



Cynulliad Cenedlaethol Cymru **The National Assembly for Wales**

Y Pwyllgor Iechyd a Gofal Cymdeithasol **The Health and Social Care Committee**

Dydd Iau, 20 Tachwedd 2014
Thursday, 20 November 2014

Cynnwys **Contents**

Cyflwyniadau, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

Gweithredu Deddf Gwasanaethau Cymdeithasol a Llesiant (Cymru) 2014: Sesiwn Frifffio Ffeithiol gan Swyddogion Llywodraeth Cymru
Implementation of the Social Services and Well-being (Wales) Act 2014: Factual Briefing from Welsh Government Officials

Gwaith Craffu ar ôl Deddfu ar Fesur Iechyd Meddwl (Cymru) 2010: Sesiwn i Graffu ar Waith y Gweinidog
Post-legislative Scrutiny of the Mental Health (Wales) Measure 2010: Ministerial Scrutiny Session

Papurau i'w Nodi
Papers to Note

Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd
Motion under Standing Order 17.42 to Resolve to Exclude the Public

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

The 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

Alun Davies	Llafur Labour
Janet Finch-Saunders	Ceidwadwyr Cymreig Welsh Conservatives
John Griffiths	Llafur Labour
Elin Jones	Plaid Cymru The Party of Wales
Lynne Neagle	Llafur Labour
Gwyn R. Price	Llafur Labour
David Rees	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Lindsay Whittle	Plaid Cymru The Party of Wales
Kirsty Williams	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Alistair Davey	Dirprwy Gyfarwyddwr, yr Is-adran Cyflawni Polisiâu ar gyfer Plant ac Oedolion, Llywodraeth Cymru Deputy Director, Delivering Policy for Children & Adults Division, Welsh Government
Mark Drakeford	Aelod Cynulliad, Llafur (y Gweinidog Iechyd a Gwasanaethau Cymdeithasol) Assembly Member, Labour (Minister for Health and Social Services)
Andrea Gray	Rheolwr Deddfwriaeth Iechyd Meddwl, Llywodraeth Cymru Mental Health Legislation Manager, Welsh Government
Anthony Jordan	Pennaeth Gweithredu Gwasanaethau Cymdeithasol Cynaliadwy, Llywodraeth Cymru Head of Sustainable Social Services Implementation, Welsh Government
Mike Lubienski	Uwch Gyfreithiwr, Tîm Gofal Cymdeithasol, Llywodraeth Cymru Senior Lawyer, Social Care Team, Welsh Government
Margaret Provis	Dirprwy Gyfarwyddwr Is-adran Strategaeth a Gwella Gwasanaethau Cymdeithasol Deputy Director Social Services Strategy Leadership and Improvement
Dr Sarah Watkins	Is-adran Grwpiau Iechyd Meddwl ac Agored i Niwed/Uwch Swyddog Meddygol, Llywodraeth Cymru Head of Mental Health & Vulnerable Groups Division/Senior Medical Officer, Welsh Government

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

Stephen Boyce	Y Gwasanaeth Ymchwil Research Service
Amy Clifton	Y Gwasanaeth Ymchwil Research Service
Helen Finlayson	Ail Glerc Second Clerk
Sian Giddins	Dirprwy Glerc Deputy Clerk
Llinos Madeley	Clerc Clerc
Joanest Varney-Jackson	Uwch-gynghorydd Cyfreithiol Senior Legal Adviser

Dechreuodd rhan gyhoeddus y cyfarfod am 10:14.
The public part of the meeting began at 10:14.

Cyflwyniadau, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **David Rees:** Good morning. Can I welcome Members to this morning's session of the Health and Social Care Committee? This morning, we will be taking evidence from officials on the implementation of the Social Services and Well-being (Wales) Act 2014. Later, we will be taking evidence from the Minister for Health and Social Services in relation to the Mental Health (Wales) Measure 2010: post-legislation scrutiny.

10:15

[2] Before we start, I will just do some housekeeping. I remind Members please to turn off their mobile phones and equipment, as I did not do yesterday afternoon. Please ensure that any equipment that may interfere with the broadcasting equipment is also turned off. There is no scheduled fire alarm today, so if one occurs please follow the directions of the ushers. For those who require translation, simultaneous translation from Welsh to English is available on the headphones on channel 1. Amplification is on channel 0. We have had apologies this morning from Darren Millar. No substitute has been identified.

Gweithredu Deddf Gwasanaethau Cymdeithasol a Llesiant (Cymru) 2014:
Sesiwn Frifio Ffeithiol gan Swyddogion Llywodraeth Cymru
Implementation of the Social Services and Well-being (Wales) Act 2014: Factual Briefing from Welsh Government Officials

[3] **David Rees:** We now move on to the next item on the agenda, which is the factual briefing from Welsh Government officials. Good morning. May I thank you for your written evidence before we start? I want to introduce Margaret Provis who is the deputy director social services strategy, leadership and improvement and also the leader on this this morning. Margaret, please will you introduce your team?

