanted to come at this issue from the perspective of education and of my experience as chair of the cross-party group on eating disorders. I recently had a meeting with the former Minister for Children, Education, Lifelong Learning and Skills with regard to introducing confidence and wellbeing lessons as part of the curriculum in Wales. I do not know whether that concept was as well received as I would have liked, but I think that there is definite need for that to be embraced by Government. At the moment, there are quite a lot of small-scale plans in schools to encourage wellbeing and self-esteem, which is at the core of stopping the development of mental health problems, be they eating disorders or other problems. At the moment, the Government lacks the drive to embrace new concepts. The local authorities in Caerphilly and Merthyr Tydfil have introduced programmes that have not been introduced across the board in Wales. How serious are you in your plans to address this,

given that the Welsh Assembly Government's education department is not as ready as the Government's health service to embrace this as a way forward for our young people?

[130] **Mr Williams:** As you rightly indicate, education has that responsibility. We are now engaging as civil servants through the directorate-general model, and I am working closely with David Hawker, director general for education, and Emyr Roberts, director general for local government. We meet regularly and, where cross-cutting themes are important, we might major on our area. I know that David Hawker has signalled the importance of this area for the children and young people's partnerships, and he sees it as a priority. We can take this back—and Keith might want to talk a bit more about the detail—but we are mindful of the fact that this is a complex area. The new way in which we are working at the Welsh Assembly Government, as directors general, will definitely help in this regard, and we are continuing to strengthen partnership working between the health service at the local level and local government. Keith might want to come in with some detail.

10.40 a.m.

[131] **Mr Ingham:** The promotion of mental and emotional health is a major aspect of the work carried out by my colleagues in the health promotion area and with the education portfolio in developing the Welsh network of healthy schools schemes. The Welsh Assembly Government accredits local schemes as part of that programme. I understand that all 22 local schemes have been accredited. More than 1,700 schools are actively involved in the local network of healthy schools schemes, and the education department's objective is to involve all maintained schools in that programme by March 2010.

[132] **Bethan Jenkins:** I know that the co-ordinators of those schemes are well trained on issues such as nutrition but, from the research that I have done based on information provided by local authorities, hardly any of them are trained in identifying and dealing with mental health issues. That is a key area to be developed.

[133] **Mr Ingham:** That is clearly an issue that we can take up as part of developing further work alongside our education colleagues.

[134] **Jonathan Morgan:** I suspect that there will be a sense of urgency for that.

[135] **Sandy Mewies:** Paragraphs 1.18 to 1.49 of the report show the extent of not only the staff who work on a daily basis with the children and young people who could face these problems, but also the staff who work with them through the various disciplines, including health, education, social services and within divisions. Bethan has just touched on the issue of identification, which is one point. Reading these paragraphs, some consistent themes seemed to come through relating to training not always being adequate and the need for consistency of approach and so on. So, how confident are you that, in the future national health service, education and social services staff, who work with these children and young people daily, will routinely provide the appropriate support for their emotional and mental health problems? Following on from that, these great empires—and they were empires—used to work entirely in silos, and a lot of work has been done to prevent that from happening now, but it will still be a complex task to influence such a broad range of staff in the different disciplines within the NHS, along with school teachers and social workers. How will you cope with that? You are all sitting together there, which is a nice visual image, but perhaps you would like to expand on that in practice.

[136] **Mr Williams:** Certainly. First, we need to examine whether we have variation in the plan or programme. We also need to ensure that we have a universal service, or access to the more specialist levels as required. Within that, the requirements of partnership working should almost become the normal way in which business is done, so that has to be instilled in

the system. A lot more work needs to be done on that—reducing the complexity in the health service will certainly go a long way towards resolving that. When 'Everybody's Business' came out, we had some 15 trusts, 22 local health boards, three regions, Health Commission Wales, and so on, and then you overlaid that with local government and all its various partnerships. Since then, we have had the Beecham review and the reorganisation of the health service, and we are now working much more collectively as directors general. This is an important area and I am meeting with the directors of social services on Friday to talk about some of these issues. Perhaps the professor wants to come in with the practical ways in which we are taking this forward, because that is an important question.

[137] **Professor Williams:** Probably one of the most important aspects of the whole enterprise is that of trying to achieve a seamless service. Its seamlessness between professionals and their understanding is clearly what you are asking us about. There are a number of different levels. Mr Williams is commenting on the policy levels but you are also thinking about matters within the NHS, and of removing the barriers that get in the way. This is also a matter for the professionals and the professional organisations. We have made strides in the past several years to change the training of the various professions to which you have alluded. For instance, my own college, the Royal College of Psychiatrists, has been working with the Royal College of Paediatrics and Child Health to produce some joint training programmes on mental health for paediatricians so that children's doctors are better informed.

[138] An ongoing piece of work, led by my college, is being undertaken jointly with the Royal College of General Practitioners, and that is about increasing the sophistication of GPs' understanding of mental health aspects, including as related to children. That piece of work is being led by the immediate past vice-president of the college, who is a Welsh psychiatrist.

