Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Plant, Pobl Ifanc ac Addysg
The Children, Young People and Education Committee

Dydd Mercher, 19 Mawrth 2014
Wednesday, 19 March 2014

Cynnwys
Contents

Cofnodir y trafodion hyn yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir trawsgrifiad o'r cyfieithu ar y pryd.

These proceedings are reported in the language in which they were spoken in the committee. In addition, a transcription of the simultaneous interpretation is included.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Angela Burns	Ceidwadwyr Cymreig Welsh Conservatives

Keith Davies	Llafur Labour
Suzy Davies	Ceidwadwyr Cymreig Welsh Conservatives
Rebecca Evans	Llafur Labour
Bethan Jenkins	Plaid Cymru The Party of Wales
Ann Jones	Llafur (Cadeirydd y Pwyllgor) Labour (Chair of the Committee)
Lynne Neagle	Llafur Labour
David Rees	Llafur Labour
Aled Roberts	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Simon Thomas	Plaid Cymru The Party of Wales

Eraill yn bresennol
Others in attendance

Dr Alka S Ahuja	Seiciatrydd Ymgynghorol Plant a'r Glasoed, Bwrdd Iechyd Lleol Anuerin Bevan a Chadeirydd, Cyfadran Seiciatreg Plant a'r Glasoed, Coleg Brenhinol y Seiciatryddion yng Nghymru Consultant Child and Adolescent Psychiatrist, Anuerin Bevan Local Health Board and Chair, Faculty of Child and Adolescent Psychiatry, Royal College of Psychiatrists in Wales
Simon Brown	Cyfarwyddwr Strategol, Estyn Strategic Director, Estyn
Ann Keane	Prif Arolygydd Addysg a Hyfforddiant Cymru Chief Inspector of Education and Training in Wales
Dr Clare Lamb	Seiciatrydd Ymgynghorol Plant a'r Glasoed, Arweinydd Polisi a Chyswllt Seneddol, Coleg Brenhinol y Seiciatryddion yng Nghymru Consultant Child and Adolescent Psychiatrist, Lead for Policy and Parliamentary Liaison, Royal College of Psychiatrists in Wales
Sarah Payne	Rheolwr Gwasanaeth Cadarn yng Nghaerdydd, Barnardo's Service Manager for the Cadarn Service in Cardiff, Barnardo's
Meilyr Rowlands	Cyfarwyddwr Strategol, Estyn Strategic Director, Estyn
Menna Thomas	Uwch-swyddog Ymchwil a Pholisi, Barnardo's Senior Research and Policy Officer, Barnardo's

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

Sarah Bartlett	Dirprwy Glerc Deputy Clerk
Siân Hughes	Y Gwasanaeth Ymchwil Research Service
Marc Wyn Jones	Clerc Clerk

Siân Thomas — Gwasanaeth Ymchwil
Research Service

Dechreuodd y cyfarfod am 09:30.
The meeting began at 09:30.

Cyflwyniadau, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **Ann Jones:** Good morning, everybody. Welcome to the Children, Young People and Education Committee. May I just do the usual housekeeping rules, please? Would Members check that their phones are turned off? I know that people are using computers, but, if you could turn the sound off on your computer, that would be helpful. It affects the broadcasting and translation, so that would be really good; we need that done. We operate in Welsh or English, so, if you need them, there are translation facilities. Channel 1 provides the translation from Welsh to English, and channel 0 is for floor-language amplification should you need it. We are not expecting the fire alarm to operate, so if it does, we will take our instructions from the ushers, who will show us where to assemble. I believe that a fire alarm test was operated in Tŷ Hywel yesterday, which all went very well. So, that all bodes well. As we are starting a new inquiry into child and adolescent mental health services, or CAMHS for short, do Members need to declare any interests that they have not previously declared on the register? I see that no-one needs to do that. That is good. We will turn to our first session on child and adolescent mental health services.

09:31

Ymchwiliad i Wasanaethau Iechyd Meddwl Plant a'r Glasoed—Sesiwn Dystiolaeth 1
Inquiry into Child and Adolescent Mental Health Services—Evidence Session 1

[2] **Ann Jones:** This is our first session, and we have witnesses from the Royal College of Psychiatrists with us. Thank you very much for your written papers. We have received an awful lot of written evidence, which we are looking at. However, may I ask you both to introduce yourselves for the record, and then, if it is okay with you, we will go straight into some questions? We have about an hour for this session, but, in my experience, we always run right up to the wire. So, could we start with the introductions?

[3] **Dr Lamb:** Okay. I am Clare Lamb. I am a consultant child and adolescent psychiatrist and I work in the north Wales adolescent service—tier 4 CAMHS—providing the clinical leadership for an intensive outreach team there. I also work one day a week for the forensic adolescent and consultation treatment service team for Wales. I am here in my role as the lead for policy and parliamentary liaison for the Royal College of Psychiatrists in Wales.

[4] **Ann Jones:** Okay. Thank you.

[5] **Dr Ahuja:** I am Alka Ahuja. I am a consultant child and adolescent psychiatrist in Aneurin Bevan health board, and part of the tier 3 neuro developmental service for Gwent. As part of my responsibilities, I am an academic fellow for the University of South Wales. I am here in my capacity as the chair of the faculty of child and adolescent psychiatry of the Royal College of Psychiatrists in Wales.

[6] **Ann Jones:** Thank you very much. The areas that we are looking to cover will be community specialist CAMHS at tier 2 and above that, including access to psychological therapies; the extent to which CAMHS is embedded within a broader health and social care

strategy; the priority given to CAMHS within the broader health and social services care and in that, I think, is the allocation of resources as well; the regional variation in access to CAMHS; access to CAMHS on an emergency basis; and safeguarding children's rights and engagement. So, as you can see, we are up against it. However, it is roughly those areas and anything else that your answers may prompt Members to ask. So, those are the broad outlines of the questions, if that is okay. Angela, do you want to start with the first question on CAMHS tier 2?

[7] **Angela Burns:** Yes, I certainly will, and thank you very much for coming along today and for your evidence. I appreciate that one of you specialises in tier 4 and one of you specialises in tier 3, but I wonder whether you can reiterate for the record an overview of your views on our capability to deliver tier 2 services at present throughout Wales.

[8] **Dr Lamb:** One of the important things is that, whatever level you are working in in CAMHS, it has to be a whole-systems approach. I think that our paper probably reflected that there are areas of good practice across Wales where we think the tier 2 approach is working reasonably well.

[9] The important thing about the tier 2 approach is that you are providing specialist intervention from people who are specialists and have specialist CAMHS skills, whatever profession they are in, to the people working with children and young people on the front line. We know, from experience, that the best way of doing that is through consultation; being very accessible in terms of giving advice; providing some targeted group interventions; working with school groups—classes or whole schools; and running parenting groups. It is about working alongside front-line professionals, but also providing some very short face-to-face interventions, such as solution-focused therapies or very short cognitive behaviour-type therapies, and identifying the young people who need to go up a level to the specialist services.

[10] **Angela Burns:** May I just come in there, because I appreciate our time issues? You paint a great picture of what this should be like. However, I know from my experience as a constituency Assembly Member in my patch, which is down in Pembrokeshire and Carmarthenshire—and I am sure that this is replicated throughout Wales—that those people whom you talk about—the tier 2 support workers and professionals—are simply not in evidence. It is very difficult to get to them. Provision is very patchy. They have capabilities in some areas that they can offer support in, but not in others. Could you expand on that a little more?

[11] **Dr Lamb:** Alka has some examples relating to areas in south Wales. I will address one thing that seems to have happened with the introduction of the Mental Health (Wales) Measure 2010, relating to situations where there were primary mental health workers—the people doing those functions that I have described. We have very good policy in Wales; it is about how we have implemented it differently in different patches. In some areas, it seems that what they have done is used the mental health Measure in the development of primary mental health support services to, in a sense, use the adult model. In some areas, this has resulted in a reduction in primary mental health work for children and young people. So, under primary mental health support services, they are providing a focused service for a smaller number of young people, and people have been trying to train up adult specialists to do that. In other areas, certainly in the Betsi Cadwaladr area, they decided that, to meet the requirements of the Measure, they would focus on GP localities, not just the primary mental health support service at GP surgeries. So, they are still remaining embedded with specialist CAMHS while fulfilling the function outlined by the Measure. For the mental health Measure, they only record GP referrals, for instance. That is at the top of the targets, if you like. Certainly, in north Wales, we have made a decision not to restrict referrals from primary mental health support services to GPs. They are still accepting referrals from front-line

services. Regarding other areas like Pembrokeshire—and Alka has some examples for south Wales—it is different.

[12] **Dr Ahuja:** The reality is that most CAMHS teams at secondary level are functioning at 20% to 25% of their capacity. This does not necessarily mean that they have the right skill mix to deliver the evidence-based therapies that we know work with children. The Measure has definitely had an impact. Some areas have had to increase the threshold of what is accepted, which has created a gap where these children fall when they do not fit into the primary mental health group or the secondary teams. They are the ones who have been lost as a result of this. The amount of work that has been put into the Measure is a welcome initiative for clinicians. However, it means that a lot of clinical time has been spent in making sure that the care and treatment plans are in place and that the care co-ordinator role in fulfilled, as dictated by the Measure.

[13] **Angela Burns:** Dr Aruja, I would like to pick you up on something. You said that the CAMHS teams, looking at tier 2, are working at about 25% of their capacity. Could you identify, very quickly, in your opinion, the greatest barriers to increasing that 25% to going on for 100%? What is it that they are not getting, that we are not providing or that they are not doing to make that a better percentage outcome?

[14] **Dr Ahuja:** I think you have to bear in mind that CAMHS works very differently from other specialities, and it has to be acknowledged that it is everybody's business. The economic cuts have not only affected the health service, but had an equal impact on the voluntary sector and local authorities, which often complemented and provided services along with the health service. We know of initiatives of joint working with social services and education, looking at looked-after children and children with special educational needs. Those were done jointly. As a result of the cuts, they have been withdrawn, and a lot has been left to the health service to mop up, which has resulted in resources being limited. We have only the same number of people working with a bigger mass of population, and delivering much more than was in the past delivered by other agencies.

[15] **Angela Burns:** You may not be able to say this, but I certainly can, so I will translate that, then. There are cuts, and there are cuts everywhere. We are under stringent financial measures, but my reading of the situation, with the people I have met in my patch, is that CAMHS is a cinderella service, and until we start to recognise that mental health issues in young people and adults are as important as a cancer of some form, or a heart issue of some form, then it will remain a cinderella service. It is an illness that people cannot see and that local authorities and health boards just keep pushing away. I have to tell you that, in my area, we are very poorly served, and we have endless young people—I am going to stop my hobby horse any second now—who eventually get the help, but it is an 'eventually'. It is way down the road when, in fact, an earlier intervention might have been able to put them on a much better course earlier.

[16] **Dr Lamb:** May I add to that? We know that 20% of children and young people have significant mental health problems. We also have a deal of evidence and research—we actually know which evidence-based interventions work at the early intervention level, at the medium level, and at the very high-end level. We have also done quite lot of work in the Royal College of Psychiatrists on benchmarking and pulling the evidence together, and working out the workforce capacity and skills that are required to deliver those evidence-based interventions. On the point that you were making about tier 2, you need very skilled intervention at that level. These are not low, or more junior, support workers. The people who do this really effective work with our tier 1, if you like—GPs, teachers, social workers—do very skilled work, but, in a sense, it is frustrating because our tools are our workforce. We must have parity of esteem with physical health. If you compare it with a team carrying out a general operation, be that tonsils or adenoidectomies, or if you think of the nursing team and

the theatre, the bed and this and that, our ordinary interventions require people and a decent building.

[17] So, I guess from the royal college point of view, we would like to see really integrated, multidisciplinary teams, where we are working with psychology, psychiatry, nursing and therapists—really working together where we have the workforce capacity recommendations. Seventy-five per cent of our skills in specialist CAMHS should be behavioural, cognitive and systemic therapy. That should be 75% of our skill in any team. We have this information. We have very good policy in Wales. We just need to find ways also of being much more integrated with our partners, because the provision that you require also depends on what your local agencies are providing, your partner agencies. If you are working in an area where you have an extremely effective team around the family, or you have a third sector body such as Barnardo's doing something, that would make a difference to what you can set up for children and young people in schools, and in hospitals, for that matter.

09:45

[18] **Angela Burns:** Is it not one of the realities, Dr Lamb, that your tier 1 colleagues are very often not trained sufficiently well to identify when they need to call in tier 2 support?

[19] **Dr Lamb:** That is the whole system.

[20] **Dr Ahuja:** That is where the main gap is, because most of the primary mental health teams are very adult-oriented. So, the lack of knowledge as regards CAMHS has been one of the big issues. We know that early intervention works; we know that 75% of illnesses in adults start before the age of 18. We know that investing in that area is worth it. We immunise our children and we vaccinate them so that they do not acquire illnesses later on in life. Why do we not think of doing something similar in providing them with that resilience and those attachments so that, when faced with challenges, they can have the same sort of ability to deal with them.

[21] **Dr Lamb:** We know how to do it.

[22] **Dr Ahuja:** I think that that is the frustration, because we know how to do it and we know that it works, but it is about having the people to do it with.

[23] **Ann Jones:** I have a number of Members that want to come in. I have Aled, Rebecca and Keith, and then perhaps we will try to make some progress on to the third theme, which is the extent to which it is embedded within broader services. Aled is first.

[24] **Aled Roberts:** Rwy'n mynd i ofyn yn Gymraeg. Rwyf eisiau cwestiynu eich dadansoddiad i ryw raddau, achos roeddech yn dweud bod Mesur Iechyd Meddwl (Cymru) 2010 wedi newid y ffordd mae'r gwasanaeth yn cael ei strwythuro mewn rhai rhannau o Gymru. Fodd bynnag, rwyf eisiau mynd yn ôl i adroddiad Swyddfa Archwilio Cymru ac Arolygiaeth Gofal Iechyd Cymru yn 2009, a oedd yn dweud bod gwasanaethau ar gyfer plant a phobl ifanc yng Nghymru wedi eu tanddatblygu mewn llawer o ardaloedd yng Nghymru. Wrth sôn am weithwyr sylfaenol, dywedodd hefyd bod problemau ynglŷn â chyflogi gweithwyr

Aled Roberts: I am going to ask my question in Welsh. I want to question your interpretation to some extent, because you said that the Mental Health (Wales) Measure 2010 had changed the way that the service was structured in some parts of Wales. However, I want to go back to the Wales Audit Office and Healthcare Inspectorate Wales report of 2009, which said that services for children and adolescents in Wales had been underdeveloped in many areas of Wales. In discussing primary workers, it also said that there were problems with employing primary workers in some areas. So, this interpretation that the situation

sylfaenol mewn rhai ardaloedd. Felly, nid yw'r dadansoddiad fod y sefyllfa wedi gwaethygu ers i'r Mesur gael ei gyflwyno hwyrach yn adlewyrchiad teg o'r sefyllfa.

has deteriorated after the introduction of the Measure is not perhaps a fair reflection of the situation.

[25] A gaf i hefyd eich cwestiynu ar y sefyllfa yn y gogledd? Roeddech yn sôn am yr ymateb yn y gogledd lle roedd yr hen strwythurau wedi cael eu diogelu i ryw raddau. Rwy'n cofio pan roedd partneriaeth plant a phobl ifanc yn y gogledd-ddwyrain lle cafodd nifer o weithwyr eu cyflogi. Roedd cais i fwrdd iechyd Betsi Cadwaladr i ysgwyddo rhan o'r baich fel bod y gweithwyr yn cael eu cyflogi ar y cyd, ond roedd y bwrdd iechyd yn gwrthod gwneud hynny achos roedd yn gweld bod cyfle i roi'r cyfrifoldeb ar awdurdodau lleol. Felly, fel Aelod sy'n byw yn y gogledd, nid wyf yn gweld bod y gwasanaeth yn y gogledd yn llawer iawn yn ôl y darlun rydych wedi ei gyflwyno.

May I also question you on the situation in north Wales? You mentioned the response in the north where the old structures were safeguarded to some extent. I remember when there was a children and young people partnership in the north-east where a number of workers were employed. There was a bid for Betsi Cadwaladr health board to shoulder some of the burden so that the workers were employed jointly, but the health board refused to do that because it saw that there was an opportunity to give the responsibility to local authorities. So, as a Member who lives in the north, I do not see that the service is very much in accordance with the picture that you have painted for us.

[26] **Dr Lamb:** I guess what people have been trying to do is—. If you interpret the Measure literally, then we would have the lifespan primary mental health support service, and that makes a lot of sense in many ways. What has happened in some areas of Wales—as a royal college, we have been hearing about it—is that they have reduced the albeit low provision of the primary mental health work function in CAMHS, and have gone into the lifespan service. So, in some senses, that has ended up in a reduction of the child and young people-oriented broader early intervention agenda. I think that all of us are aware that there have been gaps in provision across Wales for some time. We know that there are patches where it is working well and patches where it is not. I do not know the details of those funding discussions in Betsi—I am here for the royal college. However, I do know that the work that has been going on over the last year or two is to make sure that in north Wales they do not narrow the agenda for early intervention prevention. So, they still probably only have, I guess—. They certainly do not have the full number of what I would call the tier 2 specialist CAMHS professionals needed to serve the needs of the population. So, I would agree with you that the service is not up to scratch yet. However, as I said, I do not know the details of those financial discussions.

[27] **Aled Roberts:** Y rhwystredigaeth rydym yn ei theimlo yw, os edrychwn yn ôl dros y 15 mlynedd olaf, gwelwn adroddiad ar ôl adroddiad, hyd yn oed cyn i'r cwtogi o fewn gwasanaeth iechyd ddechrau, ac a dweud y gwir, gwasanaeth nad yw, yn ôl pob adroddiad, yn llwyddiant mawr.

Aled Roberts: The frustration that we feel is that, if we look back over the last 15 years, we have seen report after report, even before these cuts within the health service, and, truth be told, a service that, according to every report, is not a great success.

[28] **Dr Lamb:** I think that has certainly been—. Among the frustrations that we have seen is that there has been some really good policy, it just never seems to get implemented fully. I think part of that is possibly to do with funding streams, but the other thing is that there is such a variation in—I will call it commissioning; I know that we do not have competitive commissioning in Wales, but it is about the expert commissioning and the multi-agency partner work, integrated with social services and with education, to really commission effective services. The quality of the commissioning is the most important thing—people who

understand how to have a whole-system approach with the step up, the step down, and the matched services, so that you are actually moving quickly to the level that you need and matching need with provision. Where we have had good commissioning and good planning, there are little pockets of fantastic practice, but it is very patchy.

[29] **Ann Jones:** I have Keith first, and then Bethan, then I will come to Rebecca.

[30] **Bethan Jenkins:** Mine is on that exact point, though.

[31] **Ann Jones:** Well, I think Keith's is on the questioning.

[32] **Bethan Jenkins:** All right.