[4] **Ms Provis:** Thank you very much. Mike, would you like to introduce yourself?

[5] **Mr Lubienski:** I am Mike Lubienski. I am the senior lawyer in the social care team in Welsh Government Legal Services.

[6] **Mr Davey:** I am Alistair Davey. I am deputy director of delivering policy for children and adults.

[7] **Mr Jordan:** I am Anthony Jordan. I am head of sustainable social services implementation, working to Margaret on the implementation of the Act.

[8] **David Rees:** Thank you. I remind Members that this is a factual briefing and therefore we are here to try to get as much information as we can on the implementation of the Act. I will ask the team now to perhaps give us an overview of the implementation.

[9] **Ms Provis:** Thank you very much. We are pleased to be able to talk to you today about the implementation programme that we have in place. Clearly, the development of the Act itself has been a major piece of work for the Assembly and all those involved. We therefore are approaching implementation in a similar way with a full programme of implementation in hand. So, what we thought we would do this morning is just give you an overview of that programme and then, obviously, respond to your questions.

[10] So, as we have gone through the implementation programme—. Sorry, can I just have a drink before I start? I am clearly about to lose my voice.

[11] **David Rees:** That is okay.

[12] **Ms Provis:** So, the Act itself was given Royal Assent in May of this year. Between May and July, we discussed with Ministers the approach to implementation. In July, the Government published a statement on how we would take this forward. As you are aware, the Act is a large and complex piece of legislation, and it has a range of implementation arrangements around it.

[13] The Act itself was developed and founded on a range of evidence and work done by advisory groups and other groups, which brought together, in 2011, ‘Sustainable Social Services for Wales: A Framework for Action’. We have always described this as a whole-system change designed to support an overall programme of change in the delivery of social services. The key factors that we are pushing forward are really around putting people at the centre of their care, strengthening their voice, and giving them more control and focusing on people’s wellbeing. To do that, we need to develop and embed a new focus on prevention and early intervention, ensure that people have access to information and advice, and reduce the complexity and bureaucracy of the current system. That includes driving greater integration.

[14] What that means is that the Act needs to be implemented as a whole. Each part of the Act is dependent on the other parts. That is why we have to have a programme that takes that whole piece of work forward at the same time. There are, as you know, a wide range of regulations to be made, and the Act provides that statutory codes of practice can also be made to bring the Act into force. The approach that we have agreed to take that forward is based on breaking the Act into its parts. What we want to do is to have a programme that makes sense to the people who have to implement it. In looking at the Act, we felt that the way to do that was to approach it in its separate parts, to see those parts as discrete pieces of work that join together to form the whole. We have broken those parts into two tranches. That will mean that we are able to ensure that the way in which we take this forward is transparent, but that the whole of it is seen as being linked together. So, our overall plan for implementation is being delivered in this way—the regulations, the codes of practice, the training, the implementation and the publication of good practice guidance—focusing on those parts of the Act and making sure that they work together.

[15] The way we would like to envision it in the future is that practitioners and partners will have a library of resources that they can look at—I imagine them taking it off a shelf, but

I am sure that they will probably be lifting it out of an electronic filing system—and that each of those components will make sense to them as they take forward this major change. This will give us a managed and phased approach to both the making of the legislation and for local authorities and others with regard to the delivery of the duties.

[16] In tranche 1, we are covering the general duties, namely the key guiding overarching duties, and the specific duties to individuals, so that partners can see these parts working together and can comment on these in the consultation in a way that allows them to comment on the whole thing. Tranche 1 is subject to consultation now, and the regulations will be brought forward in May. I will say a little bit more about the detail of that later. In tranche 2, we are covering the remaining parts of the Act, which will include Part 5, which is about charging, Part 6, which is about looked-after children, as well as Part 9 on the partnership and integration powers.

[17] So, that is our framework. This approach has been welcomed by our partners. Key to our implementation work is that partnership and engagement, and, in developing the detailed arrangements under the Act, both in respect of the regulations and codes of practice that we are consulting on now and in respect of the work that we are preparing for the next tranche, we have been working closely either with technical groups or other advisory groups to ensure that we really ground this approach in the reality of delivering the duties. We have had over 200 people involved in working with us in tranche 1, and that has included input from the citizen panel that is in place.

[18] We have really valued the commitment and engagement of our partners, we have learned a lot from that approach, and it is one that we want to build on as we go forward. Of course, that has been in advance of the formal consultation. You will know from our paper that we are also working very closely with local government and other partners on the local and regional delivery implementation plan.

[19] We expect each region, based on that local health board footprint, to work closely together on preparing for implementation, and to include in that private and voluntary sector partners. The delivering transformation grant has been made available again this year, and we are expecting to see as a result of that grant an implementation plan for each area. These arrangements will help us to drive forward the implementation and ensure that all our partners, at national and regional level, are able to fully engage with the programme, building on the opportunities and tackling the challenges and barriers together. The regional leadership arrangements that Ministers have announced they require to be put in place will be significant in taking this forward, particularly as Ministers have indicated that they expect to see regional citizen panels in place during next year.