[139] At the professional level, we are beginning to take steps to break down boundaries and to see training that crosses boundaries. That is where this needs to start. We need to look inside the NHS at multidisciplinary in-service training that crosses boundaries if we are to sustain this. In the health board that employs me, I am working on such a training strategy at the moment. So, little by little—and I am not trying to imply that we have achieved more than is reasonable for me to assert—we have grasped the vital importance of this, and it will take some time for it to feed through into the work that we are doing.

[140] We have tried to focus this on several particular areas in the child and adolescent mental health arena. The work that has been done on the suicide reduction aspects during the past 18 months has focused on joint working across boundaries and training. Similarly, we have specified in the annual operating framework targets a requirement for primary mental health workers to offer training to organisations other than the specialist child and adolescent mental health services. So, I am pointing these out as areas in which we are beginning to grasp the nettle that you identified.

[141] **Mr Pickford:** To go to the other end of the process and to the discussion about the professional part of that, we are looking at the planning and joint working elements. There is an opportunity here to recast the children and young persons' planning process. The discussions in which I am involved from the social services side, as well as health colleagues and education colleagues, look at how we can cast that joint planning guidance so that it focuses on a number of small key areas. This is one of them, because, as you rightly said, classically, it is everybody's business and it spreads across a number of areas. That requires us to be more specific and focused on the outcomes that we expect from the children and young persons' planning process. It is in that process that people can get together locally to crack some of the issues that they face.

[142] **Mr Williams:** Just to complete the loop, the thing that has exercised us—and you may want to touch on this later—is how to improve performance management, and how to

ask the right questions, not just in chasing targets, but in understanding whether behaviour is changing across the directorates-general, particularly with regard to local government outcome agreements and how we can bind things together. So, there is a lot more work to do on this one.

[143] **Janet Ryder:** You have talked a lot about the training needs of health professionals but, apart from their parents, the person who has the most contact with young people is their classroom teacher or schoolteachers. The initial teacher training courses have not changed. They are not equipping teachers with the skills to identify additional educational needs, let alone the mental health needs of young children. When will those courses be changed to be brought into line with those for health professionals? Teachers should rightly be the ones to identify those needs very early on. Without training the professionals, as you said, it is not going to happen. So, when will the ITT course be changing?

[144] **Mr Williams:** That is a matter that I had better take back to my colleague, David Hawker, to see that it is reflected in his plans. It is a very important point, and we will take it back.

[145] **Jonathan Morgan:** Given that a couple of questions have been raised about the involvement of education and local authorities, we would be more than happy to receive a written note on the questions that have been raised, if you feel that that might be appropriate for your colleagues, as these points are extremely important.

[146] **Mr Williams:** Absolutely, yes. Thank you.

[147] **Michael German:** On a procedural point, I asked a question of the auditor general at the last meeting about whether a single accounting officer has responsibility for all these matters, and I was assured that there was. I need to clarify that, because it is very difficult for Paul to answer questions about someone else's responsibility.

10.50 a.m.

[148] **Jonathan Morgan:** Otherwise, we may have to ask more than one accounting officer in future.

[149] **Mr Williams:** I was mindful of that in your response. This is a complex area that cuts across to other directorates-general and agencies. I am happy to take those points back.

[150] **Michael German:** On that point, is there a single accounting officer?

[151] **Mr Williams:** No. I am responsible for health.

[152] **Michael German:** I thought that that may be the case. That is a matter for the committee to reflect on with regard to the way that we deal with these issues.

[153] **Jonathan Morgan:** There is nothing that we can do about that at this point, but we will reflect on it. In future, if we feel that there is no single point of accounting, we will ask more than one accounting officer to attend this committee. There is one final authority, the permanent secretary, but I am loath to drag her to every committee meeting. Professor Williams, do you want to reply to that question?

[154] **Professor Williams:** Yes, I would like to add a point to that. One of our intentions in creating the post of primary mental health worker was to create a bridge at that level between teachers and the health service. It should now be available in every area of Wales, for teachers to consult with professionals from the health service. One of the intentions is that, through

those consultations, the staff will gain expertise in being able to identify rather earlier, as you just described, people whose mental health is considered to be a problem.

[155] **Jonathan Morgan:** Thank you. Sandy, do you have any more supplementary questions to your question?

[156] **Sandy Mewies:** No, but I have a comment to make. I take from what Richard said that there is ongoing work on training to ensure that it can be applied to all the agencies involved.

[157] **Professor Williams:** I do not want to give you a false—

[158] **Sandy Mewies:** You did not over-egg the pudding. You said that you said—

[159] **Professor Williams:** I do not want to give you a feeling that there is an organised network. There are initiatives taking place bilaterally between various partners, particularly in the professional domain. This needs to be embedded, and I think that the NHS and the local authorities are well placed to do that. It all comes back to the joint working that we have already spoken about.

[160] **Alun Davies:** What is your view on the need to develop specialist mental health services for children under the age of five, because I understand that that has happened elsewhere in the UK?

[161] **Mr Williams:** I will respond first, but this is definitely an area for Professor Williams. We do not exclude younger children; we are quite happy to take referrals into the service. The primary contact tends to be at the general practitioner and health visitor level. We are aware that there are different models within the UK as to how we approach this issue, but we are certainly not excluding younger children. Professor Williams's experience will help us to have an understanding of exactly what the issues are.