[33] **Keith Davies:** Rwy'n mynd i ofyn fy nghwestiwn yn Gymraeg hefyd. I ddilyn yr hyn roedd Angela'n ei ddweud, cawsom bapur oddi wrth y Gweinidog iechyd pan oeddem yn edrych ar y cyllid am y flwyddyn nesaf. Yr hyn a ddywedodd ef yn y papur hwnnw oedd mai gwasanaethau iechyd meddwl sydd â'r gwariant mwyaf yn y gwasanaeth iechyd cenedlaethol. Pan wyf yn edrych ar y ffigurau, maent wedi mynd lan yn y pum mlynedd ddiwethaf o £387 miliwn i £587 miliwn, sy'n £200 miliwn mewn pum mlynedd i'r gwasanaethau iechyd meddwl. Fodd bynnag, pan wyf yn edrych ar CAMHS, mae'r cyllid ond yn 10% o'r gyllideb honno. Pam taw dim ond 10% yw hwnnw? Wedyn, wrth gymharu â Lloegr, rydym yn cael ond 50% o'r gwariant ar CAMHS fesul plentyn neu berson ifanc yn Lloegr. Pwy sy'n gwneud y penderfyniad hwnnw? Rydym wedi cynyddu'r cyllid £200 miliwn mewn pum mlynedd—rydym bron wedi ei ddyblu—ond faint sy'n dod i CAMHS? Deg y cant; dyna'i gyd. Pwy sy'n gwneud y penderfyniadau hynny? Rydym i gyd wedi sylweddoli—dyna'r hyn a ddywedodd Aled—bod problemau cenedlaethol gyda ni. Fodd bynnag, rwy'n dweud bod y cyllid yno. Pwy sy'n gwneud y penderfyniadau hyn, felly, ar sut i wario'r cyllid?

Keith Davies: I am going to ask my question in Welsh as well. To follow on from what Angela was saying, we had a paper from the Minister for health when we were looking at the funding for next year. What he told us in that paper was that mental health services have the largest expenditure in the national health service. When I look at the figures, they have gone up in the last five years from £387 million to £587 million, which is £200 million in five years for mental health services. However, when I look at CAMHS, the funding is only 10% of that budget. Why is it only 10%? Compared with England, we have only 50% of the expenditure on CAMHS per child or young person in England. Who makes that decision? We have increased the budget by £200 million in five years—we have nearly doubled it—but how much is coming to CAMHS? Ten per cent; that is all. Who makes these decisions? We have all realised—this is what Aled was saying—that we have national problems. However, I am saying that the funding is there. Who makes these decisions, then, on how to spend the funding?

[34] **Dr Ahuja:** We would be interested in knowing who makes the decisions as well, because we know that a disproportionate amount is dedicated to CAMHS as compared to the adult services. I think that what was the last straw for us was when we moved up to 18 years of age. We started seeing children in most areas in Wales up to the age of 18 from 2012. We know that the age group between 16 and 18 is where you start seeing the early evidence of serious mental illness. The expectation was that this would get absorbed and the numbers would not be that great, but, going through the referrals we are having, and the out-of-hours assessments we are conducting, this is the group that keeps coming again and again. It has very high demands and needs a lot of intensive work, not only from medical professionals but from a multi-disciplinary team. So, you would imagine that there would be more investment at this end. So, I think that Clare and I would ask the same question as to why there is that

disproportionate funding.

[35] **Dr Lamb:** For me, again, it comes back to finding ways and finding really thoughtful, experienced commissioners at the high levels in our health boards who can really help us integrate effectively with the other agencies in the area and with children and adult services—CAMHS and paediatrics. We are part of a whole system for children and young people. However, as I said, the royal college is there to think about what we know is needed in the way of professional training and what multi-disciplinary interventions and evidence-based interventions young people need. Also, we work hard with our carers and users to try to represent and improve the quality of service.

[36] **Keith Davies:** It is such a striking difference, is it not? There is the huge increase for mental health services over the five years and yet, for CAMHS, when we compare with England, we see that we just spent half—

[37] **Dr Ahuja:** As part of that, I think there are areas where there are examples of good practice, where the voluntary sector and the local authority are working with CAMHS, dealing with these very high-risk young people. It is not about trying to do more of the same, but doing more with the same. We are trying to be innovative, but there comes a point when you need those resources.

[38] **Ann Jones:** There is an issue around the allocation of resources that David is going to touch on, so I think that we will probably return to this a bit later on. I know that I have already said to Aled that he cannot come back, but he can come back in on the allocation of resources. I have put your name down. Bethan is next and then we will move to Rebecca's set of questions.

[39] **Bethan Jenkins:** Sorry, it is just a really quick question with regard to what you were saying on commissioning and multi-agency work. Is it the case that the skills on the tier 2 level are more broad-based and general skills, so, when you are dealing with young people with very complex and varied conditions, that sometimes—as you talked about professional development—those staff may not have the skills to put them in the right place? For example, I have done work on eating disorders and some young people will say, 'CBT didn't work for me' and they are potentially not being offered the alternatives in that area. So, is that something to do with commissioning or is that just to do with the skills in existence in that particular area?

[40] **Dr Lamb:** If you have really set up your whole system for that stepped care—going up or down through the levels—you should be very mindful of what is required at each level. So, I guess that you must have parallels for your children with heart problems. I am not involved in that planning, but you know when there are some problems that can be dealt with at a certain level and then at the levels through to major surgery. The skills that our primary mental health workers need are to be able to deliver consultation. Consultation is a skill, and you need somebody high level to do that. So, if you are training other professionals, supporting teachers, or working alongside GPs, you need to have a high level of expertise to do that effectively. Also, if you have a young person who perhaps has just stopped eating for a couple of weeks and may be copying some friends, you can intervene quite well through a few sessions with your primary mental health worker and giving a bit of training to the school. If, however, it is much more complex and they have complex family problems, or a bereavement on top of that, they are losing weight further and then they get depressed—. You can see how it goes up through the steps. So, a good tier 2 professional should then be able to access quickly, in a timely way, the professionals they need. So, if someone is drastically losing weight and they are depressed, they are going to want to pull in their psychiatrist and perhaps a paediatrician to check, in addition to whichever therapy—and family therapy is key. We do not have enough family therapy in Wales.

[41] **Bethan Jenkins:** I am just wondering, if it is all so clear—and I do a lot of work in this area—how it is constantly the case that there are gaps, if the structures and the pathways are clear. I think that that is where we want to try to get an idea—

[42] **Dr Lamb:** There is a lack of workforce—

[43] **Bethan Jenkins:** That is the main issue, you would say.

[44] **Dr Lamb:** Also, there are training gaps, but the other thing to remember in Wales, which links to what Mr Davies was saying, is that we have very high levels of poverty. Our referrals are increasing; referral rates are increasing. The level of complexity and severity of children and young people's mental health problems are increasing. We know that that is happening across the UK, as well as in Wales, but our levels of child poverty are higher, I think, than they are in other jurisdictions, and we know that levels of poverty affect the incidence of mental health problems.

[45] **Dr Ahuja:** Again, I suppose, there is the geography, really. It goes back to your point that we know that what happens in west Wales is probably very different from what happens in Cardiff, but it is about having the knowledge and skills mix to deal with it. We do not want people to be travelling miles to get the service that they want. So, ideally, it would be something that could be available closer to home, because it is not the best thing for children to have no links with their family, with education or with the community that they are part of. However, it is about getting the right workforce and the resources to do that.

10:00

[46] **Ann Jones:** We have about half an hour left, and we have only just done the first set of questions. Anyway, there we go, we will see how we get on. I believe that you have a question Rebecca.

[47] **Rebecca Evans:** Yes. You say that we need to be more integrated in the delivery of services, but at the same time you say that we have good policies here in Wales. Therefore, I suppose that my question is: what is stopping us delivering those good policies on the ground? You mentioned the Everybody's Business strategy specifically, and you talked about the economic challenges of implementing that. Are there other challenges as well? You have talked about training, but is this a leadership issue as well?

[48] **Dr Ahuja:** I think that it is a bit of both, because, obviously, we know that children are everybody's business, and, to make an ideal children's service, we do need input from education, local authorities and so on. In some respects, I think that the intention of the Measure was to tighten the process, and to get people across the table talking about the same child. However, unfortunately, because of the economic cuts, a lot of services that were provided for looked-after children, and the educational input that was provided for children with special educational needs, in huge areas of Wales, have been withdrawn, and it is left up to the health service to bear the burden. Obviously, when you have other crises to deal with, this is almost as an add-on to what you are doing. So, that definitely has had an impact.

[49] The other thing is recruitment. We have a couple of vacancies, at all levels—not just medical, but at nursing levels—and we have not been able to fill the posts. We are aware that that is a challenge, because, if we are not able to fill posts, we do not have people there to see these children and young people who need to be seen. So, I think that that is something that needs to be considered when we talk about this.

[50] **Rebecca Evans:** Why are you unable to recruit to those posts? Is it the same issue

that we are seeing in specialities such as A&E, where people want to work in dynamic teams, which are on the cutting edge of what they are doing? Also, do you have particular problems recruiting to rural areas?

[51] **Dr Lamb:** I think that there is a mixture. It is quite interesting, because, over the last few years in north Wales, we now have no vacancies at senior level, and we are very integrated with psychology. I even had a phone call from a child psychiatrist who had just come off a rotation in Manchester last week, asking whether there were any posts in north Wales. I said, 'No, sorry, not at the moment'. There are some in south Wales. So, I think that things tend to ebb and flow. However, places where you have good practice— the academic centres in south Wales, for instance—are seen as very attractive places to work, but my colleague in north Powys has great difficulty recruiting. Their CAMHS team is way below benchmarking workforce recommendations. They have some fantastic people there, but there are not enough of them. So, I think that we need slightly different models for the rural areas. There is also something about making Wales seem more attractive—we need some good headlines, and I think that we need to promote the stuff that we are doing really well, so that people see that. We try to do that in the royal college, with our training, conferences and things.

[52] Psychology is quite interesting, because of the different backgrounds and cultures in south and north Wales. In north Wales, psychology, for years, has been very integrated as part of the CAMHS teams, whereas I believe that it is a little separate in south Wales.

[53] **Dr Ahuja:** Again, I think that it has been historical, and it is individuals, very often, who make teams work.

[54] **Ann Jones:** Simon has a point on this issue.

[55] **Simon Thomas:** I just wanted to pick up on what you said there about the disparity, and the need for a different model in rural areas. I noticed that, when the first terms of reference for Marcus Longley's examination of healthcare in mid Wales were published, there was no mention of mental health services. I think that that is illustrative of where we are at—everyone takes a very interventionist, medical, surgery-based approach to medicine. It is there now, because some of us made representations. However, we already have a rural healthcare plan, which was adopted by the previous Government. Has that been used at all in terms of shaping mental health services in rural areas?

[56] **Dr Lamb:** Do you know, I actually do not know.

[57] **Simon Thomas:** That is interesting, because that is seen as a starting point for this second piece of work on mid Wales, which is a rural area, but it does not cover all rural areas in Wales—even I would admit that. Where do we go now in terms of trying to discover a model that would work in rural areas?

[58] **Dr Lamb:** I suppose that an example would be that, in north Wales we have now developed this integrated tier for CAMHS; so, we have the ward and we have the intensive outreach team, which covers all of north Wales. That is where I work.

[59] **Simon Thomas:** Is that one ward in one location?

[60] **Dr Lamb:** The adolescent in-patient unit is in Abergele. We actually take in-patients from north Powys, because it is a little closer than Bridgend, although it still means great distances. I was asked to look at whether it would be possible to roll out our intensive outreach to north Powys, in just discussing with colleagues. You immediately see—although in north Wales we go to Anglesey, Machynlleth and Wrexham, which are great distances—

that, when you look at the geography, the number of staff that you would need, for instance, to provide intensive outreach, would be different. So, you need to look at some of these hub and spoke models, and look at some of the stuff that has been done in Cornwall in terms of early intervention. We do think about it, but it actually makes it more expensive. So, you then have to persuade the commissioners that some of the models for rural areas are more expensive per head of population.

[61] **Simon Thomas:** Indeed they can be, but do you, as the royal college, also have flexibility about the way that you benchmark for both?

[62] **Dr Lamb:** Yes; definitely. So, if you are doing a needs assessment, you need to take into account the deprivation indices of your population and the geography. So, for instance, the young people we would see in Pwllheli will not be able to get a bus to see us in Abergele or wherever. You really need to adapt your models. The royal college is very thoughtful about that. You then have to argue for different resource. Wales is so different, as we know. In terms of the language, with my population of young people, I must have Welsh speakers in my team; that varies across Wales.

[63] **Rebecca Evans:** The 2009 Wales Audit Office and Health Inspectorate Wales report found weak co-ordination between specialist CAMHS and educational psychology services. What is your assessment on any progress that has been made since then?

[64] **Dr Ahuja:** I suppose that we try to work in partnership because, very often, it is a matter of trying to work with the same group of children and young people. It was shocking, at the end of last year, when it was declared that the educational psychology course that was run by the university would be withdrawn. That is a shame, because we know the importance and we know the good work that is done by educational psychologists in the education setting. Very often, these children do not need to come to see someone in specialist CAMHS if they can access those resources. We know how well it works as regards counselling, providing the first-aid service, and providing assessments. When I think of my speciality and when we look at autism and ADHD, we find that we get valuable information from the educational psychology service. Again, I think that what comes across from there, and what has been mentioned, are the difficulties under which they work, because they are fewer in number, trying to cover a huge number of schools. With the changes that are happening, there is also a lot of demand on their workload. It would be ideal if we could work together, because it would prevent duplication. This is also something that we hear all the time from families: they have seen someone, a piece of work has been done, but then it is duplicated by someone else. Therefore, better integration would definitely be better for the children and young people.

[65] **Rebecca Evans:** So, there has not really been any progress since the 2009 report.

[66] **Dr Ahuja:** I suppose. Again, there are pockets of good practice. In some services, the educational psychologists actually sit in the clinic room while assessments are done. In other areas, there are multi-agency fora where educational psychology forms a very important part of the core groups, or the PPP meetings, which we refer to as the psychiatry, psychology and paediatric groups. That is very valuable; it means that we are talking about the same child, looking at a very holistic approach, whereas in other places very little communication occurs.

[67] **Dr Lamb:** I do not know what the situation is across Wales, and probably our educational psychology colleagues would better know the figures, but my sense is that we have not had an increase in resource. We would need to check that out.

[68] **Dr Ahuja**: Obviously, with this course being scrapped, we are not going to have any educational psychologists going through training in Wales, which means looking across the

border. All the educational psychology services in England have a contract that states that, when they finish training, they are supposed to work in England for two years. So, there is very little hope of somebody crossing the border and coming across the bridge to work here. We really have to think about how we attract the educational psychology service.

[69] **Ann Jones:** I promised, Aled, that we would return to the allocation of resources. I think that you have a supplementary question on that. If you can remember what it is, you can ask it now; that is fine.

[70] **Aled Roberts:** You were mentioning the commissioning arrangements. Our paper suggests that certain elements of tier 3, and certainly all tier 4 services, are commissioned centrally through the Welsh Health Specialised Services Committee.

[71] **Dr Lamb:** Tier 4 is done like that, currently.

[72] **Aled Roberts:** Our paper says that certain elements of tier 3 are as well.

[73] **Dr Lamb:** Yes.

[74] **Aled Roberts:** What sort of discourse do you have with the Welsh Health Specialised Services Committee? You said that you are responsible for the tier 4 provision in north Wales as the intensive outreach—

[75] **Dr Lamb:** We are based in one integrated tier 4 CAMHS service. My colleague Robin Glaze is the clinical lead there. We also have a clinical lead for CAMHS and senior operational managers. They have regular meetings with WHSSC by video link, which is also joined by the tier 4 CAMHS services in south Wales. So, there are regular meetings; I think that they are called tier 4 planning meetings. Also, for instance, if a young person requires a psychiatric intensive care bed, a forensic bed or a young child's bed—that is, an under-12 bed, which we do not have in Wales—then some of us are gatekeepers. That would include my colleague and me in north Wales and colleagues in south Wales for out-of-area beds. Since we have had our new intensive outreach team, we have not had a single out-of-area referral—since October, or the beginning of November, which is when we came on board. We have not had a single young person go out of area, for generic or psychiatric intensive care. So, there are models that we know can work. Yes, WHSSC is very much linked in to us, but also with the forensic team; the other person that joins that tier 4 planning meeting is the lead for the forensic adolescent consultation and treatment service team in Wales, which is the all-Wales tier 4 forensic CAMHS service.

[76] **Aled Roberts:** When there is criticism in the WAO report of the speed of roll out of tier 4 recommendations from previous reports—you mentioned before that you have to go to the commissioners and convince them—has that been due to WHSSC turning down approaches or has there been no approach made to WHSSC for the type of resources that Keith was talking about?

[77] **Dr Lamb:** I am only working, clinically, with north Wales, in my clinical role. We have found that WHSSC is working very closely with us and that it is facilitating the development of services.

[78] **Dr Ahuja:** I suppose that the model is quite different in south Wales, because a lot of areas in the south do not have the equivalent of community outreach teams, which means that, very often, these very high-risk individuals are either contained in the community, which means that the community teams flex up to work, or they will end up waiting for a bed in the in-patient unit, which means that they get admitted onto a paediatric ward or another ward, or they are sent out of area. So, there is a big variation in terms of how it works in north and

south Wales.

[79] **Aled Roberts:** However, if north Wales has been able to ensure that there are no out-of-area placements et cetera—. In our evidence there was a disturbing case of a young lady from Pembrokeshire who had to be taken to London and then repatriated to Bridgend some weeks afterwards. If the model has been seen to work in north Wales, why has there been no approach by the south Wales health boards to WHSSC with regard to—

[80] **Dr Lamb:** We are representing the Royal College of Psychiatrists, so we are not absolutely aware of all the stuff going on in all the health boards, but I am aware that different colleagues have developed different business plans for different areas. It is easier in north Wales; we are one health board, so we are all working across. The different localities, some of which are quite a distance from Bridgend, have been working up different models of alternatives to admission, and they are at different stages. That is my understanding, but I am not party to those.

10:15

[81] **Ann Jones:** Okay, thanks. We have touched on the issue of regional variation. Simon has another couple of questions on that. I do not know whether Aled wants to come in on it. No, I see that Aled is happy with that. Simon, I will bring you in now, but I also want to get on to the issue of access to CAMHS on an emergency basis.

[82] **Simon Thomas:** Rwyf am ofyn fy nghwestiynau yn y Gymraeg, os gaf i. Rydym eisoes wedi trafod nifer o agweddau o'r gwahaniaethau ar draws Cymru a'r gwahaniaeth rhwng ardaloedd gwledig ac ardaloedd trefol hefyd. Fodd bynnag, wrth edrych ar y darlun cyflawn—gyda'ch het coleg brenhinol ymlaen yn hytrach nag unrhyw un arall—lle yr ydych yn gweld y pryder mwyaf o ran yr amrywiaeth hon mewn darpariaeth? Ai pryder ar lefel ddaearyddol yw hwn neu ai pryder ynghylch mynediad at wasanaethau lefel 3 neu lefel 4?

Simon Thomas: I will be asking my questions in Welsh, if I may. We have already discussed a number of aspects of the differences across Wales and the difference between the rural areas and the urban areas as well. However, in looking at the complete picture—and wearing your royal college hat rather than any other—where do you see the greatest concern in relation to this variation in provision? Is it a concern on a geographical level or is it a concern regarding access to level 3 or level 4 services?

[83] **Dr Ahuja:** I would say that it is a bit of both. It is obviously the geography and having access to tier 3 and 4 services. As Clare mentioned, in the north, they have a community intensive therapy team, which works in parallel with the community teams and tier 4 services. Unfortunately, this is quite a scattered arrangement in the south. We are aware, looking at the emergency service, that some parts of Wales do not have any on-call services. We do not have any in Powys; we do not have any in west Wales. Very often, if a child or young person presents out of hours, it is about finding the best arrangement possible. Similarly, when we think about the section 136 assessments, there are a lot of local health boards that still do not have a designated place of safety, which means that these vulnerable children are moved from one place to another, which is not ideal considering their mental health problems or social problems at that stage. So, there is a large amount of variation, even looking at just south Wales. Clare talks about north Wales, and it is very different. I think that that is not so much to do with geography; it is probably more to do with the resources and the access that we have. Experience in places where the community teams work well—the community intensive therapy team—shows that they are able to contain the young people in the community, which prevents a lot of people going out of area or or even needing an in-patient admission. In places where that is not possible, very often these things do happen.