[20] Alongside this consultation and the work that we are doing with our partners, we are also preparing a national training programme to support implementation. That training programme will be for everyone who will be involved in delivering duties under the Act.

[21] So, the consultation on tranche 1 opened on 6 November and will close at the beginning of February. We intend to lay all of the regulations associated with tranche 1 in May in order that they can all be considered before the end of July. The codes from tranche 1 and tranche 2 will be brought to the Assembly together, in the autumn of 2015.

[22] So, these are all the regulations in Parts 2, 3, 4 and 7 and two sets of regulations in relation to Part 11, and our paper details those regulations and the statutory codes of practice and guidance for Parts 2, 3, 4, 7 and 11. I want to emphasise the fact that these are statutory codes of practice, and that this is quite a different way of working, one we have worked closely with our partners on putting together.

[23] We have packaged the consultation in such a way as to make it as accessible as possible to as wide a range of stakeholders as possible. We are holding two events, one in north Wales and one in south Wales, and we are also arranging a series of specific engagement events with people who use services, or organisations that represent people who use services, across the range of adults, children and carers.

[24] This tranche includes the consultation on Parts 3 and 4—assessment, care planning and meeting needs, which includes eligibility and direct payments. I know Members are very interested in both those aspects. This tranche also includes other very important and significant areas that Members have indicated an interest in, including Part 7, which is the safeguarding element of the Act, and Part 2, which includes the general duties and the duties on local authorities to promote alternative service models and provide information, advice and assistance. Part 11 includes the code on prisoners.

[25] We are also during this same period undertaking a consultation on the directions in relation to the National Adoption Service, which was launched very recently.

[26] As part of the consultation, we are asking our partners what else they will need to help them to implement this new arrangement. We hope that, in drawing together that information with the information that we will have from regions about their own implementation plans and their statement of readiness, we will have a good package of information as we close down the tranche 1 consultation to really take forward that plan during 2015-16.

[27] That is also why we have issued our wellbeing statement and code on measuring wellbeing during this period, so that that is available as a working document at this stage for people to comment on, and to consider as an overarching part of the implementation of the Act.

[28] I hope that provides you with the overview that you were expecting. We are more than happy to answer your questions now and to provide you with more detail in those areas.

[29] **David Rees:** Thank you for that, Margaret. I am sure that Members will want to ask some questions in relation to some of the issues you have raised and also those in your paper. Gwyn is first and then Lindsay.

[30] **Gwyn R. Price:** Good morning to you all. How have you identified the training needs of the programme for the relevant staff to develop and deliver support in the implementation of the Act?

[31] **Ms Provis:** We have in place a programme called the social care workforce development programme, which is funded by the Welsh Government. We provide 70% of the funding for that programme and local authorities themselves provide 30%. That programme is funded to the tune of, overall, something close to £10 million. As regular components of that programme, local authorities are working across the sector to look at the training needs of all staff engaged in delivering social care in that area.

10:30

[32] So, we are building on that programme and we have already asked in this financial year for the social care workforce development partnerships to be considering their needs around training and development for implementation of the Act. So, we already have that piece in hand.

[33] However, broadly, we are of the view that everybody will need to have a general

understanding, and we are preparing for implementation very shortly of that general piece of work that we will expect to be delivered widely and we will make available to a range of organisations. In order to ensure that that targets the correct people, we will be providing a training the trainers programme for that piece of work so that we can equip people to deliver it. Alongside that, there will be a programme that will target the specific parts of the Act. So, as I have said, we are going to implement in relation to the parts, and there will be a training programme that relates to each part. Then, around that, there will also need to be a range of specialist training. So, for example, if you are a professional who is going to be working under the new safeguarding arrangements, you will require specialist training in relation to that. There are other groups of people that would also come into that; for example, the judiciary will want to be involved in that, and, this week, we are talking to the Family Justice Network about exactly these matters.

[34] So, that is the approach that we are taking. We have a small stakeholder group helping us with that work, which includes local authorities, the third sector and the private sector.

[35] **Gwyn R. Price:** Would you put a timescale on the authorities coming back to you, so that we get results and it does not go on and on?

[36] **Ms Provis:** We will. That is a very important element of it. We see this very much as being something that we need to provide. We need to provide the material to local authorities and partners so that they are equipped to deliver this, but we also need to be absolutely sure that that is reaching the people that it needs to reach. So, we will be doing that.

[37] **Mr Davey:** Just to confirm that the workforce development programme grant is £8.2 million for 2014-15.

[38] **David Rees:** Lindsay is next, followed by Lynne.

[39] **Lindsay Whittle:** Thank you, Chair. The legislative framework is very complicated. There are two pages of it here, with the relevant parts of the Act. I know that, in the south-east, five local authorities have already appointed a co-ordinator to try to work on this. I wondered how that is panning out across the rest of Wales, and what measures are being taken on the ground to get a good communications strategy to the service users, some of whom will clearly need some assistance as well to understand the legislative framework.