[162] **Professor Williams:** There are several points to be made on this issue. First, I do not know of a service that would exclude people before school age. It is true—and we have information to this effect—that it is not so much the paucity of clinics, but the small number of referrals that are made. We do not quite know why that is the case. We have international statistics on the numbers of people who have problems that amount to being a disorder in pre-school age. One confounding issue may be that there are a variety of services provided for by different sectors and in different arenas for people of this age. One thing that is in the report that is not entirely clear to me is that the data that we sent through shows that there is an array of clinics that have different ages of eligibility; some of them focus quite appropriately on adolescents. It would be inappropriate for all of the clinics to cover all of the age ranges. So, the profile of clinics that I have in the mapping data from 2008, for instance, which is not covered by the report, shows that broad spread of clinics, but I am not aware of any area without clinical services for children below the age of attending school.

[163] It is fair to say—and I think that this was part of your question—that services in Wales do not necessarily have a very specialist focus in this area, but the general services at tier 2 should be open—and, as far as I am aware, are open—to people of all ages, up to the higher end, where we could have a further debate about age; but that is not what you are interested in. My sense is that we could look at that for development in the future, but it is paucity of referral that is the driver here, not preparedness to see people at this age.

[164] **Bethan Jenkins:** I have two questions, the first on issues around the training of general practitioners. The figures on GP awareness and training are quite stark. When I have asked about GPs providing service level agreements on eating disorders, I have been told that

unless they are paid to do it, they will not train their GPs to perform those duties. That is worrying because GPs are the first port of call in many instances—most of the time—but are unable to transfer patients because there is nowhere for them to go within the health service. So, my first question is: what progress have you made with regard to the training of GPs in that area? I then have a question about access to children and adult mental health services.

[165] **Professor Williams:** I am not in a very strong position to answer your question. I cannot speak authoritatively about general practitioners or their training. However, the training for general practice has changed over the years, and it is fair to say that many general practitioners would accept that they are ill-equipped to deal with children, in particular, and mental disorder. The threshold for GPs making referrals, as we perceive it in the specialist services, tends to be much lower than it might be in recognition of that expertise. That is one of the reasons why we have been very keen to develop primary mental health workers to provide expert advice that is more locally available to GPs—in the hope that they would then develop greater skills in determining who needs a referral, and who needs access to other services such as those provided by health visitors or education services. That work is under way. I am fairly confident that more modern general practitioners, who trained more recently, have had more training in interpersonal matters than was previously the case. I remember a survey that I was involved with some years ago that showed that most people in general practice had had something like three days of training in children's mental health in the totality of their training, but that was 20 years ago.

[166] **Bethan Jenkins:** That is your opinion; I differ on that.

[167] **Mr Williams:** If I could answer on the issue of access to primary care workers, I do not think that the report identifies how much progress we have made in that area. We are almost up to 100 per cent now on our investment in primary care workers. So, GPs may have had difficulty in the past with knowing where to get advice from, but the accessibility of primary care workers is now significant.

[168] **Jonathan Morgan:** The issue is that if a young person has an emotional concern or is developing a mental illness, and the family thinks of ringing the GP, as most families do, there is still no guarantee that their initial contact will be with someone who has the relevant expertise or experience to deal with that problem.

11.00 a.m.

[169] **Mr Williams:** That is a danger, and we will have to take it up with general practitioners. However, there has been a concern in the past that once GPs have picked up on a problem, they have not been able to refer patients easily. We have made a significant investment in primary care workers. I know that that does not completely answer the question, but, at least, as regards our commitment, we are developing that important part of our plan. It is almost up to 100 per cent now.

[170] **Bethan Jenkins:** However, to address this, GPs have to feel that there is pressure upon them from the Government to change their working practices so that, whether they were trained in 1966 or 2010, they have the skills to deal with these issues.

[171] **Mr Williams:** We can certainly talk to the royal college and providers of postgraduate education in general practice about that very important point. We will take that away.

[172] **Bethan Jenkins:** In paragraphs 2.19 to 2.33, it says that some young people are excluded from services because, in many areas, the services do not exist and they cannot access them—people with learning disabilities, substance misuse problems, conduct disorders

and, of course, there is the age-old problem of those aged between 16 and 18 falling between child and adolescent mental health services and adult services. Could you update the committee on plans to ensure that all specialist CAMHS teams provide support to all young people up to the age of 18 regardless of their conditions or the geographical area in which they seek treatment?

[173] **Professor Williams:** If you look at the draft of the annual operating framework for the next financial year, you will see that we have repeated in it a number of the targets for previous years, but there is an addition, which is that we are requiring each of the health boards to bring forward plans by October this year for submission to the Assembly regarding how they will extend the age range of their services up to, but not including, the age of 18—in other words, to the age of 17 and the eve of the eighteenth birthday.

[174] The document also signals an intention to require that those plans are delivered by the end of March 2012. There has been a substantial investment in the employment of more new staff, therefore there has to be a time delay in the implementation, and there may be training issues, and problems relating to facilities—providing facilities that are age appropriate. Our view is that the services require some notice of this, but the notice has been served and new recurrent moneys from next year's allocation are to be made available to support that development.