[84] **Simon Thomas:** Is that an issue around recruitment, as you mentioned in north Powys, or are there other structural things that are difficult here?

[85] **Dr Lamb:** I want to go back again to the commissioning and planning of services, because I think that, if we had really robust commissioning and planning of strong early intervention in preventive services with skilled people embedded in the specialist CAMHS, it would increase the capacity of the tier 3 level and the tier 4 level. In a sense, that whole-system approach should enable that freer flow between the services. Some of it may be about variability in how the different health boards have been approaching it. That also links to how they release the moneys as well.

[86] **Simon Thomas:** Yes. Do you have information on whether the health boards, on their boards, have people with knowledge of CAMHS?

[87] **Dr Lamb:** I think that most of them have to now with the national mental health partnership board and the local mental health partnership boards. They should all have representation from CAMHS—

[88] **Dr Ahuja:** And I think it is on the agenda. They have the interest of the Minister as well, so CAMHS are considered, but whether they attract resources is a different question.

[89] **Simon Thomas:** Indeed. My final point, therefore, is that you have talked a lot about the commissioning and the need for expertise at a very strategic level in order to make the change at a very local level. The evidence that I have seen leads me to believe that that is not uniformly done by every health board in Wales. Is there a case for having this commissioned at a national level in Wales?

[90] **Dr Lamb:** Well, we have now moved to central planning, have we not—

[91] **Simon Thomas:** With the Welsh Health Specialised Services Committee, yes—

[92] **Dr Lamb:** I think you really need to be able to use local strategic knowledge, but it is about ensuring that you have enough people in the different localities with the right expertise and that they are supported to do things. For example, you were talking about financing—. There were some implementation moneys with the Mental Health (Wales) Measure 2010. Now, I know that, in our health board, some of that went to specialist CAMHS for their bit of the development of the primary mental health support services. In other areas, that has not happened—there is that variability. It should not just come down to working relationships on the ground. So, I do not know what the answer is. We do not want everything directed in a controlled, central way, you need to have flexibility locally, but there has to be a minimum standard of thoughtful, integrated and strategic planning.

[93] **Simon Thomas:** However, those standards are there, really.

[94] **Dr Lamb:** They should be.

[95] **Simon Thomas:** They are the benchmarks, and they are not being met in all parts.

[96] **Ann Jones:** I call on Angela to speak very briefly, and then Rebecca, because I want to get to emergency situations.

[97] **Angela Burns:** I just wanted to build on Simon's point, because we talk about health boards, but, for example, in Hywel Dda health board, which has to engage with the county councils in order to be able to provide the services, I have evidence that, on some of the areas that are deemed to be the responsibility of CAMHS, Ceredigion, Carmarthenshire and

Pembrokeshire all have different methodologies and, therefore, there are different waiting times and different accesses to service within one health board, let alone the other health boards that we have throughout Wales.

[98] **Dr Ahuja:** I think that that reflects what happens in our health board, because we have five different local authorities. In the job that I did before this, I was dealing with two different local authorities, and it was almost next to impossible for us to get our heads around that, let alone explain to families and young people who are coming through the door why the waits were happening and why things were different in one part of Gwent compared with another. So, I think that that is challenging.

[99] **Dr Lamb:** However, there are ways around it. We have six different local authorities in the north, but we know who our heads of service are, and there are heads of service meetings, so we can say, 'Can I come to the heads of service meeting?', and then you can talk to the heads who are all together in the room. There must be ways that we can find of creatively working together. However, I guess that when resources are short, you find that people are pushed, and then they cannot make meetings. If you have a demand, both as local authority officers and clinicians, you will go to meet the needs of a young person and cancel a meeting. That is happening quite a bit, I think, so people who have the will, perhaps, to plan together are not always getting to the meetings these days. I have noticed that in the last couple of years.

[100] **Rebecca Evans:** You mentioned early intervention and the importance of a whole-system approach. I just wanted to take your view on the training and expertise among GPs with regard to child and adolescent mental health.

[101] **Dr Lamb:** I think that GPs vary. There are some GPs who are really interested in mental health and take a leadership or championing role in those areas. There are others who do not have the time or the training. They still have 10-minute appointments, which is tricky.

[102] **Dr Ahuja:** There is enough evidence from the Royal College of General Practitioners to suggest that 60% to 70% of the cases that GPs see are related to children and young people, but CAMHS is one of the biggest areas of gaps in their training. If the primary mental health services were working the way that they should be, which is what we refer to as the 'TLC model' of looking at training, signposting, offering liaison or consultation and doing the clinical work, then they could be doing that sort of work with GPs, looking at and identifying their training needs. Most GP practices now have somebody who is a champion on orthopaedic problems or on sexually transmitted diseases. Very rarely do we hear about GPs being champions for CAMHS.

[103] **Dr Lamb:** There are models, though, in the UK that I think that we should look at, where some GPs pick up cases for a number of practices in their area and see young people. Some of them are in more urban areas, but they have a walk-in GP clinic, where they deal with sexual health, mental health and skin stuff, which are the things that adolescents would be more likely to come about, and they have people from mental health services, youth services and counselling services on-site. There are lots of models of ways that we could think creatively, and maybe there could be a GP in a geographical patch who has that interest, a bit like the one who deals with diabetes or rheumatoid arthritis. However, certainly, as Alka was saying, if you have the tier 2 level working effectively, that does result in training for GPs as well.

[104] **Ann Jones:** We have a few minutes left, but we will have to look at the emergency access. Bethan and Suzy have questions around this. We will see how far we go with this, but perhaps we will have to finish up by writing to you for some more information. Who wants to go first? Bethan.

[105] **Bethan Jenkins:** I will not be long. With regard to the emergency services, from what I can see from the Wales Audit Office and HIW report, many of these issues are prevalent not only in children's services but also in adult services with regard to the lack of knowledge on accident and emergency wards, and children being put on the wrong wards, for example. That has been reported. Also, the amount of new in-patient beds was not up to what was originally planned. I do not know whether you have views on that. I have heard you say—and we all know this, do we not?—that the preventive side is key, but when people do get to that stage where they are in that very vulnerable position, if they do not know it, and if the wrong person is making the decision, or if there is no capacity in the system, what do they feel that they can do in that type of circumstance so that they can feel that they can at least try to go to the right place?

[106] **Dr Ahuja:** In much of the out-of-hours work that comes through A&E departments there are pathways in place, but, again, they are very much dependent on multi-agency working, and for that working to be the best that it can be. Many of these children who present as a crisis may not actually need that much health input, as they would need support from social services at that stage, and it is a matter of trying to get them on board. If an admission is required and if, unfortunately, both in-patient units do not have any emergency beds available—

[107] **Bethan Jenkins:** I am sorry; what did you say?

[108] **Dr Ahuja:** If there is no access to emergency beds, or if there is very minimal access to emergency beds, if a young person needs to be admitted—on the very rare occasion when this would arise—I suppose that, in those cases, it is up to the clinician to make the right judgment as to what is appropriate for the child. For example, most places will admit a child presenting with self-harm or an overdose to the paediatric ward, and there will be an understanding locally between the paediatricians and CAMHS that an assessment will be done by the CAMHS team the next morning. However, that does not mean that, in the meantime, a proper psychosocial assessment cannot be done by someone in A&E or the paediatric team itself. It is not that the child needs to wait for that to happen. Similarly, there are occasions when these young people need to be admitted to another ward, which may be a designated adult ward. I suppose that it is a matter of keeping in mind the risk of sending this child back home if this does not happen, and also the developmental age of this child. We have a lot of 16-year-olds and 17-year-olds who probably would be better off being on that ward than on a paediatric ward. It is also a matter of keeping all of the safeguarding issues in mind, checking whether we have the appropriate staffing levels and whether the staff are appropriately trained to deal with these young people, and what the skill mix available to deal with this is.

[109] **Bethan Jenkins:** Are there instances where people are sent back too early and then there is not that team around them when they do go back to the community? Is that also patchy across Wales?

[110] **Dr Lamb:** There are a number of issues in your question. We know that there are quite high numbers, as Alka said, of young people presenting to A&E in distress, for whatever reason. There are very clear protocols that, if a young person presents with self-harm, it is very important, in general, that they do have that bit of space where a biopsychosocial assessment can be carried out. The majority of young people who are admitted to paediatric or even the adult psychiatric ward do not require psychiatric beds and, in the end, go out quite quickly, and they should have the correct support. That is the key—they should have the correct support. In Wales, the number of young people being admitted to adult wards is too high. Again, it has reduced in north Wales, but we have a different geography and a different population there. I think that there were four in the whole of last

year. I think that in south Wales it was something over 30.

[111] **Bethan Jenkins:** Do you also have any evidence that, in a perverse way, because children are going onto the adult wards, the adults are going to different wards? I have examples of adults with mental health problems not being on mental health wards when they should be on those wards.

[112] **Dr Lamb:** There are two issues there, really. If you have a good service, you should not be admitting many children to adult wards. Sometimes, it is appropriate. If you have a 17-and-a-half-year-old, sometimes that is their preference, but that is by the by. The adult beds have massively reduced in any case.

10:30

[113] Adult services are under a lot of pressure. We have not talked about transition today, but I really would welcome the chance to work closely with our adult colleagues to develop effective youth intervention for some of our transition young people. Again, it means sitting down with the leaders in adult services, the leaders in CAMHS and the leaders in social services so that you have a good crisis response. It should be a multi-agency response, which would also address some of the needs of the few young people who come in under section 136. We find that the use of section 136 goes down if you train the police as well. The majority of young people who present on a section 136 do not have a mental disorder—the children, that is. I feel as though I keep saying the same thing. If we were able to have a very good crisis response, where we worked jointly with our social services colleagues—. I have some excellent working meetings with social service colleagues, and there are some really good people, but we need to plan together. It is variable, depending on where you are in Wales—that is our other theme, is it not?

[114] **Dr Ahuja:** With section 136, we have seen that the ones coming back are usually the same individuals in that age group of 16-18. We recently did an audit, and 90% did not need any health input, but again, it is about keeping in mind that we need that joint working and a place where these people could be contained and revisited.

[115] **Suzy Davies:** You have anticipated my question in a way. I need some idea of context. By its very definition, an emergency means that it is very difficult to plan for. Can you give me an idea whether most of the children and young people that would present at A&E are children and young people who are already known to CAMHS and social services? Do they present with problems that could be identified separately as tier 1, tier 2 and so forth? Is it a real mixture?

[116] **Dr Ahuja:** It is. A handful of them would be known to CAMHS or to services in general, but a lot of children are presenting in distress, as Clare was saying, who have probably never been known but who have come to a situation where they need some sort of help. It is identifying those; they are very often discharged the next day and may not need any input at all. It is having the—

[117] **Suzy Davies:** Do they always get an assessment, if they have turned up for the first time?

[118] **Dr Ahuja:** They should be getting some sort of psychosocial assessment. We always tell our trainees that the very presentation is important; it is a cry for help from the young person who has presented. So, it is about teasing out what is needed. That may not be possible on that night, but we need a mechanism of following up and making sure that support is there for the young person.

[119] **Dr Lamb:** In every district general hospital and every paediatric unit, there should be a joint protocol between paediatrics and CAMHS. Certainly, in most areas, there is an automatic process where, if a young person is admitted with an overdose, the next morning there will be a phone call to CAMHS, and the self-harm assessment team comes out. That also links with the NICE guidance recommendations and the royal college recommendations. It should happen.

[120] **Suzy Davies:** Of those people who are previously unknown to CAMHS that come through A&E, are you able to give us a rough idea of how many are admitted, even if it is only overnight?

[121] **Dr Lamb:** Our protocol is that every single one should be.

[122] **Dr Ahuja:** Even if they are discharged, there has to be a consultation with the on-call person for CAMHS to make sure that it has been discussed and that there is a plan in place, be it from CAMHS or from elsewhere.

[123] **Suzy Davies:** So, it would be reasonable to say that no one turns up to A&E and is dismissed accidentally.

[124] **Dr Lamb:** They should not be. The safeguarding is the most important aspect of this. Children and young people take overdoses or self-harm for a myriad of reasons. So, the safeguarding issue is key. Then, you are asking whether there is mental disorder as well. We need to look holistically at what is going on, such that a young person has done something like that.

[125] **Suzy Davies:** Having come through the A&E route, is there then a presumption from the families and those children and young people that their future help lies with the NHS rather than with the other partnership organisations?

[126] **Dr Lamb:** I think that that is often—

[127] **Dr Ahuja:** It is just the same with the other services. The moment that it is at the door, it is as if everyone else backs off.

[128] **Suzy Davies:** That is what I was coming round to.

[129] **Dr Ahuja:** That is where we want the inter-agency framework to work; we want people to be on board. These children may not need input from health, but they will need it from somewhere else.

[130] **Suzy Davies:** What I am saying is that it is not all about resources and social services and the third sector backing off. The expectation is from the family and the child or young person themselves.

[131] **Dr Lamb:** Yes. Years ago, when I was a junior, we always had a social worker embedded in the team in the hospitals. Every paediatric ward had one, and every psychiatric ward had one.

[132] **Suzy Davies:** One day soon.

[133] **Ann Jones:** As I am a very nice person, Simon, you can have another question. Go on. Be very quick though.

[134] **Simon Thomas:** It is a very quick question. In effect, in my region of mid and west

Wales, it strikes me that paediatricians are, in fact, the initial port of call when emergency presentation happens. However, it is now the case that several hospitals, and Withybush hospital is one, are moving away from having a 24-hour paediatrician service to a 12-hour paediatrician service. How on earth, therefore—. Could you put your finger on this—

[135] **Keith Davies:** There are some district general hospitals where there is no paediatrician.

[136] **Simon Thomas:** And some have none whatsoever, yes. So, how do we have that assessment done when there is not even a paediatrician on-site when an emergency presentation happens?

[137] **Dr Ahuja:** That is a challenge. We have heard similar stories from elsewhere as well. Very often, it may be about providing the training to the A&E staff who could do a psychosocial assessment.

[138] **Simon Thomas:** But that is moving further and further away from—

[139] **Dr Ahuja:** It is not ideal, but it is about having some assessment so as to make sure that the risks are considered and having a protocol to say, 'This child is safe until an assessment is done by the specialist CAMHS team or paediatrics'. However, it is not acceptable—

[140] **Dr Lamb:** There are areas where specialist CAMHS nurses are providing some assessment. However, actually, if you have a young person who has taken an overdose, they must have to have some way of knowing that they are medically fit, unless they are going to drive them some 50 miles—

[141] **Simon Thomas:** [Inaudible.]—still needs to be involved.

[142] **Dr Ahuja:** We have had had a lot of specialist nurses who, in the past, would see these children aged 16 to 18, because they came under the adult remit. However, from 2012, we have had those nurses saying that they feel de-skilled for seeing this lot, who they saw two years ago. There is a lot of variation in practice across Wales.

[143] **Ann Jones:** That rounds things off as we started. There are a number of questions that we did not get to, and this is our very first session, so we are still thinking about what journey we are going to travel as a committee for our report, so, if there are any more issues, could we come back to you once we have checked the transcript?

[144] **Dr Lamb:** Yes.

[145] **Dr Ahuja:** Yes.

[146] **Ann Jones:** You will get a copy of the transcript to check for accuracy so that you can see that we did not put anything down that you did not say. I thank you both very much. I think that we have found it very interesting; it has certainly given us quite a lot to think about. Thank you both very much for coming and for your written evidence. I think that most Members have something to think about now with regard to which way we go. Thank you both very much. If the committee is agreeable, we will break for five minutes before we start the next session.

Gohiriwyd y cyfarfod rhwng 10:37 a 10:47.
The meeting adjourned between 10:37 and 10:47.

Ymchwiliad i Wasanaethau Iechyd Meddwl Plant a'r Glasoed—Sesiwn Dystiolaeth 2
Inquiry into Child and Adolescent Mental Health Services—Evidence Session 2

[147] **Ann Jones:** We will reconvene now. If you have switched your phone on, can you make sure that you have turned it off?

[148] We will move on to the second session of our scoping inquiry into CAMHS. We have with us people from Barnado's, who have submitted written evidence and we will now have a question and answer session. Would you both introduce yourselves for the record, and we will then go into some questions, if that is okay?

[149] **Ms Thomas:** I am Menna Thomas and I am a senior policy and research officer at Barnado's.

[150] **Ms Payne:** I am Sarah Payne, and I am the children's service manager with Barnado's, which is also the operational lead for the emotional health and wellbeing strand of the Families First strategy in Cardiff.

[151] **Ann Jones:** Thank you very much. As I said, you have provided us with some written evidence. We have a few areas that we want to cover. One is on the early intervention services and the community specialist CAMHS at tier 2 and above, and how that is embedded in the broader health and social care strategy, including financial resources; regional variation; access to CAMHS on an emergency basis; and safeguarding children's rights and engagement. There might then be a couple of other issues depending on how the time goes; we are short on time at the moment. David, do you want to take the first set of questions, on early intervention?

[152] **David Rees:** Thank you, Chair. Good morning. In your evidence, you state that you welcome the additional early intervention resources that were made available and introduced under the Mental Health (Wales) Measure 2010. However, you then go on to say that early interventions for those identified with emerging difficulties are a dwindling resource. Can you match the two up?

[153] **Ms Thomas:** That is primarily because the primary mental health services are intended to be delivered as a multi-agency resource. So, the view is that all agencies have a part to play in CAMHS, as should be the case right the way through the tiers. With regard to primary mental health, what our services have always had access to, prior to the Measure, are primary mental health workers. Where they had a good relationship with that local primary mental health worker, that was very much appreciated. What the Measure brought in—and it was in response to an absence of provision with regard to adults, actually—was some additional resource with regard to addressing primary mental health problems in adults, and CAMHS was included in that. So, what we experienced was a slight increase in the capacity of provision.

[154] Now, with regard to all services, what they still report is that the link with the primary mental health practitioner is the key valued link. I spoke to a couple of services, and they said very clearly, 'We deliver quite a strong element of emotional mental health support through our services. If we need consultation, or if we need extra support, we have a person—a primary mental health practitioner—who we can have contact with'. That is a really important element of it.

[155] So, with regard to the dwindling element of the provision as a whole—because services have, obviously, been reduced over the past few years—we have experienced the loss

of quite important early intervention services, such as parenting. Parenting is a really key one, actually, which we have lost. That is a really important early intervention provision for children and young people. So, you know, there are elements of primary mental health provision that are actually delivered through the voluntary sector through other sectors that have come under pressure. In that respect, the entire primary mental health provision has been reduced.

[156] **David Rees:** Is it as a result of the funding cuts that we are seeing happening?

[157] **Ms Thomas:** Yes.

[158] **David Rees:** Is it also a possibility that the other agencies that you interact with are suffering the same?

[159] **Ms Thomas:** Yes, I think that we are seeing all agencies—statutory and voluntary—experiencing this reduction in service. That is a reality that we all have to deal with. However, what I am hearing from my services is that there is an increased level of empowerment and confidence in terms of their being recognised as deliverers of a primary mental health service. I think that that is a significant shift in terms of the fact that they are being really valued far more in terms of what they can deliver, and recognised as such.