[40] **Ms Provis:** As part of the delivering transformation grants, we ask each region to appoint or nominate a lead director for the region, and also to have in place an implementation manager. At this point in time, we understand that all of those people are in place. We are, in fact, meeting the Association of Directors for Social Services Cymru and the NHS Confederation this afternoon to talk to them a little bit more about how the plan for the readiness statement et cetera is rolling forward. We also have in hand plans to bring together the lead directors and the implementation managers in the next couple of weeks, as we take the consultation forward, so that we can begin to talk to them about what we can do to help them at that regional level in terms of their implementation plans.

[41] You asked about communication. We have a communication plan in place ourselves. That will include, later on, in 2015-16, a broader public information campaign, I suppose is a way of putting it, but also we want to be able to work with local authorities and their partners, to enable them to have a public information campaign—although we have not confirmed any of this with them. There is something about how we match what we do with what they are able to do, so if there is anything that we can do to help them with that, we will do that. However, in the end, the duties will be delivered by the local authorities and they will need to have control over how they manage that message.

[42] **Mr Jordan:** If I could add, we also have a funding agreement—a grant—in place with the Health and Social Care Alliance of Alliances and one of the things that it is undertaking for and with us is work directly with service users to make sure that they are, in the first instance, able to input into our consultation, but also to help disseminate the messages about what service users should be able to expect under the Act once it is implemented.

[43] **Lindsay Whittle:** If I could just quickly follow up, you almost foresaw the second part of my question: local authorities have a tradition of saying that there is not enough money, but if there is not enough, are there any contingency plans to put more money in to help implement this?

[44] **Kirsty Williams:** It is supposed to be cost-neutral.

[45] **Lindsay Whittle:** I do not know if it is going to be cost-neutral, but clearly there will be monitoring of it.

[46] **Ms Provis:** On our current delivering transformation grant, I am sure that you will recall that, as we were developing the Bill through the scrutiny process, one of the issues was that the current system cannot be sustained, so we have to shift the system. What we have always said is that we would want to support the changes that have to be made. I think that making the change is actually the difficult thing. So, the delivering transformation grant is about that. Last year, it was £1.5 million; this year, it is £1.5 million and we have made that grant available—not just this year—to local authorities, the ADSSC and the NHS Confederation, but also, as Anthony says, to the Health and Social Care Alliance of Alliances to support third sector engagement in implementation and to Care Forum to support the private sector in that engagement. So, that fund is the fund that will support the change in the system and I think that that will be how we take that forward. Clearly, as we bring the regulations forward for formal laying, they will be accompanied by a full regulatory impact assessment, and that will include a detailed financial assessment of each regulation. So, that work will be done following that consultation.

[47] **Lynne Neagle:** I had two questions. One was along the lines of Lindsay's question. Obviously, we know that local authorities are having to make some very tough decisions at the moment, including in the area of social care. I wondered what kind of dialogue was going on between Welsh Government and local authorities to make sure that they are not making decisions now to mitigate cuts that are going to have an adverse impact on implementing this legislation in the not-too-distant future, because I think that that is a real danger.

[48] My other question was in relation to children. The children's commissioner still has some quite serious misgivings about the Act because of the people-focused nature of it. When he came to the Children, Young People and Education Committee last week, he indicated that he was trying to influence the regulation-making process. However, when I asked how he felt that was going, he said that the jury is still out on that. So, I just wondered how you were taking into account those kinds of concerns, because they were not just the children's commissioner's concerns; they were shared by a lot of children's organisations.

[49] **Ms Provis:** May I respond to the children element first and then come back to the financial one? Clearly, this has been an issue that we have had to consider through the whole of the making of the Act. Our intention is to ensure that everybody, who is covered by the Act, is considered in the context of their whole life—their family and their community, including children, carers and adults with need. I think that we have particularly taken that into account in developing the regulations and the codes of practice. Our technical groups have covered all of the relevant organisations. We have had a strong representation from children's organisations in that development work. I think that we are now out to consultation

and those are the questions that we want people to tell us about. If we need to strengthen that, then that is what we will do, but we have taken that into account. Our regulations—for example, the eligibility regulations—deal separately with children, adults and carers. We have taken all of that into account, but we want to talk to people about that. We will be talking to children’s organisations as part of this consultation, and we will be talking to children themselves; I think that that is one of the ways that we can make sure that we have hit the right note with that.

[50] Just to add to that, what we are consulting on now is the regulations and the statutory code of practice. I think that we are clear that we will want to work with local authorities and their partners to supplement that statutory code of practice, potentially with good-practice guidance or other opportunities, like, for example, action learning sets where people actually test some of that out. So, I think that there are other things that we will want to do as we roll forward the implementation. I will come back to the finance question.

[51] **David Rees:** Do you want to move on to the finance question?