[175] **Bethan Jenkins:** I obviously welcome that announcement, but how realistic will that be if many of the health services in the local areas do not have the expertise or the staff provision to be able to cope? Can the new moneys be used, for example, to recruit new staff to deal with those who have severe conduct disorders? Will they be able to initiate those plans by the timeline that you have proposed?

[176] **Professor Williams:** Yes, indeed. In a sense, you are agreeing with me about our having to be cautious regarding where the timeline is. If we said to you that this should be achieved within a year, it would not be deliverable. That is my opinion and not a fact. This is why I am rather keen that the service is given notice and has to bring forward reasonable, helpful and appropriate plans. In other words, the Assembly wants to engage with the health boards in discussing the appropriateness of the plans when they are delivered. However, the target for the upcoming year is to deliver the plans by the end of October.

[177] With regard to whether they can recruit the extra staff, we have based the thinking—as far as we can—on the mapping data that we have had for 2008 and into 2009, which was not available when the report was generated. Those suggest that many teams are not having the kind of problems in recruiting additional staff that had perhaps been forecast. Of the 68 teams that were mapped, only nine of them told us that they had repeated problems with recruiting new staff. I am not sure whether I am totally confident about that; there is considerable planning to be done behind that intention. However, that does lend some optimism that if we give the service a reasonable length of time, we can begin to put plans into action to address the issue.

[178] **Mr Williams:** To further enhance the response, I refer to the development of the two specialist units, in south and north Wales. In south Wales, there are no out-of-area placements because the unit is providing a wider range.

[179] **Bethan Jenkins:** I am sorry; I did not catch what you just said.

[180] **Mr Williams:** I said that there are no out-of-area placements for the services that they are providing, which suggests that the comprehensiveness of the service has improved. I spoke yesterday to my colleague in north Wales and I was told that they have had no out-of-area placements in north Wales since October, and there are two placements that they are

currently bringing back into north Wales. There are some difficulties within the forensic adolescent care team, and, therefore a few specialist areas that we need to look at. I am referring, for instance, to the pressures relating to learning difficulties and autistic spectrum disorders. So, we are identifying these problems and we are improving, and, as part of the plan and of what was laid in the annual operating framework, we are becoming much more focused on dealing with those shortfalls in provision.

[181] **Bethan Jenkins:** Will you be working specifically with other organisations such as youth offending teams and substance misuse organisations?

[182] **Mr Williams:** Yes, absolutely. That comes back to the multi-agency approach to this plan, which also includes the third sector, as it has a huge amount to contribute in this area.

[183] **Mr Ingham:** Part of the development around primary mental health work is to ensure that youth offending teams have attached primary mental health workers to support them.

[184] **Janet Ryder:** I think that some of my questions may have been answered, Chair. I wanted to ask about points 2.35 to 2.44 on the community intensive therapy and treatment services that are available in some places, but not in other places at the time of the writing of the report. You have mentioned reviews that have taken place. What have you done, and how far have you advanced your plans for an evidence-based review of community intensive therapy and treatment services across Wales?

[185] **Mr Williams:** I will want to address that within this programme for the next few months, because there are differences of opinion as to how these services are best provided. I think that you are right that what we now need to do is to get some evaluation and evidence on what really works, and to recognise that there is a need for some local flexibility. Again, Professor Williams can probably talk about some of these issues from a practical point of view.

[186] **Professor Williams:** The difference of opinion that Mr Williams mentioned is an international difference of opinion; it is not a Welsh matter of local people being in disagreement. I wanted to make that plain. Last year, as an editor of a journal, I commissioned an article in this area that laid out the various models that may be available to be chosen. The outcome of that article was clear—there is a need for further work in this area before we can be clear about what works and for whom. So, we have various models of intensive care that are available, and we need to learn more about which of the members of the client group they work with the best and which members of the client group may require a different service.

11.10 a.m.

[187] For instance, there are big differences in the needs of people who may be beginning to suffer early onset psychosis, as compared with preventing people entering the care of a local authority. Although there is some overlap in the general needs of young people, the profession does not know enough about this topic area yet to be able to answer with authority what the spread of types of intensive services should be.

[188] **Janet Ryder:** I appreciate what you have just said, which is that we need to identify the most appropriate care services for individual cases and how that can be developed, but while that is being done, those people still need the services. So, what kind of timeline are you working to and how will you deliver it, given the increasingly difficult financial circumstances that we are in?

[189] **Professor Williams:** We are talking about diversity of care. In the past, and certainly

in the health service, we have had a rather more circumscribed model that was based on people being out-patients, day patients or in-patients, and we are talking about diversifying that. Simply because an intensive care facility that works in people's homes is not available in an area does not necessarily mean that they are denied treatment. For instance, in the area in which I work, where we do not have such a team, we have an effective day unit. So, many of the same people would go to the day unit. Again, along with that, it is a matter of discovering what range of problems the day unit is best able to cater for. I would not want you to think that people are necessarily receiving no input simply because there is an uneven spread of community intensive therapy services across Wales.

[190] **Nick Ramsay:** I have a brief question about the child-friendliness of services. There has been concern that children do not always feel that they are at the centre of the circle of service provision and that that is down to culture more than anything else. How do you think that that culture can be challenged and what would you propose as the best way of ensuring that children and families are better consulted on the type of care that they want to receive?