[160] **David Rees:** Clearly, early intervention, as we always appreciate, is a critical element to target at the point where we can actually prevent later problems, in any individual. What do you see as the problems and the impacts that the early intervention loss will have on the children? You mentioned parenting—that is one aspect. What other aspects are we talking about?

[161] **Ms Thomas:** With regard to mental health problems in children, the earlier that you can intervene, the better. It is possible to identify mothers, who are just about to have babies, who may have a long history of problems themselves, and it is important to get provision in quite early, and put services around those young parents—mothers and fathers, actually—to support them to bring up their children.

[162] It is a huge question that you have just asked me, actually, because the way that early intervention is delivered is a really broad question. First and foremost, preventative services are separate from early intervention services. Preventative services are primarily delivered through universal provision, through schools, doctors' surgeries, and so on—the front-line services that we all use. What we have always delivered are services to very vulnerable groups of children, young people and families, who have been identified as having a need. We will come in to play at a point where there is an identified need, and we will go in and offer a provision. Now, I would say that all of our services, in that respect, offer an element of early intervention provision. We work with families and with children, we work in a child-centred way, we deliver family support services, and we deliver Flying Start services—all of those, in a way, are early intervention services. What we have seen over the past five years is that, for those services, the thresholds are having to go up and up, because there is more of a squeeze on all the services.

[163] **Ms Payne:** May I just add to that? The demands are also getting higher within that. That is probably on account of the fact that there is a vast array of services that are working in a preventive way that are being funded through various different opportunities now, which means that people are more astute and more aware of emerging issues. I think that that has had an impact as well, in that it has meant that there has been more of a need identified by practitioners. There is a mismatch there then.

[164] **David Rees:** As a consequence of that, do you believe that the tier 1 area of this is

actually given enough emphasis, and perhaps resources, to address those points? We talked about tiers 2, 3 and 4 earlier, but we are clearly talking about tier 1 here. Is that actually a prominent element of the whole process, in your view?

[165] **Ms Payne:** I think that we would both say that, in our experience, there have been great developments, through the Measure, with the primary mental health services that we see out there. Certainly, in Cardiff, I think that it has made a big impact, and will continue to do so, and that lots of opportunities are created through that. There may be regional—

[166] **David Rees:** I was going to ask the question of whether there is variation across—

[167] **Ms Payne:** There are differences that you might know more about, Menna.

[168] **Ms Thomas:** It has also been in combination with the development of Families First, really, which is an element of it.

[169] **Ann Jones:** Shall we move to community specialist CAMHS at tier 2 and above, Angela?

[170] **Angela Burns:** I apologise for not being here at the start of your evidence session. I was really interested to read the commentary that you made in your evidence that CAMHS closed cases of young people who were receiving support from Barnardo's. I would also like to build on some of the evidence that we heard in the earlier session about the patchy provision of tier 2 support. I just want to make the point that, for example, in the area that I represent there is a seven-year waiting list for diagnostic help and then support for children with autism—the range of autism spectrum disorders. So, I would just like to have your take on that, for a start.

[171] **Ms Thomas:** We were talking in our evidence about the experience of our Taith and Seraf services, which have varying experiences in relation to different CAMHS teams. Both teams work across quite a large geographical area. It may be useful for the committee to have some further written evidence about those specific cases. We are certainly aware that tier 2 CAMHS is under an enormous amount of stress. On these huge waiting lists that you referred to, I have been given some evidence from our service about huge waiting lists in terms of teams that are having to focus very specifically on some very high-end issues because they really do not have the resource, and are not having the resource, to deal with other mental health issues as a result of that. It is a very serious concern that the resource is not available to reach all of these quite complex high-end mental health cases that are brought to CAMHS.

[172] **Angela Burns:** May I ask you to just give us a view as to the differing kinds of effects that it would have on a young person if some of their earlier needs were addressed? For example, would the following be a fair statement: if you can get it early, you are actually saving that child, but with an awful lot of these issues, the longer you leave them the harder they become to resolve, and the greater impact that they would have on that young person and then that person as an adult? Perhaps you could share any views that you might have on the psychological and emotional cost to that person, and the cost to the state, of us not being able to provide that level of support out in the community—specialist support to help the tier 1 professionals in their interactions with those individuals.

[173] **Ms Payne:** As someone who has worked in the past as a clinical nurse specialist for looked-after children, I know that there is an obvious group of young people there. You know who they are going to be. There are those who are in the adoption and fostering services, and in the looked-after teams. What you have there are obvious attachment issues. Some of the problems with accessing services there are that attachment has not historically been recognised as something that CAMHS would deal with.

11:00

[174] As time has progressed, where you would have people like specialist family therapy teams working alongside CAMHS at the tier 2 level, what has happened over the past two years, certainly in Cardiff, is that the local authority has taken those teams back into the local authority and they are working specifically in family teams that are not necessarily seeing those people who may be suffering with an attachment disorder where there is an additional factor, which could be an underlying mental health disorder or a very complex issue to be unpicked. That would be a classic issue.

[175] **Ms Thomas:** But there is nothing to disagree with in what you said. If you are family with a child who has an autistic spectrum disorder and you know that there is a service that is available and that there is a known the model of working with that child and with that family, of course you want to have that input. If you then discover that you are on a seven-year waiting list and you have a six-year-old, you are looking at adolescence before that child and the family have any kind of input at all. Common sense tells you that things are not going to get any better. There is going to be distress and fury, really, at not being able to access that. Then, you have to come to terms with the fact that you are going to have to do without a service and wait for a service and, potentially, see your child not get the support they need for quite a long period of time.

[176] **Ms Payne:** Yes, and part of the frustration is linked to the fact that children have developmental needs and that children who are not picked up or managed, and whose families are not helped to negotiate some of those needs, will find that they are not able to develop in the same way. Therefore, there will be an impact on their attainment and achievement in school and on their ability to socialise and take on opportunities in education, training and employment. All of those will be affected and the costs there are phenomenal, if you could sit down and work them out. So, we would probably agree with that.

[177] **Angela Burns:** May I ask for your views on the provision for nought to five-year-olds? I ask because I am aware of the Wales Audit Office report. However, I have also heard from professionals in the past that there is a great range of disorders that you cannot diagnose at an early age and that, therefore, the child has to get to a certain level of maturity. So, do we beat ourselves up unnecessarily over the lack of provision for children aged between nought and five or is there this woeful gap that appears to be indicated?

[178] **Ms Payne:** In my experience, you know with a child aged between nought and five that something is wrong. The fact that it cannot be diagnosed is by the by in some respects, because you can still put the inputs in to help people to deal with whatever the issue is that is manifesting itself, thereby giving them the skills and coping strategies to manage in a way that they will have to develop on as time progresses and as needs change for the child.

[179] **Ms Thomas:** We can recognise that some parents are going to have more problems than others and that they might need support with parenting from early on. Flying Start makes that provision to a certain extent, but there is not a specialist mental health resource. I noticed in the NSPCC's evidence that the mother and baby unit in Cardiff, which is the only mother and baby unit available in Wales that deals very specifically with mental health problems in the parent that will have an impact on the child—. Everything you do as a parent has an impact on the development of your child. So, it was worrying to see that that was potentially under threat because, even though we have Flying Start, which has the capacity to recognise and pick up on the really, really worrying and difficult psychiatric problems that there might be in families, there is not necessarily the provision locally to deal with it.

[180] There was also a child psychotherapist who put in some evidence who was running

an attachment clinic for children aged nought to three out in Monmouthshire. That sounded like a really positive resource. She was working alongside Flying Start in that provision. I cannot imagine that that is a provision available across the country. We know so much about attachment and the impact of that on neurological development, and the impact of attachment and good relationships on neurological development throughout the life course, and certainly into adolescence, up to the age of 18, so we need to be taking note of this evidence and treating it seriously. I think that we do that to a large extent. Flying Start is a really good example of how we have taken that evidence very seriously, but there is a bit that is missing and it is that very specific group that have mental health disorders that can be recognised and addressed early on, perhaps before they become a fully-blown diagnosable adult mental health problem. There are certainly going to be young people that are very much at risk.

[181] **Angela Burns:** May I just make one very—

[182] **Ann Jones:** You can.

[183] **Angela Burns:** CAMHS provided a list of the kind of disorders that it deals with. It recognises that it deals with people with autistic spectrum disorder, et cetera. I am so interested in what you have to say about attachment disorder, because that reflected a lot of the evidence that we heard during the inquiry into adoption, that attachment is—. It is slightly more nebulous, is it not? It is not a thing that you can put a label on and say, 'Right; that agency will deal with it'. I do wonder, and would have an interest in your view, as to how many of the issues that we sometimes see, particularly in our schools with young children who have enormously challenging behaviour, where there is temper and they end up being expelled or put into other facilities for education, are actually not to do with one of the diagnosed and accepted areas, but this whole business, and what we can do to translate that into a thing that can be put in a box so that we can start diagnosing it and putting in intervention.

[184] **Ms Thomas:** When you have a problem such as that with a child at an early age you cannot look just at the child or just at delivering the intervention to the child. You have to look at delivering the intervention to the family as a whole, and you have to look at where the child is in school and what the implications are for the way that the child is educated. This is all part of being able to include everyone in school and maintain the forward momentum of a child's development. They need to be kept in school; they need to be supported to learn in a way that is suitable to their needs. There is so much evidence to tell us that, if you are going to address a problem with regard to a child, you have to look more broadly and look at the family. If you can support the family, there is far more opportunity for that child to develop successfully.

[185] It is always an enormous worry for parents. Parents know when there is something wrong with a child. When parents are in conflict, they worry about the implications of that on their children. If there is an illness or a trauma in the family, they worry about how that will affect the child. When they have illnesses themselves, they think, 'Has my child inherited this genetically from me?' We have to think about all of these things when we are looking at problems in children. It is a concern if what you have is a diagnosis that focuses very much on the illness inside the child and does not look more broadly at the context of that illness and the context of that child's development.

[186] **Angela Burns:** It is the holistic angle that I hope that we might start addressing through the special educational needs Bill, because that will pick up that. I am sure that it will pick up on that sort of holistic attitude.

[187] **Ann Jones:** Rebecca has a point on this, and then you can go into your questions as well.

[188] **Rebecca Evans:** I want to take you back to your comments on autism spectrum disorder. The Deputy Minister has been clear that a lack of diagnosis should not be a barrier to accessing services and support. Is it your experience that that is happening at all, or is it still the case that diagnosis is the gateway to getting the help that families need?

[189] **Ms Payne:** I am not sure that I can answer on that. I do not have the experience—

[190] **Ms Thomas:** Are you thinking about ASD specifically?

[191] **Rebecca Evans:** Yes; it is part of the ASD strategic action plan. It followed on from that.

[192] **Ms Thomas:** Could you just repeat the question?

[193] **Rebecca Evans:** Yes. The Deputy Minister has said that you should still be able to access services and support, even if you do not have a formal diagnosis, if there is a suspicion that there is a potential diagnosis of ASD. Not having the diagnosis should not stop you from accessing the help that you need.

[194] **Ms Thomas:** Services. Right. Okay. I do not think that we are in a position to respond to that, are we? I certainly do not have the information—

[195] **Ms Payne:** I know that we do have services locally that deal with children with ASD, but I am not in a position to say whether or not that is with a diagnosis or without.

[196] **Rebecca Evans:** That is fine. I just picked up on it in your answer to Angela.

[197] On a different issue, the Wales Audit Office and Healthcare Inspectorate Wales report from 2009 said that joint working between the health, local authority and voluntary sectors was often ineffective. Has there been any progress on that?

[198] **Ms Payne:** Yes. We have been working tirelessly over the years, despite what has been going on politically, to work with children and young people who are obviously known to statutory services, and we have been developing relationships along the way with all sorts of people. As a result of that, we are also represented on different partnership boards, so that our voices are heard. We work very well in partnership with primary mental health services and there are lots of opportunities that will be afforded to us by working through partnerships, such as the Families First partnership in Cardiff, which is a joined-up strategic approach that seems to work well.

[199] I think that we are probably in a position where we are able to evidence outcomes, because we are under quite a high degree of scrutiny. Therefore, people are having to take notice of the fact that, where we do get involved and where we can work together, we can actually make a difference, and parents and children are reporting on that, and schools are reporting on that, and that does have a positive flavour. There is lots of work to be done, but I think that early indications are—I say ‘early indications’, but it does not feel like it has taken a short amount of time.

[200] **Ms Thomas:** Yes. I think that, within the Families First context, what we have seen is the Families First services commissioned as a partnership service. So, a number of different organisations have been commissioned simultaneously to deliver a thought-through programme to a targeted service user group, and the report that we get back on that from our services is that that is definitely an improvement.

[201] **Rebecca Evans:** I was pleased to read in your evidence the positive work that is going on with the youth offending teams and the substance misuse services. Are those isolated examples of good practice, or is this right across the board?

[202] **Ms Thomas:** It is another example of our services being very pleased to have access to a specialist CAMHS resource. So, within the youth offending teams, where we work with the same cases as the youth offending teams, it gives us an opportunity to have more direct contact with a CAMHS professional. That will enable us to make a referral on, or support a referral on, to a specialist tier 2 service, where that is needed, or just to have access to that resource so that we can maybe take some consultation and advice at various points.

[203] Where you have an opportunity for CAMHS professionals to come out into services in the community that we interface with, it is always useful to be able to see those people and to know that you can turn to them, or have some access to them. Obviously, we cannot have direct access to them, but, via the youth service, working with the same children, we can have that support. It is not wonderful, and it is not what it should be, but it is positive that that is being retained. We would like to see that being retained. I think that maybe that is the change of position; we would like to have some things retained. In an environment where so many things are disappearing, we are looking around and thinking, 'Right, that is quite important, we would like to retain that', rather than, 'We would like to have more of that, because that is not enough'.

[204] **Ms Payne:** May I add to that? I think that the potential there has been that people are much more aware of the different models and how the different models work in practice. What you have with the CAMHS model is very much a medical view; you are using diagnostic criteria to guide the work. Of course, what voluntary sector services generally do is very much a social model of care and there is a bit of an itch between those two things in practice. However, what we have done, I think, is that we have gone full circle. When you think about the family therapy teams that have left the health boards and gone back into local authorities, part of that is because there was always this issue of, 'We need to be diagnosing illnesses, as CAMHS, and the family therapy issue is somebody else's business; that needs to go somewhere else', rather than embracing it together. I think that, from an operational and practitioner's view, what we see in YOS is something that is actually bringing those two things back together, because it makes sense and it is more systemic in terms of the holistic framework.

11:15

[205] **Rebecca Evans:** I have one last question relating to that audit office report from 2009. It found that there was weak co-ordination between specialist CAMHS and educational psychology services. I am trying to establish whether there has been any progress since 2009. Do you have any experience of that?

[206] **Ms Thomas:** We have a major concern about the capacity of tier 2 CAMHS to work in partnership with other agencies. Specifically on educational psychologists, I am not sure that we are in a position to comment on that. Tier 2 CAMHS should be using and working to a care and treatment planning model now, which should be a very much service-user-focused care and treatment planning model. We are beginning to see that coming in to tier 2 services. As part of that, educational psychology should be working more closely with CAMHS as a consequence. Whether that is happening in practice, we cannot comment.

[207] **Rebecca Evans:** There are a lot of 'should be's.

[208] **Ms Thomas:** Certainly, our experience is that for care and treatment planning with some CAMHS teams we are recognised and drawn into the loop and involved in strategy

meetings. However, there are other CAMHS teams where we still do not really know what they are doing with the young person or child they are working with and we are not part of any care and treatment planning approach. It may be that it will take a while for the skills to develop and the practice and the culture of using that approach to move on.

[209] **Ms Payne:** I was at a presentation last week and part of what was being presented were statistics about CAMHS and what the Royal College of Psychiatry felt would be the full-time equivalent numbers for the population. The upshot was that, in the particular area that I was sitting in, they were saying that they had 20% of the recommended capacity. So, I can understand why educational psychologists might not be part of something, because, if they have only 20% of the capacity, some priorities will have to be made. As you were saying earlier, it is always going to be the safeguarding, high-risk, high-end services area that people will look to deliver on. The implications of that are why we are sat here today.

[210] **Ann Jones:** We will move on to access and regional variations. Simon and Aled have some points on that.

[211] **Simon Thomas:** Rwyf am ofyn fy nghwestiwn yn Gymraeg. Un o'r pethau oedd yn amlwg iawn yn eich tystiolaeth oedd y ffaith bod CAMHS yn gyffredinol wedi cael ei danariannu, cyn y toriadau diweddar hyn. Rydym wedi cael y dystiolaeth honno gan bobl eraill hefyd. Felly, mae gwasanaeth a oedd eisoes yn ddiffygiol mewn mannau o Gymru, fel rydych newydd amlinellu, nawr yn gorfod delio gyda thoriadau pellach. A allwch chi roi trosolwg o'r sefyllfa yng Nghymru, gan fod Barnardo's yn gweithio yn 20 o'r awdurdodau lleol, o ran yr amrywiaeth sy'n bodoli o ran mynediad at wasanaethau a darpariaeth CAMHS, fel rydych chi'n ei weld?

Simon Thomas: I will ask my question in Welsh. One of the things that was quite evident in the evidence you provided to us was the fact that CAMHS, in general, has been underfunded, before the recent cuts. We have had that evidence from other people as well. So, a service that was already deficient in areas of Wales, as you have just outlined, now has to deal with further cuts. Can you provide us with an overview of the situation in Wales, as Barnardo's works in 20 of the 22 local authorities in Wales, in terms of the variation that exists in terms of accessing services and CAMHS provision, as you see it?

[212] **Ms Thomas:** Fe wnaf ateb yn Saesneg, gan fy mod wedi ysgrifennu fy nodiadau yn Saesneg.

Ms Thomas: I will answer in English because I wrote my notes in English.

[213] Clearly, we have some evidence of a variety of provisions in different parts of the country. What we have experienced in terms of the various mental health fora we have sat on is—. Hang on; I will start again with this. Right. What happened, and what we have known for quite a long time, is that specialist CAMHS are under-resourced. There have always been complaints that specialist CAMHS have been under-resourced. In some parts of Wales, we have huge difficulties getting children into services. There are a number of reasons for that. One of the reasons is that a large proportion of our service users have emotional and behavioural problems that are not necessarily recognised as diagnosable mental health issues. They do not make it into specialist CAMHS; they do not meet the criteria. So, they are not served. They have enormous emotional problems and mental health problems, but they do not make it into those services. That might be appropriate for some, but it might be inappropriate for others.

[214] As things have moved on in Wales, we have had more policies that have drawn services together. We have had far more multi-agency work. There has been a drive towards more multi-agency working. You see that in Flying Start, as I have mentioned, in Families First and in the care and treatment planning element of the Mental Health (Wales) Measure

2010, and we will see it more in social care, now that adult and children and young people's services have come together. I have gone into a number of mental health fora previously, in relation to the policy developments regarding 'Together for Mental Health' and the development of the Measure; I am one of a very small number representing children and young people, but there is a vast number of adult mental health service representatives around the table. Historically, it has been the case that CAMHS has been this tiny little bit of children's services, and adult mental health has been a significant section of the health service.