[52] **Ms Provis:** Obviously, the discussion around finances with local authorities is a very lively and current one. The Government has provided an additional £10 million in the revenue support grant this year, and that will go some way toward dealing with the current pressures. However, I think that the bottom line—certainly, the sector is well aware of this—is that the current system cannot sustain itself. Simply having a system that pushes people further up the ladder for more expensive interventions—. We have to grip the community and preventative elements of that work, so we are having those discussions. We have had a very engaged technical group around the duties to develop other kinds of services. We have a conference, during the consultation period, on the development of alternative models of care and a more preventative approach, so we are dealing with that in that way, to keep that dialogue open and to help local authorities and their partners to think about different models of care and how those can be developed and approached.

[53] **Lynne Neagle:** I hear what you are saying, but it is the preventative work that is, I think, most at risk of being cut by local authorities, because, obviously, they have pressures and they have no choice but to deal with the most immediate ones. So, is there any evidence that local authorities are scaling back on the preventative work, which is going to undermine directly what you are trying to do with this piece of legislation?

[54] **Ms Provis:** I am not aware of any direct evidence, but we know the financial position. I think that we need to flush out some of those issues in the consultation. Part of the consultation, in this tranche, is about the development of preventative services. You will know that the Act requires that local authorities and health boards undertake an assessment of the needs of their population, and that they also undertake an assessment of the services that are needed to prevent those needs escalating. As part of that consultation, obviously, there will be a dialogue about what that actually means and how that can be achieved. I think that that population assessment is a core plank, really, of taking forward a more preventative approach.

[55] **David Rees:** I have two Members who want to ask specific questions based on the answers that you have just given. So, I turn to Kirsty first, on the financial aspect, and then John will come in on the issue of children.

[56] **Kirsty Williams:** With regard to local authorities taking actions now, I would share Lynne Neagle’s concerns. There are reports practically on a daily basis that say that local authorities are looking to close day centres, looking to close respite care centres and looking to withdraw funding from a whole range of preventative measures—that is on the news on a daily basis. They are looking to change their eligibility criteria so that councils that were

previously providing care at a moderate level are taking that out and only providing care—. That is happening daily; you do not have to go very far to find the evidence for that.

10:45

[57] I am wondering, when you said that you were discussing with them different models of care, is what you are saying that you expect local authorities to make these changes and stop providing these services themselves? Do you have any evidence that when they are doing that, those services are actively being replaced by action from the third sector or the private sector? I share Lynne's concerns that actually what we are seeing is an entrenchment into the high-end stuff, rather than investment in the preventative measures.

[58] **Ms Provis:** I understand exactly what you are saying, obviously. I think that that element of the Act, which does focus on preventative approaches, is absolutely key to making that change. The work that is being undertaken through the development of alternative models, through social enterprises, co-operatives and services managed by users themselves, is a work stream that includes supporting some—I suppose that you would call them pilot projects—examples of how services can be delivered in a different way, and those examples will be critical to us all to understand how those services can be provided. The key is what is happening in the communities. It is not just about an alternative way of providing a service that is being provided now; it is about developing and thinking about how communities can respond themselves to some of those issues. So, supporting the organisations that provide community-based third sector services.

[59] **John Griffiths:** I am just wondering how the regional approach relates to all of these matters in terms of having regional fora and leadership groups. It will be important to hold them to account for the implementation of the Act and it will be interesting to hear a little bit about how that accountability will be achieved. But, in this crucial period that we are going through, how will that regional approach that could drive a lot of necessary progress—? How can we be confident that that sort of progress, in these difficult circumstances, will be achieved?

[60] **Ms Provis:** Obviously, the regional approach is important to us, because that is how we draw in the local health boards and ensure that local authorities and health boards are working on that regional basis. That will help us to drive better integration and a better service for people. So, partly, that will be done through the grants delivery and the requirements that we have in that grant programme. I do not know whether Anthony wants to say anything about that, particularly, but it will also be driven through the national leadership arrangements. So, the national partnership forum, which brings together the key partners and the national leadership group that brings together the officers in those key partners, will have a particular and specific interest in how that implementation arrangement is happening. We have a partnership forum meeting in a fortnight's time and the key agenda item for that is an update on that regional development. So, there is a link from the regional to the national, as well as the grant monitoring arrangements, to help us to understand how those duties are being delivered. Anthony, do you want to say something?

[61] **Mr Jordan:** Yes, picking up the point on the grant, as has been said before, we are providing funding to support the establishment of these regional leadership arrangements. We are requiring, as one of the deliverables, a regional implementation plan, which will be signed off by relevant stakeholders from across that region—local government, health, the private sector and independent sector. The fruits of that work will be an implementation plan that will come back to the Welsh Government for scrutiny. The carrot, I suppose, in terms of making sure that our first-line deliverables for the grant are delivered and that the regional implementation plan is robust and well-developed, is that it will be on the basis of that regional implementation plan that we will look to deploy what we would hope to secure as

another instalment of the delivering transformation grant for 2015-16. So, they have to demonstrate, I suppose, satisfactory performance this year in order to have a good chance of getting money to support their transformative efforts for the next year and possibly the year after that.