[191] **Mr Williams:** The national service framework process required, and still requires, the involvement of children and families in the planning of services. There is more to do here. I do not think that we are as user-friendly and inclusive as we ought to be. We have also developed advocacy, but it needs further development. We will be rolling out the national advocacy and advice service later this year. There is more to do in this area to reach out to and understand the users' perspective more effectively.

[192] **Nick Ramsay:** What about the opening times issue and the location of services? Opening times have been raised specifically as a problem. Could they be matched better to people's lifestyles today?

[193] **Mr Williams:** Absolutely. On access to the service—we are living in a 24/7 society these days, and the public sector still has work to do to catch up in that regard.

[194] **Nick Ramsay:** You can go to Tesco at any time of night to buy some milk.

[195] **Mr Williams:** That is right. So, it is an issue, in that public services must respond to how society is changing and its expectations.

[196] **Mr Ingham:** I would add that this is not exclusive to CAMHS. I can understand young people's perspective on this—they will have difficulties with missing school, for example, to go to particular appointments. I am well aware that it has been raised before in meetings between the Funky Dragon children's organisation and the Minister, particularly in the context of sexual health clinics. Young people do not want to have to say to teachers or others that they are going to a clinic, and I would hazard a guess that the same would be true of attending mental health service appointments or appointments for a range of other services. So, there are issues, and they are broader issues, as Mr Williams has said, regarding how we deliver services.

[197] **Michael German:** Overall, it seems that this report paints a grim picture, and as it has the backing of the four inspectorates with responsibility for the comprehensive nature of the services provided, we must be very worried by it. I would like to put to you three specific criticisms within the report relating to children being put at risk. I would like to know whether you believe that these practices are well known and well documented. Have these deficiencies been known for some time? The first criticism is the inappropriate placing of children on adult or paediatric wards. The second is that practitioners do not share information on individual cases. The third criticism relates to the closing of cases following non-attendance and not following up the appointments afterwards. Have we known about those problems for some time?

[198] **Mr Williams:** First and foremost, we take this report very seriously. However, I do not think that the report recognises the significant improvements that have been made and the significant investment that has been made over the last few years. Some £14 million in revenue has been invested, and we are approaching £40 million in capital terms. On performance, 90 per cent of children are being seen for treatment within our requirement of 16 weeks, and we have invested significantly in staff. Colleagues will have the exact figures, but the number of children being referred to adult wards is relatively small. As part of this issue, we have the difficult borderline as to when an adolescent becomes an adult. The new units will almost eradicate the issue, if they have not done so already. With regard to sharing information at the practitioner level, there should be no excuse for that. We must be clear as regards the point that there are no barriers here and about any need to change culture and be specific about the issue.

[199] In relation to waiting time targets, there is always the danger of missed appointments leading to cases being closed. The need does not necessarily go away, but clinicians sometimes go to extraordinary lengths to ensure that patients are being seen. We are moving into engaging with what we call clinicians' intelligent targets. Intelligent targets will help us to move away from targets that could have counterproductive outcomes. First and foremost, my impression is that we have a highly committed workforce, and the staff do their damnedest to meet the requirements of the user. I think that Professor Williams has the number of patients being referred to an adult setting.

[200] **Professor Williams:** Since the report was published, the data on the number of admissions, in the context that you described, are now available. The total number of children admitted to adult mental health units during the 2008-09 financial year was 19. Of those 19, nine turned 18 while they were admitted, and two of the three who were 16 turned 17. In other words, nine of the 19 were very close to birthdays. During their stay, eight of the 19 stayed fewer than four days, and 16 of the 19 stayed fewer than 10 days. Those are the facts for that financial year.

[201] **Michael German:** We are told by the four inspectorates, which cover a massive area of concern between them, that the field work was done in October 2009, and you now tell us that the figures for 2008-09 have only just become available. Are we to understand that prior to October 2009, these figures were not collected or available and it is only subsequent to this report that the actual numbers have been collected? If that is the case, it would indicate that a lesson has been learned from this report and that changes need to be made. We are clearly concerned about what comes under your action plan, so could you tell us what will happen in these three key areas to make a difference? What will make that change in the coming months, prior to the publication of your action plan?

11.20 a.m.

[202] **Mr Williams:** We have had similar conversations on other topics, on how information was collected previously under the old system of commissioners and providers, and how we are now moving to a much more focused planning and performance management system. We are very aware of the need for these figures. If they show deterioration, we will need to take corrective action, and that is where the performance management comes in. I am confident that this will be the exception rather than the rule, particularly with the investment in the new units. I do not think that the rule was that significant, given that the figure was 19 with mitigating circumstances. That does not demonstrate to me that there was a major issue. Nevertheless, we need to look at every case individually.

[203] We also need to look at how we improve practice in information sharing, and how we make sure that nobody is lost in the system. A target is seen just as a way of cancelling out a

patient for convenience's sake, but we should be looking to see whether somebody is caught up in the system who is not getting appropriate support. That is where we need to become much more sophisticated in our performance management, and we should not just be chasing hard targets.