[215] So, we go to the fora—and there is an issue about the way in which we speak to each other, to start with. There is a difference in language. We talk about mental health using certain types of terminology, and they talk about mental health using adult terminology. So, there is a problem of communication there. There is also the basic problem of voice—not being able to get yourself heard, because there just are not enough of you. I feel that specialist CAMHS have come under the cosh ferociously over the years, and I really do not know why there is such a limited resource. If there was a fairly good spread of professionals in each of those specialist CAMHS services, in each part of Wales, that in itself would, first, create an opportunity where we could speak to them more easily, to start with. Linguistically, we would be able to speak very easily to family therapists, child psychotherapists, psychologists, occupational therapists—people who are highly professionally trained CAMHS specialists.

[216] If you go to many of the specialist CAMHS teams in Wales, you see that they have lots of psychiatrists and nurses, who are absolutely needed in those services, but they are monocultures, practically. You will get the odd therapist or family therapist within them, but I cannot imagine how that professional would feel within the context of working with such clinical practitioners. It is difficult.

[217] **Ms Payne:** It is difficult to contain the whole when you are working in isolation, in the way in which they have to work because of the set-up of those services. I also think that, if you look at the commissioning of the services and the specifications of the services, you see that there are some key features to be found in those about continuity and coherence. Also, the voice of the child and the family need to be pitched in there in a way that is meaningful enough. What you have is a service that, in my understanding, is fairly clinic-led—other than the community intervention teams. Sometimes, it is very difficult to get a family to a clinic, when there is work and school, during the times at which clinics are available. So, you have to think about accessibility and expectations. I have a giggle sometimes when I think that I have spent 25 years actively trying to say to people, 'It's not CAMHS you want', because there is a belief out there, which is a fixed false belief, that CAMHS is the way to go. However, I was very pleased with the direction of travel in terms of the politics when 'Everybody's Business' came out, because it is everybody's business. We are still on that road, which is interesting. However, that is because there is such a complex set of issues to unpick. However, there are some very clear opportunities in there, through things like the service specifications and the commissioning arrangements, to create something a bit different that would be better for families.

[218] **Simon Thomas:** Un o'r pethau a ddaeth mas o'ch tystiolaeth ysgrifenedig, ac sy'n amlwg o'ch tystiolaeth y bore yma, yw'r diffyg ymwybyddiaeth ar lefel gomisiynu o'r effaith ar lawr gwlad—bod comisiynu yn cael ei wneud ar lefel strategol, ond nid oes darpariaeth wedyn. Rwy'n ceisio gweld y ffordd ymlaen. Rydych wedi dweud nad CAMHS yw'r ateb weithiau. A ydych yn sôn am rywbeth mwy meddal, fel therapi, gwaith

Simon Thomas: One of the things that came out of your written evidence, and has come out of your evidence this morning, is the lack of awareness at the commissioning level of the impact at the grass-roots level—commissioning is done at a strategic level, but there is then no provision. I am trying to see the way forward here. You have said that CAMHS is not always the answer. Are you talking about something softer, such as

gyda theulu ac ymyrraeth gynnar, efallai? Dro arall, mae angen CAMHS ond oherwydd bod dynesiad CAMHS yn eithaf clinigol, nid yw o reidrwydd yn delio gydag ymddygiad emosiynol ehangach y plentyn. Sut y gallwn wneud y ddau beth? Mae angen rhyw fath o wasanaeth. Ai chi sy'n codi'r rhai sy'n syrthio drwy'r craciau, fel petai?

therapy, work with families or early intervention, perhaps? At other times, there is a need for CAMHS but because the CAMHS approach is relatively clinical, it does not always deal with the wider emotional behaviour of the child. How can we do those two things? There is a need for some sort of service. Is it you that picks up those people who fall between the cracks, as it were?

[219] **Ms Thomas:** There are two issues that Sarah has described. There is a culture, which is quite important, because what we are saying about primary CAMHS is that, yes, we can deliver primary level emotional support, but sometimes we hit a barrier and we need a specialist to advise us. It is probably going to be the same within specialist CAMHS if you go up to tier 2. We could develop a specialist service to address particular needs. Maybe we could develop something around addressing the emotional and psychological needs of children with behavioural and emotional difficulties. However, we occasionally get stuck and we need to take the advice of a mental health professional, who can make an assessment and decide whether there is an element of mental illness in there that is more genetic and physiological, which needs treatment in a different way. It needs to be a combination of these different types of approach. So, there is the culture issue.

[220] There is also a real size issue. If you look at Cardiff and Vale, for example, we have one tier 2 community CAMHS team. You have six adult community CAMHS teams in Cardiff and one in Cardiff and Vale. I am sure that there are far more adults than children and young people who potentially need the service—there must be a reason behind that—

[221] **Simon Thomas:** Those adults are the children who did not get the intervention at the right time.

[222] **Ms Thomas:** Yes. I am sure that there is an imbalance. I do not have statistical evidence, but instinctively you just know, and you know from practice, that that is not enough; we need more. If what we have are these very small teams that are being forced to work in a very limited way, how can they possibly be expected to take on developing partnership work? That takes time. How can they possibly be expected to do really good participative work with children? That takes time. You have to make time for that. You have to have skills for that. Those things are important features of good mental health work. Participation is a really important feature of good mental health work. It is fundamental within the care and treatment planning approach; it is one of the underlying principles. It is a shame that we are not in a position to deliver, because it is really the right way forward, in our view.

[223] **Ms Payne:** We also have very good local examples, going back to the issue around how we work together, of setting up things like bereavement services, where we know that there are gaps. Given the priorities, it would be those sorts of things that would be less of a priority. We have managed to develop a clinical service, because we have bought in the clinical psychology and set up a partnership with the local university health board. So, where we can, we will get in and do the bit to support, hopefully, the services dealing with what they need to deal with as well. However, you have to be confident and able to do that in practice.

[224] **Ann Jones:** We have about quarter of an hour left, and there are two other areas that I want to come on to. Aled, you have some questions around regional variance.

[225] **Aled Roberts:** Roedd Keith Davies yn dweud bod cynnydd o rhyw £200 miliwn

Aled Roberts: Keith Davies said that there had been an increase of around £200 million

yn ystod y pum mlynedd diwethaf ar wariant ar wasanaethau iechyd meddwl. Fodd bynnag, dim ond tua 10% o'r ffigur a aeth i wasanaethau plant a phobl ifanc. Os yw'r holl fforymau hyn yn cyfarfod ar draws Cymru yn ymwneud â mudiadau gwirfoddol, llywodraeth leol a'r gwasanaeth iechyd, a'n bod, 15 mlynedd ar ôl datganoli, yn gweld bod y gwasanaeth yn union yn yr un man—hwyrach bod hynny yn rhy ddifrifol, ond nid oes llawer o symud wedi bod—pam nad yw'r holl drafodaethau hyn ar gomisiynu gwasanaethau ychwanegol yn digwydd o fewn y fforymau? Dyna beth sydd yn anodd i'w ddeall. Rydych chi i gyd yn cyfarfod yn fisol, rydych yn gweld nad yw'r system yn gweithio, felly pam nad oes trafodaeth ynglŷn â newid y ffordd y mae pethau yn cael eu trefnu?

over the past five years in mental health services expenditure. However, only 10% of that figure had filtered down to CAMHS. If all of these fora meet across Wales in relation to voluntary groups, local government and the health service, and we are, 15 years on from devolution, seeing that the service is in the same place—perhaps that is too critical, but there has not been a great deal of movement forward—why do all of these discussions and the commissioning of additional services not take place within these fora? That is what is difficult to understand. You all meet monthly, you see that the service and the system are not working, why is there no discussion about changing the way that things are arranged?

11:30

[226] **Ms Thomas:** Mae hwnnw'n gwestiwn da iawn. Pam nad yw hyn wedi digwydd?

Ms Thomas: That is a very good question. Why has this not happened?

[227] It is a very difficult question to answer. Why has CAMHS not been prioritised? Why has it not been embedded? I think that the response is partly similar to the one that I gave to Simon: if you are not big enough, you cannot get involved in the fora. You cannot fully make your voice heard if you are so small and limited and you are dealing with having to get to grips with new legislation, having to get to grips with being asked to improve your transition services or to improve your learning disability services because it has been noticed that they are falling short. It is a very tiny service, is it not? If you have, historically, a very tiny staffed service, you cannot suddenly expect that service to be able to participate fully in those kinds of fora. Making excuses for CAMHS is terrible, really.

[228] **Aled Roberts:** Your written evidence talks of it being a non-age-focused system now and you say that that creates problems with adult services dominating the discussion. Surely, those same adult services should recognise that, unless services are dealt with through intervention as early in the age group as possible, it would show through in the pressures on their own services, albeit after some time. Those discussions are not taking place, by the sound of it.

[229] **Ms Payne:** Certainly, the group that I am in does not have the mandate to be the commissioners of the—

[230] **Aled Roberts:** Do any of the commissioners come along to these fora?

[231] **Ms Thomas:** No, you attend a local forum at the moment. I have actually—. Sorry; you go on, Sarah.

[232] **Ann Jones:** Everyone is pinching everybody else's questions today, so carry on.

[233] **Ms Payne:** I am not aware of commissioning discussions taking place at those meetings. I do think that the agendas are very tight; they are very adult orientated and focused

on things like feeding back into the delivery and action plans put together for mental health in a way that is at quite a high strategic level. They are being driven in a way that, perhaps, does not allow them the opportunity or the time to be innovative and to think about working together differently. Where partnership arrangements in commissioning have worked well, in some areas, is through things like Families First functions, because there has been a different driver, perhaps.

[234] **Ann Jones:** Next, we come to access to CAMHS on an emergency basis. Bethan and Suzy, I do not know who is going first.

[235] **Bethan Jenkins:** Roeddwn yn gofyn yn gynharach i Goleg Brenhinol y Seiciatryddion am bobl ifanc yn cael eu rhoi ar wardiau oedolion. A ydych yn credu bod hynny'n digwydd yn amlach neu'n llai aml yn awr? Hoffwn ofyn hefyd beth y gall staff *A&E* ei wneud o ran eu doniau i ymwneud â phobl ifanc sydd â phroblemau iechyd meddwl yng nghyd-destun y ffaith bod llai o welyau ar gael pan fydd pobl yn mynd i'r sefyllfaoedd hyn. Rwy'n gwybod eich bod wedi rhoi enghraifft o berson ifanc yn eich tystiolaeth, felly rwy'n siŵr eich bod yn gwybod beth sydd yn digwydd.

Bethan Jenkins: I was asking the Royal College of Psychiatrists earlier about young people being placed on adult wards. Do you think that that happens to a greater or a lesser extent now? I would also like to ask you what A&E staff can do in relation to their skills for dealing with young people with mental health problems in the context of fewer beds being available when young people go into these settings. I know that you gave an example of a young person in your paper, so I am sure that you are aware of what happens.

[236] **Ms Thomas:** Yn bendant, rydym yn dal i weld ambell i berson ifanc yn cael y math o brofiad yr ydych yn sôn amdano, Bethan.

Ms Thomas: We certainly are still seeing some young people having the experiences that you mention, Bethan.

[237] That is about as much as we can say about it. We are still having that experience and we should not still be having that experience. Sometimes, with the cases that we are seeing going in on an emergency basis, you can see that that emergency is building up—it is coming. You might be trying to get prior support for it and then it occurs. Yes, that is still happening and it should not be happening.

[238] I think that the point that you make about accident and emergency staff is an interesting one, because there has always been an issue around what can happen at that point. How a young person is received into an accident and emergency department—how their self-harm or hurt is responded to—makes a big difference to them. There is something about equipping those people with the emotional intelligence and skills to deal sensitively at that stage that can actually have very positive implications for that young person at that point—or the opposite, if they are treated in a very medical and rather—. I do not have much detailed evidence from my services, but I know that Sarah—.

[239] **Ms Payne:** Yes. As we have been talking, I have been thinking about how some of the approaches that the integrated family support teams use—the restorative approaches and motivational interviewing—seem to be quite useful techniques in helping people to think about the way that they communicate, not only with a distressed child, but also with a family that is in distress, because, often, there will be a family to deal with. Historically, accident and emergency will look at the child who arrives at the door—it has a lot of other issues to take into account as well, and there is a kind of harm minimisation approach in assessing the risks that are posed with having a child in that condition there at the time.

[240] There is also the youth mental health first aid that has been widely rolled out. From

discussions that I have had recently with primary mental health workers in the area that I am in, I know that we are talking about doing joint training for GPs. That would be something that we would hope that we could also roll out for other medical staff who would benefit as well.

[241] **Bethan Jenkins:** A ydych chi'n gweld hefyd bod rhai pobl ifanc yn mynd yn ôl ac ymlaen i A&E? Mae gen i enghreifftiau lle mae person ifanc wedi cyflawni rhyw fath o drosedd, efallai, ac yn cael eu trin mewn ffordd y maent yn teimlo sy'n amharchus ac maent yn cadw i fynd yn ôl, achos maent yn cadw i fynd i'r eithaf o'r sefyllfa yn hytrach na'u bod nhw yn ymwneud gyda lefel 2 neu 3 CAMHS. Maent yn gwthio yn erbyn hynny ac felly, wastad yn mynd yn ôl i'r ardal fwyaf eithaf o'r sefyllfa. A ydych chi'n cael enghreifftiau o hynny a sut ydych chi wedyn yn delio â hynny? Rwy'n siŵr eu bod yn achosion bach, ond efallai eu bod yn rhai sy'n creu lot o broblemau o fewn y system.

Bethan Jenkins: Do you also see that there are some young people who go back and forth to A&E? I have examples of where a young person has, perhaps, committed some sort of an offence and they are treated in a way that they feel is disrespectful, and they keep going back, because they keep going to that extreme, rather than being involved with CAMHS tiers 2 and 3. They push against that, so they always go back to the most extreme provision. Do you see examples of that and how do you deal with that? I am sure that they are minor cases, but they are minor cases that perhaps create a great deal of problems within the system.

[242] **Ms Thomas:** Yn bendant, gyda phlant sydd â phroblemau ymddygiad ac emosiynol—

Ms Thomas: Certainly, with children who have behavioural and emotional problems—

[243] —they get very distressed and they will present at A&E at various times, because they might be unable to get any specific clinical or mental health input from another source and it builds up and they do go back and forth. Is that what you are trying to ask me, or have I missed the point?

[244] **Bethan Jenkins:** Yes. Quite often, they will deny that they have an issue themselves, or they will feel that they have been rejected by the health service in one way or another. So, they keep presenting to that extreme, as opposed to being able, or not 'able' but willing to access—

[245] **Ms Thomas:** Yes. They are crying out for some sort of help and it is almost like a nebulous thing that they need to have addressed. I hope that I made quite a strong argument about the vast number of emotional and behavioural problems that are presented at our services, many of which will not be diagnosable and will not get a tier 2 CAMHS service, although they should get some sort of service. In fact, you would think that, in a situation like that, the tier 2 CAMHS service would think, 'Hang on; we're missing a large number of young people here. Let's approach some organisations that are able to access these young people and let's see whether we can work together'. That would be the most sensible thing to do.

[246] We have some really good examples of pilot projects that have taken place in Wales. There is an Action for Children one that is coming to an end in Aneurin Bevan health board at the moment, which focuses on work with care leavers who are very troubled—they have had severe troubles over their care histories. It uses group work in community settings with psychologists and practitioners, and it uses a dialectical behaviour therapy approach and basically offers good, close, warm, supportive, flexible and responsive relationships to these children and young people.

[247] I saw a presentation on this piece of work. It is very similar to so many pieces of

work that we have delivered over the years. The Caterpillar project is one, which was funded by the Big Lottery. This is also funded by the Big Lottery. Caterpillar was delivered along very similar lines, capturing these young people who are very fragile and have huge emotional distress issues and are somehow difficult to get hold of from the point of view of CAMHS; they just do not get to grips with them. Yes, there is a huge problem there and we need to address it. There are some models out there. I think that one of the things that it might be useful to do is scope what has happened so far and maybe do a bit of research into the features of the models that work, and into how we can develop a service for these children and young people that actually reaches them and delivers for them. There is a strong mental health element in it, but, again, it is not a clinical mental health approach that you need—you need a far more social mental health approach. You need to be very creative in your approach, and you need to work with other services. We definitely need to think about how we deal with that service user group. They are putting a lot of pressure on a number of different services, because their needs are not being addressed.

[248] **Ann Jones:** I call on Suzy, and Keith has some questions, but we have a few minutes left.

[249] **Suzy Davies:** I wanted to ask you a question about culture, as much as anything else, when it comes to emergency admissions, because, almost inevitably, emergency presentations are going to come to people's notice via the medical route through A&E and their immediate response is going to be a medical response, sometimes a physical response, but hopefully an assessment as well. We took evidence from the royal college a moment ago that that builds up an expectation among those young people and their families that the answer to all of their problems will be medical. You have given evidence as well today that says that that is not always the case, and that the social model has a lot to offer. I do not want to extrapolate just from two sets of evidence, but I get the sense from what we heard from the medical profession this morning that it is complaining that it is getting stuck with all the heavy lifting and you are telling us today that, in the third sector and non-medical part of provision, you are struggling to get your voices heard and that you are up against monocultures. Am I reading too much into this and is there a cultural problem as well as a financial and planning problem, or is this strictly a planning issue?

[250] **Ms Thomas:** I think that the two must go hand-in-hand. What I try to communicate in my evidence is that we think that the two probably go hand-in-hand. If you do not have a suitably resourced team, then it is very difficult for that team to deliver in a participative way.

[251] **Ms Payne:** I think that they are part of the same package, whichever way you look at it. You cannot say that it is either/or; it is the whole.

[252] **Suzy Davies:** Yet we have heard the medical side saying, 'As soon as we turn up, everybody else flees, because they haven't got any money'. I am sure that you do not recognise that.

[253] **Ms Payne:** It does not have to be like that. I think that I am in an interesting position, in that I have been on both sides and, therefore, I can say with confidence that it is everybody's business, and 'everybody's business' probably did not go far enough in terms of reaching out and saying, 'There's an opportunity out there for tier 1 services as well as a time and a place—

[254] **Suzy Davies:** So, can I ask you specifically, then, what your view would be on the Royal College of Psychiatrists's comment that

[255] 'there is frequently a lack of clarity as to which practitioners from which agency will take the lead responsibility for assessment and management of the case.'

[256] That is, following on from an emergency admission. It was quite clear.

[257] **Ms Payne:** I think that if it has got the evidence to support that, or if it was talking about an example where it can provide the evidence—. I do not have the evidence to provide either way on that—

[258] **Suzy Davies:** Okay, then you do not recognise that particularly.

[259] **Ms Thomas:** What you should have at that point is a holistic assessment, is it not? You should have an assessment of the child or young person when they come into emergency services—

[260] **Suzy Davies:** No, it said that that does take place, but that immediately sends everybody off down the medical model route.

[261] **Ms Thomas:** Did you say it sends everybody off on the medical model route?

[262] **Suzy Davies:** Yes. If you present at A&E, you are seen in the medical environment, you get an assessment—it admitted that an assessment takes place—but that raises an expectation in the family that all the answers in the future are likely to be medical. Then the practitioners went on to say that as soon as they get anywhere near a multi-agency time in the timeline, civil society might back off. They say that it is because of a lack of funding, and that the medical part of the team ends up having to take a lot of the lead.

[263] **Ms Thomas:** Right. I—[*Interruption.*]

[264] **Ann Jones:** [*Inaudible.*]—and it is outside of your expertise, because we are running out of—

[265] **Suzy Davies:** No, I was aware of that. I did not want the answer to go on that long.

[266] **Ms Payne:** I would say that it does not have to be like that.

[267] **Ann Jones:** We are almost out of time, so, Keith, can you wrap what is left after what everybody else has picked up into your questions?