[62] **Elin Jones:** I was fascinated to learn earlier that there is such an organisation as a Health and Social Care Alliance of Alliances. That is fascinating. We will have to have them in committee one day to find out who they are.

[63] I wanted to ask you about the regulation on duty on local authorities to promote social enterprise and different models. In your answer to Kirsty earlier you described that, as a result of financial pressures, there was already work under way by local authorities to look at whether outsourcing or delivering in a different way was already happening, and it is in my area. What, additionally, will this regulation ask local authorities to do, and what do you anticipate the expectation of social enterprise third sector models is likely to be of how things will be different after this regulation is passed?

[64] **Ms Provis:** The regulation requires that local authorities promote alternative models of service delivery. I am sure that you can imagine that the technical group on this matter had quite a lot of discussion about what 'promote' actually means. To some extent the Act, the regulations and the code of practice are quite straightforward in that they require local authorities to promote services delivered in that way, but what we have set around that is a work programme in partnership with the Wales Co-operative Centre and Social Firms Wales, which have a lot of expertise in this area, to continue to help local authorities and providers to think about how those different models can be developed on their patch, if you like.

[65] Some of it starts with an understanding of what can be achieved. We have some examples of projects where service users and communities are coming together to think about the needs that they can meet through an alternative model. As I said, at our conference, which is to be held during the first week of December, we will be exploring some of those models and actually encouraging people to think about those. The support programme this year is based on giving people advice and business support to actually develop alternative models. It is very much focused on how those models can be developed so that we can learn from that.

[66] As I said, while we have a code of practice at this stage and we are consulting on that, I would anticipate that as we work through this work we will be able to develop more good practice models of how people can work in this different way. In terms of direct payments, for example, I am not sure whether you are aware that Disability Wales and the Wales Co-operative Centre have a really fantastic project that they have gained funding for, looking at how people can come together to run and manage a direct payments scheme, which is a really exciting opportunity that we can all learn from. I think that it is very much a learning process. It has to be a quick learning process; there is no doubt about that. However, as you say, there are examples already beginning to develop.

[67] **Elin Jones:** If the regulations were passed as they are drafted currently, and say that a social enterprise in a particular area was particularly keen to undertake a piece of work that the local authority is doing now, and the local authority itself is resistant to it, how does the word 'promote' work legally in that context if a social enterprise might like to challenge the local authority in some way?

[68] **Ms Provis:** I wonder whether Mike would like to answer.

[69] **Mr Lubienski:** The duty in the Act is to promote,

[70] 'the development in its area of social enterprises'.

[71] A local authority would still have to exercise judgment in relation to any single enterprise as to whether it was or was not supportive of the local authority's general objectives in terms of developing services in its area. There might be a whole range of factors that might be relevant to a local authority's decision in relation to a single enterprise. So, the mere fact of the duty in section 16 is not a guarantee that any social enterprise in any area will, necessarily, receive the sponsorship or whatever other support there is, from the local authority.

[72] **Elin Jones:** I am just struggling to envisage how this duty makes it any different, really. You have had these discussions on what 'promote' means. Are you going to offer guidance on a kind of legal definition of what your expectation of this promotion duty is?

[73] **Ms Provis:** I think that, in practice, the duty to promote will require local authorities to take and demonstrate a proactive approach, and that is covered in the code. So, I think that, as we go through that consultation, those are the questions that I am sure we, when we have our consultation events and when we have our workshop—. However, as we further develop and understand that, it is going to be really important. Clearly, the practice around 'promote' has to include ensuring that people are full partners in those discussions and that the population assessment is a clear and published tool, so that people can understand what their needs are and how they might respond to those needs, because it is about the transparency of those opportunities, to some extent, as well.

[74] **David Rees:** May I ask a question? We have seen the Well-being of Future Generations (Wales) Bill coming before another committee, but clearly there is an implication, through an amendment, for the Social Services and Well-Being Act. What discussions are you having with officials across the Welsh Government in relation to that particular Bill and the implications of that amendment?

[75] **Ms Provis:** Clearly, there are implications. I think that the first thing that I would want to say is that, obviously, there will be no repeals to any extant legislation until the Act is fully in force. So, I think that that is the first thing. We have been in discussions with our colleagues and Ministers are currently considering an appropriate way forward.

[76] **David Rees:** Okay.

[77] **Elin Jones:** Do you have any idea why it has been placed in there? Are you able to offer any insight as to why?

[78] **Ms Provis:** I am not quite sure what you—. I am sorry.

[79] **Elin Jones:** Why is that clause in the future generations Bill?

[80] **Ms Provis:** The repeal of section 40.

[81] **Elin Jones:** Yes.

[82] **Ms Provis:** The future generations Bill is focusing on a local wellbeing plan, and so the requirement will be for a local wellbeing plan.

[83] **David Rees:** Section 40, I assume, therefore, does not allow that to happen.

[84] **Ms Provis:** Yes, but it is a different kind of plan, so it just would become one plan. So, those are the discussions that we are having currently, and Ministers are considering the way forward with that.