[204] **Lorraine Barrett:** The provision of the new in-patient units in north and south Wales are to be welcomed. However, there is some concern in the report about discrepancies between the range of therapies in each unit. In addition, apparently neither unit has comprehensive support services in place, such as social workers and education provision. I am a little concerned about why that has arisen and what steps are being taken to provide a consistent level of support. I would be particularly interested in hearing how long some of these young people have to stay. If there is not a consistent level of support in the education field or in social services, that could have an impact, although if the stay is very short, maybe it is not quite so important. Could you say something about those issues?

[205] **Mr Williams:** The unit in north Wales is physically in place, but we have a temporary facility in Bridgend as we start the £27 million investment in the Princess of Wales site. There have been staff recruitment issues, but I am told that it will be up to the full complement of beds and staff by the early spring. I noted the comments about there being no access to occupational therapy and physiotherapy. I am not sure whether that is an issue relating to a decision not to have a multidisciplinary team available, which would surprise me, or of not being able to recruit at that point in time. I tried to follow that one up for you yesterday, but I just could not get an answer because people were concentrating on the poor weather conditions. I will need to follow that one up, because it may have been exacerbated by the possibility that the ultimate solution for south Wales, in this regard, involves an acute hospital site, where it may be easier to access some of these services.

[206] Turning to the other issue in south Wales, social work support is vital. I do not know whether it reflects the complexity of having to work through the local county borough council, which is providing more of a sub-regional service on behalf of colleagues in social services, and the complexity of those negotiations, but, as I said, I will be meeting the directors of social services on Friday, and I will raise that particular point with them. If possible, Chair, I will also follow up the specifics relating to the two issues that you have identified.

[207] **Lorraine Barrett:** It sounds as though we just need an update at some point, when it is all bedded in.

[208] **Mr Williams:** Yes, I think so.

[209] **Sandy Mewies:** I will move on to the second section of the report, which outlines what are considered to be the barriers to improvement and progress in developing CAMHS. Why do you think there is still a considerable distance to travel to realise the well co-ordinated and child-centred services envisaged by the Assembly Government's 2001 strategy for CAMHS, 'Everybody's Business'? Do you think that services as they are currently organised and delivered can and will be improved to deliver the required outcomes, or are more fundamental changes needed to achieve that?

[210] **Mr Williams:** I alluded to that in my earlier remarks. For me, progress has been in two stages: the publication of 'Everybody's Business', which is an excellent document, and the complexity of achieving its goals. Just look at the health service as it was at that time. There were 15 trusts, 22 local health boards, and a central commissioning organisation performance-managed by three regions. That almost beggars belief, and that is before you start overlaying the local authorities and all the partnerships.

[211] Moving on from that, Jeremy Beecham started to ask whether partnership working was effective and then we had the 'One Wales' commitment to prioritise specific services with money—and that is important, because we had money and a commitment, both capital and revenue. Then, the 'One Wales' commitment on the reorganisation of the health service was followed through to simplify some of its structures. I am much more optimistic, but optimism is not enough. I think that that is now underpinned by the more focused way in which we work at the civil service level, with the directorates-general. I need to put in place a much more sophisticated performance management system than we had before, certainly for the health service, but then the challenge is how we work across the other two directorates-general, education and local government. There is still a lot to do, but I am much more optimistic and, when we review this the next time, I can say that we will have a much more focused approach to these issues than was hitherto the case, because of the complexities involved.

[212] **Mr Ingham:** May I add something? You just said something on the more highly specialised service. We have to see that this issue is not unique to CAMHS or the health service; it cuts across social services and specialised education services. In a relatively small country, we will struggle to some degree with that sort of issue. The development of the units in north and south Wales was prompted in part by reports some years ago—and some of you may remember them—to do with the expense of specialised services for children across health, education and social services. I remember that report quite well, from around 2004-05. It recognised that a lot of money was being spent outside Wales and a lot of children were having to travel out of Wales. We have moved back in this case by seeking to repatriate the resource to Wales. Inevitably, given the highly specialised nature of those services, we cannot have them everywhere, so some hard choices have to be made about those highly specialised services.

[213] **Alun Davies:** I understand that you have found that the Assembly Government's commitment to develop more detailed guidance to support the implementation of 'Everybody's Business' has not been met. Assuming that to be the case, do you have any action in hand or planned to meet that commitment made by the Assembly Government to develop detailed guidance to support the implementation of 'Everybody's Business'?

[214] **Mr Williams:** I think that this report is a wake-up call. I want to take this joint report, and the transcripts of your previous discussions and of these deliberations, and build them all into this new plan, which will be much more focused on those things that might not have been addressed or those things that we need to look at differently. It is a question of having a step change from here on in. Rather than looking back and asking why we have not done it, we need to recognise that there is a lot to do, that we have done a significant amount, and that there is a lot in the pipeline to take it forward. As I said, I will not be leaving it as a document. The health aspect will be reinforced by a focused performance management framework that is supported by our annual operating framework. There will be some serious checks and balances in the system to make sure that our priorities are met.

11.30 a.m.

[215] **Alun Davies:** That sounds like a long and meandering way of saying 'no', actually.

[216] **Mr Williams:** I do not think that it does, to be fair.