11:45

[268] **Keith Davies:** Diolch yn fawr, Gadeirydd. Gofynnaf fy nghwestiynau yn y Gymraeg hefyd. Rydych chi wedi sôn yn barod am y model CAMHS clinigol cymunedol ac nad yw'n gwneud digon gyda theuluoedd a bod hawliau plant wedyn yn dioddef. Roeddech chi wedi dweud hynny yn gynharach. Fodd bynnag, mae hefyd adroddiad gan Arolygiaeth Gofal Iechyd Cymru yn 2009 yn dweud nad yw'r plant yn gwybod digon—nid ydynt wedi bod yn rhan o gynllunio eu gofal eu hunain. Os yw hynny'n digwydd, yn ôl yr arolygiaeth, efallai y byddai newidiadau o ran lle mae'r arian yn mynd—y cwestiwn yr oedd Aled yn ei ofyn yn gynharach. Os byddem yn gofyn

Keith Davies: Thank you, Chair. I will ask my questions in Welsh as well. You have already mentioned the clinical community CAMHS model and that it does not do enough with families and that children's rights then suffer. You said that earlier. However, in addition, the report by Healthcare Inspectorate Wales in 2009 says that children do not know enough—they have not been part of the planning of their own care. If that happened, according to the inspectorate, perhaps there would be changes in where the funding goes—the question that Aled was asking earlier. If we asked the children, or if they had more information, perhaps we could then change the attitude of

i'r plant, neu pe bai gan y plant fwy o wybodaeth, efallai y gallem wedyn newid agwedd rhai o'r bobl sy'n penderfynu ar le mae'r arian yn cael ei wario.

some of the people who decide where the funding is spent.

[269] **Ms Thomas:** With the care and treatment planning model, which all specialist CAMHS should be delivering now—in fact, I think the 2011 review of safety issues in CAMHS evidenced that 94% of them were receiving a plan—. So, they have a plan, and that plan should be service-user centred, so those children and young people should be having a voice. Our experience is that we are not always engaged in those plans, which makes us concerned that maybe those children and young people are not being engaged fully either. Participation and listening to children takes time, skills and effort, and I think that we would need to see evidence that that was growing and improving in CAMHS. However, we do not see it at the moment.

[270] **Ms Payne:** Where there are good partnerships, we are always looking to assist in facilitating that. We have done that, and we do that as part of our core services. We work within the participation standards, and that is a big piece of what we do in terms of advocating for young people and providing evidence. Of course, that also helps us in that it supports our bids and the tenders that we put in to people like the Big Lottery Fund. It is a challenging time, because funders will say to us is that these are core services, so we have to be able to evidence by saying, 'Well, yes they are, but what young people are telling us is that they want things to be done differently.' We have a transition service in Barnardo's at the moment working to help people, children in particular, to move from child and adolescent mental health services to adult mental health services. The emphasis is very much on helping them to access education, training and employment opportunities, because despite whatever it is they have in terms of a diagnosis, they obviously need to get on and get something out of whatever their life will unfold into. It is very clear from that that the success has been that we work alongside the young person, and we are there if the young person wants us to be there. What we have said as part of our criteria is that our preferred model is to go in at a time when there is a transition meeting, so that we are part of something, because I think that, historically, voluntary sector services and other services have worked in isolation more than we should. We should be part of something more meaningful so that we can say, 'Ah, yes, but the young person wants this'. So, in a way it is to get their voices heard, recorded and, obviously, addressed.

[271] **Keith Davies:** We might get more of the finance coming down to CAMHS, then.

[272] **Ann Jones:** We are out of time. First, I thank you very much for your written evidence, and, secondly, for coming today to talk to us about some of the issues. We will send you a copy of the transcript to check for accuracy. Thank you both very much.

[273] We will move on because we are running significantly late now, so Members will just have to bear with us. I know that we are supposed to finish at 12.15 p.m., but we may have to go over.

[274] **Suzy Davies:** Can I request shorter questions?

[275] **Ann Jones:** Yes, I was going to appeal for some sort of shorter questions, if that is okay. That is great.

11:48

Craffu ar Adroddiad Blynyddol Estyn 2012-13
Scrutiny of Estyn's Annual Report 2012-13

[276] **Ann Jones:** I apologise for keeping you waiting. We are running very late. Please do not inspect the quality of the chairmanship, or chairship, here. I think I would probably get a D minus at the moment. We are running very late. I have just explained to Members that we will have to run over, but we will appeal for some very short questions and some relevant answers as well, if that is all right with you. First of all, thank you very much for coming in. This is a bit in the way that—. We have already had, as you will know, a Plenary debate on your annual report, but the committee felt that we wanted to touch on some areas that perhaps Members had not. So, as I say, apologies for running late. Will you, very briefly, introduce your team and then we will go into some questions? Simon will start the questions off.

[277] **Ms Keane:** I am Ann Keane, chief inspector of Estyn. Next to me on one side is Meilyr Rowlands.

[278] **Mr Rowlands:** I am a strategic director at Estyn.

[279] **Mr Brown:** I am Simon Brown, strategic director at Estyn.

[280] **Ann Jones:** That is great; thanks very much. Simon, do you want to start the questioning?

[281] **Simon Thomas:** Diolch, Gadeirydd. Yn gyntaf, o edrych ar yr adroddiad hwn, mae'r safonau a'r naratif yn reit debyg i adroddiad y llynedd. Ond, un lle efallai sydd yn peri pryder i mi yw'r ffaith bod cyn lleied o'r ysgolion yn cael eu cydnabod fel rhai rhagorol, yn enwedig ym maes ysgolion uwchradd, lle mae lleihad yn y nifer sy'n cael eu gweld yn rhagorol. Yng nghyd-destun y ffaith mai eich casgliad chi yn gyffredinol yw mai rhannu arfer da rhwng athrawon ac ysgolion yw'r ffordd ymlaen i'r gyfundrefn, ym mha ffordd yr ydych chi'n gweld yr adroddiad hwn yn dangos bod cynnydd a bod llwybr clir i godi safonau yng Nghymru?

Simon Thomas: Thank you, Chair. First, in looking at this report, the standards and the narrative are quite similar to last year's report. However, one area that causes me concern is the fact that so few schools are acknowledged as excellent ones, especially in relation to secondary schools, where there has been a decrease in the number that are seen as excellent. In the context of the fact that your conclusion in general is that sharing good practice between teachers and schools is the way forward for the system, in which way do you see this report showing that there has been progress and that there is a clear path to raise standards in Wales?

[282] **Ms Keane:** Nid ydym wedi gweld y gwelliannau sydd eu hangen arnom. O edrych ar y safonau yn y cynradd a'r uwchradd yn arbennig, mae hynny yn siomedig. Mae'r ffaith bod tua hanner yr ysgolion cynradd yn mynd i gael arolygiadau dilyn-i-fyny a 70% o ysgolion uwchradd yn mynd i gael arolygiadau dilyn-i-fyny, yn dangos bod consýrn gyda ni ynglŷn â'r safonau ar draws y system a'r gyfundrefn.

Ms Keane: We have not seen the improvements that are needed. Looking at the standards at primary and secondary level in particular, that is disappointing. The fact that about half of the primary schools are going to have follow-up inspections, and that 70% of secondary schools are going to have follow-up inspections, shows that we have a concern about standards across the system and the sector.

[283] Ie, rhannu arfer da yw'r ateb, a rhoi arweiniad o fewn y sector. Mae atebion eraill hefyd wrth gwrs. Mae angen i bob ysgol edrych ar sut maen nhw'n delio gydag

Yes, sharing good practice is the answer, and providing leadership within the sector. There are other answers of course. There is a need for every school to look at how they deal

anfantais ac mae angen strategaethau clir ynglŷn â hynny. Mae angen hefyd i ni edrych ar sut rydym yn adeiladau capasiti athrawon i wella a sut rydym yn llenwi'r bylchau yn eu gwybodaeth nhw a'r ffordd y maen nhw'n addysgu. Mae hynny yn her enfawr. Mae'r consortia gyda ni a nifer o bethau newydd sy'n dal heb ddylanwadu yn ddigonol ar y sectorau hyn nac ar y safonau yn y sectorau. Rwy'n sôn am y fframwaith llythrennedd a rhifedd a'r profion. Mae'r rhain i gyd yn bethau sydd yn weddol ddiweddar o ran eu cyflwyno. Dyma ein blaenoriaethau ni: delio gydag anfantais a strategaethau i ddelio gyda hynny. Rydym yn gwybod bod hynny yn flaenoriaeth i'r Gweinidog presennol yn arbennig. Hefyd, rydym am sicrhau bod safonau, nid yn unig mewn llythrennedd a rhifedd ar draws y cwricwlwm, ond mewn Saesneg, Cymraeg, mathemateg a gwyddoniaeth yn uchel, ac mae hynny'n golygu bod yn rhaid cael strategaethau i godi capasiti athrawon yn y pynciau hynny. Nid yw llythrennedd a rhifedd ar draws y cwricwlwm yn mynd i weithio oni bai bod yr athrawon Saesneg, Cymraeg a mathemateg yn gwella.

with disadvantage and clear strategies are needed for that. There is also a need for us to look at how we build the capacity of teachers to improve and how we fill the gaps in their knowledge and the way in which they teach. That is a massive challenge. We have the consortia and a number of new things that have still have not had an adequate influence on these sectors or on the standards in those sectors. I am talking about the literacy and numeracy framework and the tests. All of these are things that are quite recent in terms of introduction. These are our priorities: to deal with disadvantage and strategies to deal with that. We know that that is a priority for the current Minister in particular. Also, ensuring that standards not only in literacy and numeracy across the curriculum, but in English, Welsh, mathematics and science are high, and that means that there is a need for strategies to increase the capacity of teachers in those subjects. Literacy and numeracy across the curriculum will not work unless the English, Welsh and mathematics teachers improve.

[284] Mae ymarferwyr da yn eu plith, ond mae angen i'r rheini ddatblygu eu gallu ymhellach ac i arwain y lleill, a dyna pam rwyf yn sôn am ganolfannau rhagoriaeth. Rwy'n credu hefyd na ddylid dweud oddi uchod wrth athrawon beth i'w wneud; nid dyna'r ateb. Rhaid i ni edrych ar ffyrdd o arwain y sector sy'n cynnwys yr athrawon eu hunain, achos mae arfer da yn y sector.

There are good practitioners among them, but there is a need for them to develop their ability further and to lead the others, and that is why I talk about centres of excellence. I believe as well that teachers should not be told from high what to do; that is not the answer. We have to look at ways of leading the sector that include the teachers themselves, because there is good practice in the sector.

[285] **Simon Thomas:** Diolch am hynny. Gan eich bod yn dweud nad ydym wedi gweld y cynnydd y byddech yn dymuno ei weld er mwyn gweld y gwelliannau y mae pawb yn sôn amdanyn nhw, ond gan eich bod hefyd yn dweud bod yna arfer da yn y sector, i ba raddau y mae'r cyswllt hwnnw yn cael ei wneud ar hyn o bryd? A ydych chi wedi canfod bod y cysylltiadau yn cael eu gwneud i lefel ddigonol, naill ai gan y consortia o ran trefniadau, neu drwy'r ffaith bod ysgolion nawr yn cydweithio mwy fel teuluoedd ymysg ei gilydd? Ydy hyn yn rhoi rhyw fath o sicrwydd i chi bod hyn ar y gweill yn awr?

Simon Thomas: Thank you for that. As you have said that we have not seen the progress that you would wish to see in order to see the improvements that everyone has been talking about, but as you also say that there is good practice in the sector, to what extent is that link being made at present? Have you found that the links are being made to a sufficient degree, either by the consortia in terms of arrangements, or by the fact that schools are collaborating more as families among themselves? Does that give you some sort of certainty that this is going on now?

[286] **Ms Keane:** Nid yw'n rhoi sicrwydd i

Ms Keane: It does not give us an assurance

ni bod y gwelliannau hyn yn digwydd mewn ffordd gyson ar draws yr holl sectorau. Mae'n dangos bod mentrau a pholisïau sy'n gweithio naill ai ar lefelau gwahanol neu sy'n cael eu cynnig gan gyrff gwahanol, fel y consortia a'r rhaglen gymorth genedlaethol—yr NSP, sy'n gysylltiedig â'r fframwaith—Her Ysgolion Cymru, sef School Challenge Cymru, ac yn y consortia canolog yn y de, lle mae her sy'n debyg i'r London Challenge. Felly, mae nifer o fentrau. Mae hefyd nifer o fentrau o fewn consortia, lle maent yn dod a rhoi arweiniad i athrawon ar bethau fel y fframwaith llythrennedd a rhifedd, ac mae gennych yr NSP—y *national support programme*, sydd yn gwneud hynny hefyd.

that these improvements are taking place in a consistent way across all the sectors. It does show that there are initiatives and policies that work either on different levels or are being offered by various groups, such as the consortia and the national support programme—the NSP, which is associated with the framework—School Challenge Cymru, and in the central consortia in the south, where there is a challenge similar to the London Challenge. So, there are a number of initiatives. There are also a number of initiatives within consortia, where they come and provide guidance to teachers on things such as the literacy and numeracy framework, and you have the NSP—the national support programme, which does that as well.

[287] Un peth rwy'n poeni rhywfaint amdano yw'r ffaith ein bod yn dal i ddal pobl i gyfrif a chreu systemau newydd o ddal pobl i gyfrif, a bod gormod o bwyslais ar hynny a phwyslais rhy fach ar adeiladu capasiti o fewn y gweithlu. Mae gennym ni brofion a bandio ac mae gennym ni gategoreiddio ar ran y consortia. Mae gennym ni'r NSP yn gweithredu hefyd wrth osod targedau ac wrth fonitro sut mae'r ysgolion yn cyrraedd targedau. Mae Estyn ei hun yn ffordd o ddal pobl i gyfrif. Y cwestiwn mawr yw: pwy sy'n bwydo'r system a phwy sy'n gwella'r system? Sut ydym ni'n mynd i'r afael â hynny? Nid ydym ni'n gwneud hynny'n systematig yn genedlaethol ar hyn o bryd.

One thing that I am slightly concerned about is the fact that we still hold people to account and create new systems of holding people to account, and that there is too much emphasis on that, but not enough emphasis on building capacity within the workforce. We have tests and banding and we have categorisation on behalf of the consortia. We have the NSP operating as well by setting targets and by monitoring how schools are reaching targets. Estyn itself is a way of holding people to account. The big question is: who is feeding the system and who is improving the system? How do we address that? We are not doing that systematically on a national level at present.

[288] **Simon Thomas:** Pwy ddylai fod yn gyfrifol am wneud hynny? Ai'r consortia a ddylai wneud hynny?

Simon Thomas: Who should be responsible for doing that? Should it be the consortia?

[289] **Ms Keane:** Mater polisi i'r Llywodraeth yw penderfynu pwy ddylai wneud hynny, ond rwy'n credu'n gryf bod angen trosolwg cenedlaethol.

Ms Keane: Deciding who should do that is a matter of Government policy, but I strongly believe that there needs to be a national overview.

[290] **Simon Thomas:** Rydych chi'n dweud bod rhai o'r pethau hyn ar y gweill ond nad ydynt yn llwyr weithredol eto. Nid yw pob consortiwm yn gweithredu yn yr un ffordd, hyd yn oed heddiw. A ddaw amser pan fyddwch chi'n teimlo mai un o'ch dyletswyddau chi fel arolygwyr fydd arolygu'r consortia? Rydych yn arolygu'r awdurdodau ond—

Simon Thomas: You say that some of the plans that are in the pipeline are not yet fully operational. Not every consortium operates in the same way, even today. Will there come a time when you will feel that one of your duties as inspectors will be to inspect the consortia? You inspect the authorities, but—

[291] **Ms Keane:** Rydym ni'n mynd i arolygu'r consortia. Rydym ni'n gwneud arolwg eleni a fydd yn adrodd ar draws y consortia i gyd ac yn cael ei gyhoeddi yng ngwanwyn y flwyddyn nesaf. Fodd bynnag, ar ôl hynny, byddwn hefyd yn arolygu'r consortia bob tymor am bedwar tymor hyd nes bydd beth bynnag fydd y drefn yn amlygu ei hun o ran arolygu yn y dyfodol.

Ms Keane: We are going to inspect the consortia. We are undertaking an inspection this year that will report across all the consortia and will be published next spring. However, following that, we will be inspecting the consortia every term for four terms until the regime in terms of inspection in the future emerges.

[292] **Simon Thomas:** Ai pwrpas hynny fydd edrych ar sut maen nhw'n adeiladu'r capasiti hwn, yn hytrach nag edrych ar y gwaith sydd yn digwydd, neu'r broses? Hynny yw, bydd yn edrych yn hytrach ar sut mae rhywbeth yn deillio o'r broses hon.

Simon Thomas: Will the purpose of that be to look at how they build this capacity, rather than looking at the work that is happening, or the process? That is, it will look instead at how outcomes emerge from this process

[293] **Ms Keane:** Mae'r arweinyddion system, sydd bellach ar fin cael eu galw'n 'ymgynghorwyr her', yn dal pobl i gyfrif, a byddwn ni'n edrych i weld i ba raddau y mae'r rheini wedi bod yn effeithiol.

Ms Keane: The system leaders, who are now about to be called 'challenge consultants', hold people to account, and we will look at the extent to which they have been effective.

[294] **Mr Rowlands:** Efallai ei fod yn werth nodi y byddwn yn edrych eleni, mewn arolwg thematig, ar y ffordd mae ysgolion yn rhannu arfer da o ysgol i ysgol. Mae lot o baru ysgolion ar hyn o bryd, ac rydym yn mynd i edrych ar lwyddiannau a methiannau'r system honno.

Mr Rowlands: Perhaps it is worth noting that this year, in a thematic inspection, we will be looking at the way that schools are sharing good practice between schools. There is a lot of pairing of schools at present, and we are going to be looking at the successes and failures in that system.

[295] **Ann Jones:** Keith, you have a very short question, have you not?

[296] **Keith Davies:** Two short ones.

[297] **Ann Jones:** No, one short one. [*Laughter*.] Go on.

[298] **Keith Davies:** Gan fynd yn ôl at ysgolion, mae pum argymhelliad gennych chi i wella pethau ar ôl arolwg. Rydych chi'n sôn am hunanarfarnu, rydych chi'n sôn am gynllunio ac rydych chi'n sôn am asesu. Y cwestiwn yw a oes gobaith bod y rheini yn mynd i wella dros y cyfnod nesaf, achos dyna dri o'r pump yr ydych yn sôn amdanynt ac, yn y pen draw, yn yr ysgolion y mae'r atebion, ymysg athrawon. Rwy'n gobeithio y bydd y consortia yn penodi ymgynghorwyr pynciol, achos mae prinder yng Nghymru nawr. Dylem fynd yn ôl i'r dosbarth ac yn ôl i'r ysgol. Dyna le mae pethau'n mynd i newid. A allwch chi ddweud wrthyf, o ran y tri argymhelliad yr wyf wedi sôn amdanynt, a ydym ni'n mynd i weld y rheini'n gwella?

Keith Davies: To go back to schools, you have five recommendations for improving things after an inspection. You talk about self-evaluation, you talk about planning and you talk about assessment. The question is whether there is any hope that those are going to improve over the next period, because those are three of the five recommendations that you talk about and, ultimately, the answers are in the schools, among the teachers. I hope that the consortia will appoint subject advisers, because there is a shortage in Wales now. We should go back to the classroom and back to the school. That is where things are going to change. Can you tell me, in relation to the three recommendations that I have spoken about, whether we are going to see those improve?