- [85] **David Rees:** Okay, so that is still under consideration.
- [86] **Ms Provis:** Yes.
- [87] **David Rees:** Are there any other questions from Members? Is there anything else that you want to add to the debate this morning?
- [88] **Ms Provis:** I do not think so.
- [89] **David Rees:** May I, therefore—
- [90] **Ms Provis:** Thank you very much.
- [91] **Elin Jones:** May I just ask the Chair then, during the process of some of these regulations, as they go superaffirmative or—
- [92] **David Rees:** There is one superaffirmative, and a couple of others are affirmative.
- [93] **Elin Jones:** Are we going to ask or are they going to come to this committee?
- [94] **David Rees:** The superaffirmative one comes to the committee, does it not?
- [95] **Ms Finlayson:** Regulations would generally be a matter for the Constitutional and Legislative Affairs Committee to consider. It would be open to this committee, if it wishes to do any work on regulations. It is a matter for the committee to decide.
- [96] **Kirsty Williams:** I think that it was the clear will and intention of the committee—*[Inaudible.]*—consideration that, at the very least, the superaffirmative should come before this committee, and I would be very concerned if that did not happen.
- [97] **David Rees:** We will, therefore, write to the Chair of the Constitutional and Legislative Affairs Committee highlighting that point.
- [98] **Lynne Neagle:** Yes, David, I agree with that, because, obviously, the committee was a bit concerned about the level of detail that was being left to regulation, and I would like to see us erring on the side of caution and bringing more of the regs and codes here, really.
- 11:00
- [99] **Kirsty Williams:** Before you write, maybe it would be worth while looking through it, because it is not just the superaffirmative regulations, as there are affirmative regulations on eligibility, which were of particular concern to lots of people on the committee.
- [100] **Elin Jones:** The Constitutional and Legislative Affairs Committee will still see the regulations from its point of view, but we would look at the policy intent and delivery in relation to the regulations.
- [101] **David Rees:** Eligibility is actually under the superaffirmative procedure.
- [102] **Kirsty Williams:** I think that was because of my amendment, maybe.
- [103] **David Rees:** To clarify, we will ensure that we ask for those to come to the committee.

[104] **Lynne Neagle:** In all the assurances that were given as the Bill went through, it was said that the Health and Social Care Committee would be consulted about these.

[105] **David Rees:** We will make sure that that point is made.

[106] I thank you for your evidence this morning, and thank you for your paper once again. You will receive a copy of the Record in case there are any factual inaccuracies that you want to identify. Please let us know if there are.

[107] The Minister is scheduled to be with us from 11.30 a.m., so I propose that we have a break and recommence at 11.30 a.m..

*Gohiriwyd y cyfarfod rhwng 11:01 ac 11:29.
The meeting adjourned between 11:01 and 11:29.*

**Gwaith Craffu ar ôl Deddfu ar Fesur Iechyd Meddwl (Cymru) 2010: Sesiwn i
Graffu ar Waith y Gweinidog
Post-legislative Scrutiny of the Mental Health (Wales) Measure 2010: Ministerial
Scrutiny Session**

[108] **David Rees:** I welcome Members back to this morning's session. We move on to the next item on the agenda, which is the scrutiny of the Minister for Health and Social Services on the post-legislative consideration of the Mental Health (Wales) Measure 2010.

11:30

[109] Thank you, Minister, for your written paper, which was very helpful to us. Could you introduce your officials for us, please?

[110] **The Minister for Health and Social Services (Mark Drakeford):** Thank you very much, Chair. I have Sarah Watkins, who is the professional lead, among other things, on mental health matters for the Welsh Government, and Andrea Gray, who has been the legislation manager for the Measure since its implementation.

[111] **David Rees:** Thank you. I remind Members that this morning's session is to look at the Measure and its implementation as to whether there are any lessons learned and issues around the Measure, not mental health per se. We start questions with Gwyn Price.

[112] **Gwyn R. Price:** Thank you, Chair. Good morning. Can you tell me, Minister, your views on the impact of the Measure on primary mental health services so far?

[113] **Mark Drakeford:** Thank you very much, Gwyn. Obviously, Part 1 of the Measure established the local mental health service. I think the evidence on it so far is very encouraging. On the position before the Measure was introduced, if you look back, the evidence that was presented to the Assembly was that, in responding to somebody with a mental health need, services and places to which GPs could refer people to get the help they needed were inconsistent, patchy and certainly did not amount to a reliable approach across Wales. What the Measure has done, I think, is to make sure that there is a service everywhere. It is a local service, and that is very important. You do not want to have exactly the same service in rural Ceredigion, where I met mental health services only last week, as in the centre of Cardiff, say. You would not want them to be identical. You want them to be local but you want them to be everywhere.