[217] **Alun Davies:** I asked about actions. You can have a management framework in hand, but the one that I assume you already have in hand has not delivered the actions necessary to deliver the Assembly Government's public commitments. To be frank, having a management process in hand is one thing, and that would be required in any organisation, but the question was what actions do you have planned.

[218] **Mr Williams:** I was trying to avoid repeating what I said previously. We are in the process of investing significantly in revenue: we have invested £14 million, we have increased the number of staff by 10 per cent, we have increased the number of primary care workers by almost 100 per cent, which was the target, we have commissioned the first unit in north Wales, and we have agreed the business plan for the £26 million-worth investment in Bridgend, which we will be rolling forward. So, a lot of action is going on at the moment. Is there more to do? Yes, there is. Some of it, such as changing behaviour and sharing information, is very tricky because we are talking about working across agencies. The new plan needs to focus on those points.

[219] **Alun Davies:** I understand that you have resources available to you and that those resources have been increased, but I used to be a member of the Finance Committee, and we heard evidence that 20 per cent of the health budget is not being used appropriately. The point of my question was to ask what actions are planned to be taken. I understand the issue about resources and management frameworks. That is all fine, but my question did not relate to that. The question was about actions.

[220] **Mr Pickford:** I came into this as a relative newcomer. What strikes me about it is that the step change in CAMHS happened around the time of the 'One Wales' commitment. From looking at it, it is clear to me that what happened at that point was a different level of interest and investment—and the investment not simply of money, but of types of service.

[221] **Jonathan Morgan:** With respect, the point that Alun Davies is raising is that the Assembly Government committed to a particular course of action in support of 'Everybody's Business'. It was not our commitment or the auditor general's. What has changed? We have not heard anything from the Assembly Government to suggest that those commitments did not need to be met as a result of something else. If those commitments are still valid to ensure that professionals understand the role of CAMHS and what is expected of them in the context of workforce development, what has happened to overtake those key commitment? From an audit perspective, they were the stated policy and commitments of the Assembly Government, but they have not been met and we have not seen anything to suggest the reasons why.

[222] **Mr Williams:** It may be a case of shades of opinion, because significant progress has been made. On the performance, 90 per cent of patients or more are seen within the 16-week target, and we now have very few out-of-area placements. If you are saying that we need to go through every point in 'Everybody's Business', I can tell you that I have given a commitment to review those things that still need to be addressed in the plan. We are starting on that work now, and we will be looking to see how much progress we can make by May. It is not as though no progress has been made; very significant progress has been made. The service is changing and is changing significantly for the better. Have we hit every point? Well, we can go back through that document again. It is complex and, as I said, in the past, the detailed performance management arrangements that I am putting in place did not exist. That may sound like a wordy response, but I cannot speak for my former colleagues as to whether they felt that it was appropriate to focus on the delivery of every point made in policy documents in the past.

[223] **Mr Ingham:** Could I pick up on the point about guidance? We talk about guidance and a range of guidance and what it does or does not achieve, but there is something about setting out a model. The strategy set out a model, and a decision was made when the national service framework was conceived that a route to this would be to work through the NSF in setting out what the expectations were, and to incorporate in the NSF the targets that were being set for the health service, but to cast it in a wider frame, specifically because the NSF became the responsibility of local authorities, the NHS and of other bodies to deliver. So, that was the route that was taken at the time to carry forward work on the CAMHS strategy.

[224] There are comments on the effectiveness or otherwise of the NSF, which tells us some things about the need to do further work in a partnership context. One thing that Mr Williams has said is that through engagement across the directors general and through work to ensure that CAMHS is made a priority in the new planning guidance, we need to ensure that it is taken forward on a broader front. The development of that planning guidance is in hand now. We will need to look at the extent to which it needs to be enhanced, developed and broadened, and David Hawker and his directorate-general will need to look at it with us, to see the extent of guidance and any additional guidance that might be required to support it.

[225] **Bethan Jenkins:** Again, my question touches on planning, but it relates to planning and the commissioning of services, with paragraph 4.16 reporting that planning arrangements are complex and unclear and that often there is a lack of comprehensive local plans between CAMHS, local authorities and voluntary sector providers. Quite often, in my experience, young people are passed between tiers 2 and 3, back to tier 4 and back down, even though the services are not there. So, could you inform the committee of the latest thinking on how much simpler and clearer the planning structures could be? I know that the restructuring of Health Commission Wales could play a part in that, along with the new health boards, but how do you see this changing from the confusion and complexity of the previous system?

[226] **Mr Williams:** From a health service point of view, and we touched on this earlier, having seven integrated boards and removing the market—and those boards will also be responsible for very specialist services—removes a considerable amount of barriers and the opportunities that existed in the past to perhaps pass a problem on to another organisation. That has been central to how we intend to change how we do business and how things will be delivered.

[227] On the partnership with our colleagues in local government and the third sector, it is more difficult, because, as I said earlier, I know that David Hawker has indicated that children and young people's plans need to focus on this area. I will talk to my colleagues about how we can get a more joint approach to the partnerships and how they need to be specific about what they will deliver. So, it is a wicked and complex problem in partnership working. However, as I said earlier, this will be simplified in the health service. I know that that new First Minister is looking at the importance of the public sector improving its performance. We are working with directors general on this. So, there is a lot to do, but, as I said, we can be much more optimistic about this and much more focused on it than we have been in the past.