[299] **Ms Keane:** Un peth y gallaf i ddweud, yn yr arolygiadau dilyn-i-fyny, lle rydym ni'n mynd yn ôl ar ôl blwyddyn, neu rydym ni'n mynd yn ôl bob tymor pan maen nhw mewn mesurau arbennig, rydym ni'n rhoi'r ffocws ar yr argymhellion. Felly, yr hyn yr ydym ni'n ei wneud yw mesur y cynnydd yn erbyn yr argymhellion. Felly, oherwydd mai dyna'r *top five*, fel petai, rydym ni wastad bron yn mynd i edrych ar y cynnydd y maen nhw'n ei wneud ar asesu, hunanarfarnu ac ati. Felly, gallaf ddweud, o wybod ein bod yn dweud ar ôl blwyddyn fod y rhan fwyaf o ysgolion yn dod allan o'r categori dilyn-i-fyny, eu bod nhw'n gwella'r agweddau hynny, oherwydd ein bod ni yn mynd yn ôl i wneud *check* arnynt a'u monitro.

Ms Keane: One thing I can say is that, in the follow-up inspections, where we go back after a year, or we go back every term when they are in special measures, we put the focus on the recommendations. So, what we do is measure the improvement against the recommendations. So, because those are the top five, as it were, we are almost always going to look at the improvement that they make on assessment, self-evaluation and so on. So, I can say, from knowing that we say after a year that the majority of schools come out of that follow-up category, that they are improving on those aspects, because we go back to carry out a check and to monitor them.

[300] **Keith Davies:** Mae asesu mor bwysig, ac, yn ôl eich adroddiad chi, mae hanner yr adroddiadau yn dweud bod asesu yn wan.

Keith Davies: Assessing is so important, and, according to your report, half of the reports say that assessment is weak.

12:00

[301] **Ms Keane:** Mae hunanarfarnu yn fater i arweinyddiaeth. Nid ydym yn mynd i gael hunanarfarnu da heblaw bod arweinyddiaeth yn gryf. Felly, mae hynny'n rhywbeth iddynt hwy. Mae angen rhaglen genedlaethol o hyfforddi arweinyddion a darpar arweinyddion, a hefyd i roi mentora iddynt.

Ms Keane: Self-evaluation is a matter for the leadership. We are not going to have good self-evaluation unless there is strong leadership. So, that is something for them. There needs to be a national programme of training leaders and prospective leaders, and also to offer mentoring to them.

[302] **Keith Davies:** Thank you, Chair.

[303] **Ann Jones:** Okay, I will let you off. Suzy, you have questions on Welsh as a second language.

[304] **Suzy Davies:** I have three or four questions, and I think that they are all okay for shortish answers. I will start at secondary level. I am not going to rehearse the evidence in the report; that is there, and it is fairly scary as it is. Can you give me an indication of the uptake of Welsh as a second language at full GCSE, not the short GCSE, compared with other modern foreign languages? Are the teaching methods, in your experience, broadly the same?

[305] **Ms Keane:** The big difference between teaching Welsh as a second language and teaching modern foreign languages is that Welsh as a second language is taught for 13 years, and modern languages are taught for five at best, three at worst. I would say that the take-up of the full GCSE course is not a million miles away from the take-up of modern foreign languages at GCSE level. I am just thinking off the top of my head, but I can come back on that. It is not massively different. What we are worried about is that that take-up has declined and that the take-up of the short course has increased. The issue is that we invest in 13 years of delivery, and the question is what level of fluency we should expect from that investment.

[306] **Suzy Davies:** Let us not go anywhere near the short GCSE for now, because I appreciate that we are short of time. Can you tell me why there are no published assessment results for Welsh language provision in English-medium settings for those aged under seven?

[307] **Ms Keane:** It is not a matter for us.

[308] **Suzy Davies:** I just wondered if you happened to know, because you raise in your report the question of immersion. I am sure that most of us will know children from English-speaking backgrounds that have been to Welsh-medium primary schools, and you cannot tell the difference by the time they get to secondary schools. I am trying to follow what goes wrong at what point. What is your view—you do raise it in your report—about the fact that there is no promotion of the economic value of bilingualism apparently at any level in schools?

[309] **Ms Keane:** I think that that is a matter for the careers education people. It is also a matter for Welsh Government to raise the awareness of parents of the value of being bilingual in a bilingual country, in terms of the jobs that are open and in terms of the general richness and diversity of experience, too.

[310] **Mr Rowlands:** I think that there are two core issues to do with Welsh as a second language, the first of which is the confidence of teachers to teach it. You identified the issue at key stage 4, but it starts earlier in key stage 2 and key stage 3. There is a relatively positive picture in the foundation phase, but that is not picked up in key stage 2 or key stage 3. So, there is the whole issue that we have identified about the confidence of teachers to use more Welsh effectively in their lessons. The other big issue, and it is similar to literacy and numeracy, is that you are taught the language, but you need an opportunity to practise it.

[311] **Suzy Davies:** It is not just a subject that you sit an exam on, is it?

[312] **Mr Rowlands:** That is right. You need an opportunity to practise it across the curriculum, but also beyond the curriculum. One of the things that we say is that there should be extra-curricular activities that give you that opportunity. If you did that—it comes back to your question—you could see the importance of the language in the community. Schools should prepare opportunities for children to practise the language and to see how that language is used in the community and in employment.

[313] **Suzy Davies:** This is my final question on this, and perhaps it is a slightly cheeky question, but do you have a view on how early children from a non-Welsh-speaking background should be introduced to Welsh? You may have heard questions coming from this committee before about Flying Start, for example. You may not want to offer a view on that, of course.

[314] **Ms Keane:** We cannot offer a view on Flying Start per se because we do not look at it. In terms of three-year-olds going into the foundation phase, we know that within a term, through the immersion method, they become confident and go on to achieve as well as English-speaking pupils do in English. We have evidence of that going through the school system. I think that linguists would argue that you cannot learn any language at too young an age, so, even though we do not have direct evidence, I would say that is probably—

[315] **Suzy Davies:** May I have half a question more on that? [*Laughter.*]

[316] **Ann Jones:** You can. Go on then.

[317] **Suzy Davies:** I also notice in your report that you say that those with the better

degrees are going into education at primary level rather than secondary level. Do you think that that might have any influence on the improvement—68% is still not brilliant, but it is an improvement—in the numbers of children reaching level 4 attainment in English school settings for Welsh as a second language?

[318] **Ms Keane:** I think that it is difficult to say whether there is any direct cause and effect there. I would say that we need more confident and better qualified teachers of Welsh as a second language and we need to use the immersion method more. Interestingly, in Ireland at the moment they are introducing a scheme whereby they teach other subjects through the medium of Irish for the first time. That is interesting. It is all of the things that Meilyr mentioned, but it is difficult to say anything about cause and effect.

[319] **Suzy Davies:** Thank you for trying.

[320] **Ann Jones:** We will move on to literacy and numeracy. Bethan, you have some questions.

[321] **Bethan Jenkins:** O ddarllen eich adroddiad, mae'n amlwg bod rhifedd y tu ôl i lythrennedd yn y datblygiadau yn yr ysgolion. Mae'r datblygiadau yn llythrennedd yn well. Rydym yn gweld hynny o'r ffaith bod mwy o fyfyrwyr yn cael gradd G nac A* ym mathemateg yng Nghymru. A wnewch chi esbonio inni, gyda'r LNF a roddwyd gerbron ym mis Mawrth 2013, a ydych chi wedi gweld gwahaniaeth mewn ysgolion yn y safonau yn y sector hon? Nid wyf yn gwybod a ydych chi wedi gweld fy mod i wedi gwneud cais am wybodaeth am ysgolion Cymru yr wythnos hon. Roedd amrywiaeth eang iawn rhwng yr ysgolion a oedd yn dysgu rhifedd rhwng un ardal ac ardal arall; roedd enghraifft o 180 awr mewn un ysgol ac enghraifft o'r nesaf peth i ddim mewn ysgol arall yn *key stage 3* a *key stage 4*. A oes angen rhoi mwy o amser i'r LNF ddangos datblygiad neu a ddylem ni fod yn gweld sgiliau'n datblygu nawr gan fod y fframwaith wedi ei gyflwyno?

Bethan Jenkins: From the report that you have provided to us, it is clear that numeracy is behind literacy in the developments in schools. The developments in literacy are better. We see that from the fact that more students obtain a G grade than an A* grade in mathematics in Wales. Will you explain to us, with the LNF that was put forward in March 2013, whether you have seen a difference in the standards in schools in this area? I do not know whether you have seen it, but, this week, I have made a request for information on schools in Wales. There has been a wide variation in the schools that are teaching numeracy between one area and another; there was an example of 180 hours in one school and an example of next to nothing in another school at key stages 3 and 4. Is there a need to give more time for the LNF to show that there has been a development or should we be seeing skills developing now because it has already been introduced?

[322] **Ms Keane:** Rydym wedi bod yn arolygu llythrennedd a rhifedd ar draws y cwricwlwm. Dyma'r bedwaredd flwyddyn inni wneud hynny, felly byddem yn disgwyl gweld dylanwad erbyn hyn. Rydych chi'n iawn i ddweud bod datblygiadau o ran cynllunio ar gyfer llythrennedd ar draws y cwricwlwm wedi bod yn gynharach ac yn gyflymach na rhifedd. Byddwn yn dweud bod llythrennedd yn flaenoriaeth hefyd ac yn derbyn bod angen gwneud hynny o ran bod iaith yn gyfrwng ymhob gwers—boed yn fathemateg neu'n rhyw wers mewn iaith. Byddwn eisiau dweud bod angen inni sicrhau

Ms Keane: We have been inspecting literacy and numeracy across the curriculum. This is the fourth year for us to do that, so we would expect to see an influence by now. You are right to say that developments in terms of planning for literacy across the curriculum have happened earlier and more swiftly than in numeracy. I would say that literacy is a priority too and I would accept that we need to do that because language is a medium for every lesson—be it mathematics or a language lesson. I would want to say that there is a need for us to ensure that the departments of Welsh, English and

bod yr adrannau Saesneg, Cymraeg a mathemateg yn gwneud eu gwaith o ran arwain yn y fan hon ac yn gosod sylfeini cadarn i'r dysgu. Byddwn i hefyd am ddweud, ac rwyf yn dweud hyn yn yr adroddiad blynyddol, nid ydym fel arolygwyr eisiau mynd mewn i wersi a chreu cymaint o ofn bod angen i bawb ym mhob gwers ddweud, 'Dyma ni'r llythrennedd yn y wers hon, a dyma ni'r rhifedd'. Nid ydym eisiau tynnu rhifedd a llythrennedd mewn ffordd annaturiol ac artiffisial i bob gwers. Yr hyn yr ydym eisiau ei weld yw mwy o ddatblygu llythrennedd efallai mewn pynciau fel hanes a'r dyniaethau, ac efallai mwy o ddatblygu rhifedd ar lefel gymwys mewn gwersi gwyddoniaeth a thechnoleg—hynny yw, bod y peth yn berthnasol i'r gwaith yn hytrach na'i fod yn cael ei dynnu mewn i bob agwedd. Yr hyn rwyf yn trio dweud yw bod angen cynllunio deallus a manwl o'r ffordd y bydd ysgol yn cyflwyno llythrennedd a rhifedd ar draws y cwricwlwm. Y lle i ddechrau yw'r adrannau iaith a mathemateg—sicrhau bod y rheiny'n gryf—ac yna, yn ddeallus, datblygu ein hathrawon eraill i gyflwyno cyfleoedd sy'n datblygu llythrennedd a rhifedd ymhellach.

mathematics do sufficient work in terms of leadership here and laying firm foundations for the teaching. I would also want to say, and I say this in the annual report, that we as inspectors do not want to go into lessons and create so much fear that everyone in every lesson says, 'Well, this is the literacy in this lesson, and this is the numeracy aspect of this lesson'. We do not want to draw in literacy and numeracy in an unnatural and artificial way to every lesson. What we do want to see is greater development of literacy in subjects such as history and the humanities, and perhaps greater development of numeracy at an appropriate level in subjects such as science and technology—that is, so that the subject is relevant to the work rather than it being drawn into every aspect. What I am trying to say is that we need to plan in a sensible and detailed way in terms of how a school is going to introduce literacy and numeracy across the curriculum. The place to start is with the language and mathematics departments—to ensure that they are strong—and then sensibly and intelligently develop other teachers to introduce opportunities that develop literacy and numeracy further.

[323] Rwyf bron wedi dod i'r man lle rwy'n meddwl bod llythrennedd a rhifedd wedi mynd yn fathau o dduwiau bach, ac mae athrawon efallai yn cael cymaint o ofn eu bod yn meddwl, 'Mae'n rhaid; mae Estyn yn disgwyl i bob gwers i gael rhywbeth amboutu llythrennedd a rhywbeth amboutu rhifedd'. Mae hynny'n mynd i greu system artiffisial ac arwynebol. Yr hyn rydym eisiau yw gwaith cynllunio ar draws ysgol er mwyn datblygu'r sgiliau hyn mewn ffordd sy'n greiddiol i'r ffordd mae plant yn datblygu ac yn deall drwy'r cwricwlwm.

I have almost reached the point where I think that literacy and numeracy have turned into some sort of gods and perhaps teachers are so afraid that that they think, 'We have to; Estyn expects every lesson to have an aspect of literacy and numeracy in it'. That will create an artificial and superficial system. What we want is planning across the school to develop these skills in a way that is a core component of how children develop and understand through the curriculum.

[324] **Bethan Jenkins:** Diolch am hynny. Nid wyf yn credu y byddwn yn cytuno â'r hyn rydych yn ei ddweud am lythrennedd a rhifedd yn bethau y mae athrawon yn poeni amdanynt achos eu bod yn cael eu rhoi arnynt gan y Llywodraeth. Mae'r wybodaeth sy'n dod o bobl rwyf i wedi siarad â hwy yn dangos bod llawer o wahaniaeth rhwng ysgolion. Os oeddent mor bwysig a chynhwysfawr ar draws Cymru gyfan, byddai pawb yn eu dysgu nhw, ond nid dyna'r realiti ar lawr gwlad, yn ôl yr hyn rwyf i'n ei ddeall.

Bethan Jenkins: Thank you for that. I do not think that I would agree with what you are saying about literacy and numeracy being things that teachers are concerned about because they are put upon them by the Government. The information that I have had from people who I have spoken to shows that there is so much difference between schools. If they were so important and it was so comprehensive across the whole of Wales, then everybody would teach them, but that is not the reality at grass-roots level, from what

I understand.

[325] Y cwestiwn roeddwn i mo'yn dod ato oedd: ai'r athrawon eu hunain sydd angen yr hyfforddiant neu a oes modd dod â phobl i mewn yn fwy aml i ysgolion i helpu athrawon i ddelifro, ar ffurf gweithdai, ac i dderbyn hyfforddiant, efallai, gan arbenigwyr ym maes arian neu lythrennedd, fel nad yw'n gymaint o fwrn ar yr athrawon eu hunain? Rwy'n credu mai dyna yw'r broblem yn fwy na dim; mae athrawon yn poeni nad ydynt yn ddigon cymwys i ymwneud â'r pynciau penodol hynny.

The question that I wanted to come to was: is it the teachers themselves who need the training or is there a way of bringing people into schools on a more regular basis to help teachers to deliver, in the form of workshops, and to receive training, perhaps, from experts in finance and literacy, so that it is not so much of a burden on the teachers themselves? I think that that is what the problem is more than anything; the teachers are concerned that they are not qualified enough to deal with those specific subjects.

[326] **Ms Keane:** Os nad yw athro'n ddigon cymwys o ran ei lythrennedd ei hun i ddeall digon i fedru ei ddysgu, ni ddylai fod yn athro. Mae llythrennedd mor greiddiol bwysig i addysg, ni allwch ddweud—

Ms Keane: If a teacher is not sufficiently qualified in terms of their own literacy to understand enough to be able to teach it, they should not be teachers. Literacy is so important to education, you cannot say—

[327] **Bethan Jenkins:** Rwyf wedi cael mwy o enghreifftiau o rifedd yn ddiweddar wrth siarad ag athrawon ynglŷn â fy Mil personol i. Gyda rhifedd, efallai, nid yw athrawon eu hunain wedi derbyn yr addysg yn yr ysgol ac felly nid ydynt yn teimlo'n hyderus i ddelifro. Dyna'r hyn roeddwn i'n trio dweud.

Bethan Jenkins: I have had more examples of numeracy recently from speaking to teachers about my own personal Bill. With numeracy, teachers themselves, perhaps, have not received the education in school and therefore do not feel confident to deliver the numeracy. That is what I was trying to say.

[328] **Ms Keane:** Rwy'n derbyn gyda rhifedd nad oes angen i bob athro yn yr ysgol fod yn gymwys hyd at lefel 3, neu rywbeth, na'u bod wedi gwneud lefel A mewn rhifedd neu fathemateg, neu rywbeth felly. Byddwn i'n derbyn hynny. Yr hyn rwy'n trio dweud yw, pan fydd ysgolion yn cynllunio, mae'n rhaid iddynt gynllunio mewn ffordd sy'n ddeallus, ac yn ôl lle mae'r plant arni ac anghenion y gwahanol bynciau. Rwyf i fy hun wedi bod mewn gwersi lle mae'r athro, ar ddiwedd y wers, wedi tynnu rhyw bethau allan ar lythrennedd a rhifedd fel petai nhw'n bethau arwynebol y gellid eu gwneud ar ddiwedd gwers. Nid dyna'r math o gynllunio rydym ei eisiau. Nid cynllunio arwynebol rydym eisiau ei weld, ond cynllunio ar draws ysgol, lle mae staff hŷn yr ysgol a'r arweinyddion pynciau yn deall lle i osod y mewnbwn sy'n mynd i helpu'r plant hynny.

Ms Keane: I accept with numeracy that not all teachers in a school need to be qualified to level 3, or something, or to have done an A-level in numeracy or mathematics, or something like that. I would accept that. What I am trying to say is that when schools plan, they have to plan in a way that is intelligent and according to where the children are and the needs of the different subjects. I myself have been in lessons where the teacher, at the end of the lesson, has brought things out on literacy and numeracy as if they were superficial things that could be handed out at the end of a lesson. That is not the kind of planning that we want to see. We do not want to see superficial planning; we want to see planning across the school where the more senior staff and the subject leaders understand where to put that input that is going to help those children.

[329] Fodd bynnag, o ran llythrennedd, mae'n angenrheidiol bod pob athro yn gallu deall ac yn gallu darparu ar lythrennedd. Buaswn i'n dweud bod angen i athrawon

However, in terms of literacy, it is crucial that every teacher understands and can provide literacy content. I would say that science teachers and technology teachers

gwyddoniaeth ac athrawon technoleg ddeall rhifedd i'r lefel lle maent yn gallu ei ddarparu mewn gwersi sydd â rhywfaint o gynnwys mathemategol.

need to understand numeracy to the level where they can provide it in lessons that have some sort of mathematical content.

[330] Ni fyddwn yn anghytuno bod mewnbwn gan arbenigwyr yn berthnasol. Mae mewnbwn gan arbenigwyr ar bynciau arbennig yn y cwricwlwm yn beth diddorol iawn. Mae'n hybu diddordeb disgyblion i gael mewnbwn gan bobl o'r tu allan yn aml, yn enwedig os ydynt yn dod o ddiwydiannau neu o swyddi lle mae'r plant wedyn yn gweld bod y pwnc hwn yn bwysig, nid yn unig yn yr ysgol, ond yn y byd gwaith y tu hwnt i'r ysgol. Felly, rwyf i o blaid cael mewnbwn o'r tu allan, ond rwyf i o'r farn y dylai pob athro fod yn gallu dysgu llythrennedd a rhywfaint o rifedd.