[228] **Bethan Jenkins:** Just to clarify, for example, if tiers 2 and 3 still recognise that they do not have the expertise and refer to tier 4, how can you guarantee that they will not be able to pass the buck again, as they have done previously?

[229] **Mr Williams:** I might defer to Professor Williams on this, but, as part of the new planning system, we are reviewing how the clinical networks operate to ensure that they are working holistically and are not just, as I said, trying to move someone around the system from tier 1 to tiers 3 or 4 or wherever; we are trying to ensure that they actually own the client or the patient through the transition of the care pathway.

11.40 a.m.

[230] **Professor Williams:** My general appreciation of this as someone who works in the service part time, as well as from the other things that I do, is that, by and large, my colleagues are very keen to work with the children, young people and families that are referred to them, and not to send them to somewhere else unnecessarily. Considerable energy and passion is put into advocating the cases of particular children and young people. So, in my practice, I have not seen a lot of what you alluded to in relation to passing people on; that

is relatively rare in my personal experience.

[231] **Bethan Jenkins:** For example, to go back to eating disorders, if dieticians are not available in a particular health board, that clinician cannot exhaust all of what should be available in tier 3. Therefore, the patient is moved on to tier 4, tier 4 staff will say that tier 3 has not been exhausted, and that the clinician has not looked at dieticians and occupational therapists, so the patient is passed back down to tier 3. However, if the services do not exist there, the patient is passed back to tier 4. So, it is a never-ending cycle. That has been my experience on a wide basis.

[232] **Mr Williams:** I would not disagree with that comment. As I said, the way in which the service is now organised means that passing a parcel, if I can use that horrible expression, will not be acceptable. Ultimately, the responsibility remains with the health board, if there is a health problem, to resolve it, because there is nowhere else to go. There may be an issue about whether the service exists there because of recruitment problems or whatever, but the temptation to pass it on to someone else at another level has been removed. The unintended consequences of the previous reorganisation have been removed, but we need to track it to ensure that we have a better quality of service for patients and clients than we have perhaps had in the past.

[233] **Jonathan Morgan:** The issue here, as in so many cases, is the fact that we have staffing variations. The report identified recruitment issues and variations in staff mix, and referred to the fact that there is no comprehensive workforce plan. Would a national or local workforce plan be a solution?

[234] **Mr Williams:** That is a good point, Chair. The work of Durham University on the mapping has told us a lot about what our workforce was, and how it is improving. Where we have shortfalls, we are working with the National Leadership and Innovation Agency for Healthcare, which also commissions a lot of our workforce planning, to ensure that if we have shortfalls, they will be addressed as best as we can, depending on the market conditions.

[235] **Nick Ramsay:** I have a question on performance management. I have been anticipating your answer, and it will probably be that there has been progress but that more could be made. There have been changes to performance management arrangements in the NHS and the annual operating framework targets have been put in place. What steps do you think are needed to ensure that the wider service priorities for CAMHS become integral to the NHS as a whole and also to local authorities and their management performance?

[236] **Mr Williams:** Keith touched on this, but we have increasingly moved from the national service framework, and many requirements, guidelines and targets, into annual operating frameworks that try to distil out those that are of prime importance. We have published a new set for next year but they will need to be better informed by this piece of work—this review, plan or programme of work—to make sure that we have identified those issues where we need to make sure that we can very firmly focus on where there is a need for a change of behaviour, in working or sharing information, or where we have shortfalls in dietetics, for example, or whatever. I think that it will be much more sophisticated. I am not saying that it will be easy, but it is will be much easier than it was when we were dealing with the number of organisations that existed in the past. It comes back to the issue of intelligent targets. We need to know the right questions to ask, rather than having—if I may use this phrase today—a snowstorm of targets, It is easy just to set hundreds of targets. We have to focus on the things that we believe to be important. Therefore, if there is an issue around avoiding a patient getting pushed around the system rather than there being a very comprehensive, well thought-out care plan, we need to have those conversations with clinicians. It is one of the things that we need to ask within the performance management system. Since we have reorganised, my director of performance meets the seven health boards

monthly and I will meet those health boards probably quarterly, and have much more comprehensive sessions with them on detailed issues. Questions on these services will form part of a suite of questions that I will be asking to map our achievement against our targets.

[237] **Nick Ramsay:** Do you think that our monitoring is adequate? We have heard about patients being pushed around the system.

[238] **Mr Williams:** No. I would not say that the previous system defied monitoring, but it was very difficult to monitor. It was set up to do different things. It achieved quite a lot, in some ways, but we have moved on and we are much more sophisticated in our expectations about the integration of services—not just within health but across the public sector and into the third sector. Therefore, a different approach is required.

[239] **Jonathan Morgan:** I thank the witnesses for joining us this morning and for spending additional time answering questions. That concludes this item.

11.48 a.m.

Cynnig Trefniadol
Procedural Motion

[240] **Jonathan Morgan:** I move that

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

[241] I see that the committee is in agreement.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 11.48 a.m.
The public part of the meeting ended at 11.48 a.m.