I would not disagree that input from experts is relevant. Input from experts on specific subjects in the curriculum is very interesting. It promotes the interest of pupils to have that input from external sources, especially if they come from industry or from the world of employment, where children then can see that the subject is not only important in school, but it is also important in the workplace, beyond school. So, I am in favour of having external input, but I am of the opinion that every teacher should be able to teach literacy and numeracy to an extent.

[331] **Bethan Jenkins:** Mae fy nghwestiwn olaf ynglŷn â'r canolfannau arbenigo rydych chi'n sôn amdanynt. A allech chi esbonio rhywfaint am rheiny? Yr hyn sy'n dod yn syth i fy meddwl i yw bod lot o ysgolion yn awr yn gweld ei gilydd fel cystadleuaeth, os ydynt yn trio cyrraedd safonau penodol—bandio ac yn y blaen. Sut, a bod yn onest, fydd hyn yn gallu digwydd? Oni fyddai'n well i athrawon dderbyn datblygiad personol yn y maes llythrennedd a rhifedd, yn hytrach na bod canolfan ar gyfer hwn yn benodol? Rwy'n hapus i edrych ar sut y bydd yn gweithio, ond rwy'n teimlo bach yn nerfus amdano ar hyn o bryd.

Bethan Jenkins: My last question is in relation to these centres of excellence that you mention. Could you explain those a little? What comes straight to my mind is that many schools now see each other as competition, if they are trying to reach specific standards—banding and so on. How, to be honest, will this happen? Would it not be better for teachers to receive personal development in literacy and numeracy, rather than there being a centre specifically for this? I am happy to look at how it would work, but I am a bit nervous about it at the moment.

12:15

[332] **Ms Keane:** Nid wyf yn credu ei bod yn ganolfan go iawn, fel adeilad neu ddim byd felly. Mae'n dod yn ôl at y syniad hwn o sut yr ydym yn datblygu'r gweithlu. Hynny yw, rydym yn gwybod bod arfer da ymhlith y gweithlu, ond ni ddylem weld gwelliannau fel pethau sy'n cael eu gyrru o'r top, neu gan eraill. Dylem fabwysiadu model o ddatblygu'r gweithlu sy'n cynnwys y gweithlu. Mae hynny'n egwyddor bwysig, rwy'n credu, er mwyn gyrru pethau ymlaen, achos mae hynny yn hybu perchnogaeth o ddatblygiadau. Hynny yw, ni ddylem fabwysiadu model sy'n gweld yr athrawon i gyd fel rhai sydd angen help ac sy'n methu gwneud hyn, ac sy'n gweld rhyw bobl yn y consortia neu yn y canol rhywle fel pobl sy'n

Ms Keane: I do not think that it is a proper centre, in the sense of it being a building or anything like that. This comes back to the idea of how we develop the workforce. That is, we know that good practice exists among the workforce, but we should not see improvements as things that are driven from the top, or driven by others. We should adopt a model of developing the workforce that includes the workforce. That is an important principle, I believe, in order to drive things forward, because that promotes the ownership of developments. That is, we should not adopt a model that sees all teachers as being in need of help and being unable to do this, and that sees other people in the consortia or somewhere in the centre as

gwybod popeth, a'r unig beth sydd angen ei wneud yw dweud wrth athrawon beth sydd angen ei wneud. Nid yw'r model hwnnw yn fodel o arweinyddiaeth sy'n mynd i weithio.

people who know everything, and that all we need to do is tell teachers what to do. That is not a leadership model that is going to work.

[333] **Bethan Jenkins:** Felly, a yw'r model hwn, yr un lle rydych yn sôn am ganolfan—

Bethan Jenkins: So, is this model, where you are talking about a centre—

[334] **Ms Keane:** Dyna pam—

Ms Keane: That is why—

[335] **Bethan Jenkins:** Rwy'n cydnabod nad yw'n adeilad. A yw'n gweithio mewn unrhyw ardal arall o addysg, er mwyn inni weld ei fod yn gweithio, neu a fyddai'n beilot newydd, a ydych yn gwybod?

Bethan Jenkins: I understand that it is not a building. Does it work in any other area of education, so that we can see that it is effective, or would this be a new pilot, do you know?

[336] **Ms Keane:** Mae'n gweithio yn y SIGs yn y London Challenge—y *school improvement groups*. Yr hyn yw *school improvement groups* yw grwpiau o ysgolion sy'n dod at ei gilydd i rannu a phennu arbenigedd er mwyn arwain gwelliannau. Rydym yn gwybod ei fod wedi gweithio yn y London Challenge.

Ms Keane: It works in the SIGs in the London Challenge—the school improvement groups. The school improvement groups are groups of schools that come together to share and set expertise in order to lead on improvement. We know that it has worked in the London Challenge.

[337] **Simon Thomas:** Ai dyna beth sy'n digwydd—

Simon Thomas: Is that what is happening—

[338] **Ms Keane:** Dyna beth sy'n digwydd yn y de canol, neu beth bynnag yw ei enw. Dyna beth sy'n digwydd. Dyna, mae'n debyg, fydd y model o ran Her Ysgol Cymru. Felly, rydym yn gwybod ei fod yn gweithio.

Ms Keane: That is what is happening in south-central Wales, or whatever it is called. That is what is happening. That is what is likely to be the model in terms of Schools Challenge Wales. So, we know that it works.

[339] **Ann Jones:** I have Angela and then Simon on this point, and then we will move on to Keith.

[340] **Angela Burns:** I just very quickly wanted to ask you about the actual testing of literacy and numeracy. We obviously all signed up completely to the agenda that we need to embed it within our school curriculum, but I have had so much feedback from teachers on the one hand, and parents on the other, about how the testing regime works. You are probably aware of the recent National Union of Teachers survey, where 90% of teachers believed the tests had not provided any new information on their pupils, and 90% believed that the testing regime was inadequate or inappropriate. I have had parents come to me, particularly with children with special educational needs, who were put into settings that were, again, inappropriate for them to be truly tested. So, we are testing the ability to answer the test rather than testing the child's knowledge of numeracy or literacy. I have had parents come to me where children have received certain scores in those tests that do not bear any real-life relation to where that child is on that particular journey. I just wondered if you had any comment that you would give. For example, question 5 from the NUT to its teachers was, 'Do you think that literacy and numeracy tests are consistent with the curriculum?' and over 60% of them said that they do not believe that they are, not in the foundation phase, key stage 2, or key stage 3. I do not know if you have seen this report, but I just wonder whether you have a view.

[341] **Ms Keane:** I have to say that, when I became—. We were particularly concerned about standards of literacy initially, and about reading ages. You may remember the annual report a few years ago was very concerned about this. I have to say that I welcome something that gives us more information on a national level—in other words, so that we can make comparisons. Whereas, previously, local authorities would maybe have their own tests, there was nothing comparable across local authorities that could be used. I think that, nationally, we should know where our children are at. It is to do with national tracking and monitoring. In other words, if you do not know where the weaknesses are, how can you remedy those weaknesses? So, I am in favour of the principle of using tests—perhaps not having them forever, and certainly not using them for league tables. We should not have pupils worried about their particular results, but they should be used diagnostically. We are not going to be able to tell how well these work in terms of diagnostic usage until we have had a second tranche of tests. It will only be then that we see some information about progress being made over time.

[342] As to the mechanics of the tests, and the points you raised about the inappropriateness of the tests, I think those issues have to be taken on board and addressed in terms of how appropriate those tests are for particular children, particularly those with special needs, and so on. However, I am of the view that we were in a position in Wales where we did not have an understanding of where our pupils were at the age of 11 in terms of their reading ability and their numerical ability, and the tests do fill that gap. They should not be embedded in stone and never changed; the results should be used diagnostically. I have come across parents who have been very grateful for the printout for their child and have thought it quite useful. However, there has been just one set of tests. We need to see the next set and see how much they tell us about the progress that the children make.

[343] **Ann Jones:** Simon is next, and then Aled, on this point.

[344] **Simon Thomas:** Hoffwn fynd yn ôl at y pwynt yr oeddem yn ei drafod yn gynharach. Mae hwn i gyd yn yr adroddiad, ond mae clywed y pethau hyn ar dafod leferydd yn wahanol iawn. Mae'n ddigon i wneud i mi dynnu allan fy ngwallt, pe bai gennyf wallt, i glywed nad yw rhifedd a llythrennedd yn ail natur ac yn reddfol i grefft nifer fawr—gormod—o'n hathrawon. Rydych wedi sôn am rai o'r pethau rydych yn gobeithio—er nid chi sydd yn gyfrifol amdanynt—bydd yn gwella'r broses hon, sef canolfannau rhagoriaeth ac ati. Fodd bynnag, sut yr ydym yn mynd i sicrhau bod y rhai sy'n dod mewn i'r proffesiwn dysgu yn awr yn gwneud hynny gyda hyn yn rhan llawer mwy naturiol o'u crefft dysgu? Mae hyn yn mynd â ni at bwnc colegau ymarfer dysgu a mentrau megis Teach First, ac ati. Mae peth o'r drafodaeth hon yn yr adroddiad hefyd, ond a ydych yn gallu canfod nawr rhai o'r pethau sy'n digwydd sy'n fuddiol, neu hyd yn oed rhai o'r pethau sy'n peri pryder ichi ynglŷn â sicrhau nad ydym yn canfod ein hunain yn yr un sefyllfa 10 mlynedd lawr y lein?

Simon Thomas: I would like to go back to the point that we were discussing earlier. This is all in the report, but hearing these things spoken out loud is very different. It is enough to make me tear my hair out, if I had hair, to hear that literacy and numeracy are not second nature and instinctively part of the craft of a great many—too many—of our teachers. You have talked about some of the things that you hope—not that you are responsible for them—will improve this process, such as centres of excellence and so on. However, how are we going to ensure that those who are entering the teaching profession now do so with this as a much more natural part of their teaching craft? This takes us on to the subject of teacher training colleges and initiatives such as Teach First, and so on. Some of this is also discussed in the report, but can you see now some things happening that are beneficial in that regard, or even some things that are cause for concern with regard to ensuring that we do not find ourselves in the same situation 10 years down the line?

[345] **Ms Keane:** Rydym yn dweud pethau reit glir yn y darn ar hyfforddiant athrawon. Rydym wedi arolygu dwy ganolfan hyd yn hyn, ac mae'r trydydd yn disgwyl arolygiad. Rydym hefyd yn mynd i arolygu Teach First, ond nid ydym wedi cychwyn eto ar y gwaith hwnnw. Fodd bynnag, nid yw'r argoelion yn wych yn ôl y ddau adroddiad hynny, felly gallwch weld yr hyn rydym yn poeni amdano. Hynny yw, beth yw ansawdd y hyfforddeion? Bu ichi sôn yn gynharach am ddosbarth y graddau sydd ganddynt, ac rydym hefyd yn sôn nad oes ddigon o bwyslais ar lythrennedd a rhifedd yn y cyrsiau. Rydym yn sôn nad oes digon o her, ambell waith, yn y cyrsiau, ac mae llawer o waith i'w wneud er mwyn datblygu'r her hwnnw, yn enwedig i helpu'r hyfforddeion i adnabod pethau fel asesiadau plant ac i'w herio nhw o ran y ffordd maent yn gweithio. Mae nifer o feirniadaethau o'r ddwy ganolfan gennym yn y ddau adroddiad hynny.

Ms Keane: We state things quite clearly in the section on teacher training. We have inspected two centres so far, and the third is awaiting inspection. We are also going to inspect Teach First, but we have not begun that work yet. However, the prospects are not great following those two reports, so you can see what we are concerned about. That is, what is the quality of the trainees? You mentioned earlier the class of degree they have, and we also note that there is not enough emphasis on literacy and numeracy in the courses. We note that there is sometimes not enough of a challenge in the courses, and there is a lot of work to be done to develop that challenge, particularly with regard to helping the trainees to recognise such things as child assessments and to challenge them in terms of the way in which they work. We make a number of criticisms of the two centres in those two reports.

[346] **Simon Thomas:** Beth am y cwrs Meistr, a'r bwriad y bydd athrawon yn datblygu llawer yn fwy ar lefel proffesiynol—hynny yw, bod datblygu proffesiynol mwy dwys hyd at radd Meistr? A ydych wedi gweld unrhyw effaith yn sgîl hynny eto?

Simon Thomas: What about the Master's course, and the aim that teachers will develop a great deal more on a professional level—that is, that there is more intensive professional development towards a Master's degree? Have you seen any impact from that yet?

[347] **Ms Keane:** Bu inni argymell rhywbeth fel hynny rhyw dair neu bedair blynedd yn ôl yn ein hadroddiad blynyddol. Felly, rydym yn cefnogi'r radd Meistr. Nid ydym wedi edrych yn fanwl eto ar y deilliannau, ond rydym wedi gweld arwyddion reit obeithiol. Ni allaf ddodi barn derfynol ar hynny, ond rydym yn cefnogi'r fenter honno.

Ms Keane: We recommended something like that three or four years ago in our annual report. So, we support the Master's degree. We have not looked in detail yet at the outcomes, but we have seen quite promising signs. However, I cannot give you a final opinion on that, but we support that initiative.

[348] **Simon Thomas:** Mae'n weddol newydd ac mae Teach First yn newydd. A fyddwch yn edrych ar y pethau hyn i lawr y lein i weld os ydynt wir yn cael effaith?

Simon Thomas: It is relatively new and Teach First is new. Will you be looking at these things down the line to see whether they are truly having an effect?

[349] **Mr Rowlands:** Eleni, byddwn yn edrych ar Teach First; mae'r Gweinidog wedi gofyn inni wneud hynny, felly rydym yn gwneud arolwg ohono. Nid ydym wedi cael gwŷs i edrych ar y cwrs Meistr, ond, fel y'i dywedwyd, roedd ein hargymhellion ni yn gofyn am unedau ar lythrennedd a rhifedd mewn rhywbeth tebyg i radd Meistr ar gychwyn gyrfa athrawon, gan ei bod yn

Mr Rowlands: This year, we will be looking at Teach First; the Minister has asked us to do so, so we will be inspecting that. We have not had a request to look at the Master's course, but, as has been said, our recommendations asked for units on literacy and numeracy in something similar to a Master's degree at the beginning of teachers' careers, because it is impossible to do

amhosibl gwneud popeth mewn hyfforddiant cychwynnol athrawon. Roeddwn yn gryf o'r farn bod angen hynny, ac mae hynny wedi cael ei weithredu. Amser a ddengys, ond mae'n un o'r nifer o bethau sydd angen eu gwneud er mwyn gwella hyder athrawon o ran defnyddio llythrenedd a rhifedd.

everything in initial teacher training. We strongly believed that there was a need for that, and that has been implemented. Time will tell, but it is one of a number of things that will need to be addressed in order to improve teachers' confidence in terms of using literacy and numeracy.

[350] **Ann Jones:** Aled is next, then David. We will then have to look at the time, because you will all want to shoot out at 12.30 p.m., because it is a Wednesday.

[351] **Aled Roberts:** Rwyf eisiau datblygu'r thema, i ryw raddau. Rydych wedi bod yn feirniadol o ansawdd y bobl sy'n mynd i mewn i'r proffesiwn yn y lle cyntaf. Pa fath o ymateb sydd wedi bod gan y sefydliadau lle mae beirniadaeth wedi bod o ran hynny? Mae tystiolaeth bod y graddau sy'n cael eu gofyn amdanynt yn eithaf isel. Os nad yw'r ansawdd yn dda wrth i bobl fynd i mewn, nid oes llawer o obaith i ni weld unrhyw fath o welliant o ran natur y dysgu o fewn ein hysgolion.

Aled Roberts: I want to develop the theme, to some extent. You have been critical of the quality of people entering the profession in the first place. What sort of response has there been from those institutions where there has been criticism in that regard? There is evidence that the grades that are asked for are quite low. If the quality is not good at an entry level, there is not much hope of seeing any sort of improvement in terms of the nature of teaching in our schools.

[352] **Ms Keane:** Rydym yn gobeithio gweithio'n agos gyda'r person sydd wedi cael ei benodi i arwain yn y sector hwn yn y dyfodol er mwyn edrych ar y materion hyn.

Ms Keane: We hope to work closely with the person who has been appointed to lead in this sector in future in order to look at these matters.

[353] **Mr Rowlands:** Mae arweinyddiaeth y canolfannau hyfforddi athrawon yn bwysig iawn. Roedd yr arweinyddiaeth yn dda mewn un canolfan ac yn anfoddhaol mewn canolfan arall. Mae'n bwysig bod y canolfannau hynny yn ymwybodol o'r agenda cenedlaethol a'u bod yn gwneud yn siŵr bod eu staff yn hollol hyddysg yn y pethau sydd angen eu trosglwyddo i'r to nesaf o athrawon, gan gynnwys llythrennedd a rhifedd. Un awgrym o ran hynny yw bod athrawon yn cael eu penodi ar y cyd, fel eu bod yn gweithio rhan o'u hamser mewn ysgol, fel eu bod yn gwybod beth yw'r gwaith o ddydd i ddydd, a rhan o'u hamser yn y canolfannau hyfforddi athrawon.

Mr Rowlands: The leadership of the teacher training centres is very important. The leadership was good in one centre and unsatisfactory in another. It is important that those centres are aware of the national agenda and that they make sure that their staff are fully aware of the things that need to be transferred to the next generation of teachers, including literacy and numeracy. One suggestion in that regard is that teachers are appointed jointly, so that they work part of their time in school, so that they know what the day-to-day work is, and part of their time in the teacher training centres.

[354] **David Rees:** Aled asked my question, basically, in one sense. However, it is not just about the qualifications of individuals coming in. As you pointed out, for one of those centres, the question of leadership was raised. I am also concerned about the fact that these young individuals coming into the profession will be tomorrow's leaders. What are you doing to work with those centres to ensure that they up their standards in both leadership and in the quality of delivery to ensure that our young people going through those schemes are actually going to be able to become our next set of leaders?

[355] **Ms Keane:** We recommend in the foreword that there should be—and I think that

some work has begun on this—a national programme of leadership that is not just for headteachers and deputies, but is a national programme of leadership, and of training, coaching and mentoring, that aspiring leaders across the school system can be a part of. In other words, that there are opportunities for them to improve their skill sets at different levels in their career. Their career structure should be reflected in a kind of support scheme. At the moment, that support exists, but it exists in different forms and is patchy across Wales.

[356] **Ann Jones:** I am not going to get to the other two sections, because we are coming up to 12:30 p.m. and I am conscious that people have to be in the Chamber for 1.30 p.m., but there were some issues that we wanted to further develop with you around poverty and disadvantage—what we were looking at when you came to give evidence on 14 November—and there were also some issues around local authorities and regional consortia. Could we drop you a note on those?

[357] **Ms Keane:** Yes, that would be fine.

[358] **Ann Jones:** Thank you very much for coming in. I know that we had the debate, and Members wondered whether we would do this, but there was enough there to keep us going for at least another half an hour. Thank you all very much and thank you for the report, which I am sure we will refer to from time to time, which was very good. We will send you a copy of the transcript to check; you know all about that. Thank you all very much for coming in today. I close the meeting and remind Members that next Thursday we are meeting in private, starting at 9.15 a.m.

Daeth y cyfarfod i ben am 12:29.
The meeting ended at 12:29.