[114] More than 33,000 people made use of the new service in its first year. Members may

have seen that the interim report that was published in April this year has a table that tells you what happened to 20,000 people who had come through the service and have now been discharged from it. I think that it gives you a pretty good idea of what the local service is able to provide. So, about four out of 10 people who were discharged were discharged having received a therapeutic intervention from the local service. About one out of 10 people who were referred to the local primary care service turned out to be someone who needed secondary care services, so their needs were more significant than could be met locally. Some 37% of people were referred on to other services, and that includes one of the big successes of the Measure, I think, which is the way that it has helped to generate a much larger series of self-help and open-access services. So, about four out of 10 people get referred on to things like that, and about 16% of people were discharged having had just a simple advice session given to them in the new service. So I think you can see that there is a wide range of services becoming available.

[115] There is more to do, we know, in terms of making sure that waiting times are consistent across Wales and that we can be confident that there is a full range of local services available everywhere. However, I think that, if you measure what has been achieved against the ambitions that the Assembly had for the Measure in that Part 1, it is a success story overall.

[116] **Gwyn R. Price:** Thank you, Minister.

[117] **Janet Finch-Saunders:** On data, do there appear to be any data to enable comparison of services and patient outcomes both before and after the introduction of the Measure? Have you assessed the difference since the Measure, and what are the before and after comparisons that you can evidence to say, 'This is certainly what's happening now'?

[118] **Mark Drakeford:** Okay. Chair, I will try to just briefly go through the four Parts of the Measure answering that question. I think that it is particularly difficult in Part 1, because there was no previous local mental health service that you could identify everywhere across Wales. So, it is difficult to compare what was not there before with what is there now. I have given you some figures on what the current service is providing. We have very good data collection, post the Measure. We are refining it further in the primary care field, for example to be able to collect greater age-differentiated data in the future.

[119] In Part 2 of the Measure, the care and treatment plans, we have better evidence there. We have figures for the proportion of the population who had care and treatment plans before the Measure. For example, about 65% of older people had a care and treatment plan before the Measure was introduced, and it is over 90% now. Cardiff and Vale University Local Health Board figures show that about 55% of young people had a care and treatment plan before the Measure was introduced, and it is over 95% now. So, I think there are good—or at least better—before and after data in relation to Part 2 of the Measure, and that is showing without any doubt that a far higher and more consistent proportion of secondary care mental health patients have a care and treatment plan as a result of the Measure than had before.

[120] On Part 3 of the Measure, again, it is not possible to provide before and after data because Part 3 of the Measure provided a completely new right to patients who are discharged from secondary mental health services to ask for a reassessment of their needs, if they felt that they may have been prematurely discharged. On average, 789 people are discharged from secondary mental health services in Wales every month. Over 100 of those, on average, ask for that decision to be reviewed. That right lasts for three years, so you could have been discharged two years ago and now feel that things are not as good as they have been and you need to be reassessed. Over 100 people every month ask for a reassessment, and about 40 of those end in a readmission to secondary care, with the other 60 being helped in different sorts of ways. Again, before and after comparisons cannot be made because there was not a before.

The data post implementation I think are reliable and have settled into a good pattern.

[121] In terms of Part 4 of the Measure, which is the extension of advocacy rights, we know that over half the people who use the advocacy service today would not have been eligible to use the advocacy service before the Measure was introduced. So, an average of about 370 people use the advocacy service every month, and just over half of those, about 53%, are people who would not have been able to do it before the Measure was introduced. So, there we do have some before and after data.

[122] **Janet Finch-Saunders:** Your own paper states that there have been some inconsistencies and differences in the way that local health boards and partner agencies collect their data. We are all familiar with the fact that some agencies over the years have been quite precious in not wanting to share. There is a statement here that they have recently found ways to share this information, so that there is a clearer understanding of the impacts of this Part of the Measure. Do you think there needs to be some further work on data collection and evaluation with LHBs and their partners during the development and implementation of the Measure, and might that have helped to avoid the inconsistencies in data quality that are now apparent?

[123] **Mark Drakeford:** I think there is more work to do, Chair, in making sure that we are collecting the right information and that we are collecting the data in the same way in all parts of Wales, particularly in relation to Part 1. I think there was a genuine question in the early couple of years when the Measure was being introduced as to how detailed a data collection set you required while people were having to set up the service at the same time. There could have been a danger that people spent all their time counting things rather than doing things. So, we were trying to be proportionate in asking for proper data and reliable data to be collected. Now that the service has been there for two years, I think that the time has come for us to refine what we ask services to provide; to be a bit more detailed in some places, and in other places, where we can now see that a reliable pattern has been established, we might be able to go back a bit from the detail that we have asked for in the past. However, it is a very proper question and it is a bit about how we are learning from the implementation of what was a landmark change in the law for mental health patients in Wales.

[124] **Janet Finch-Saunders:** Finally, as an AM, in Aberconwy, I find people approaching me who have fallen through the net. How will this Measure help those people who feel that they are not on any data system and that they have not been given any support, and who usually present to me in a pretty distressed manner?

[125] **Mark Drakeford:** Obviously, it is always an ambition to have a service in which people feel secure in the part where they are being provided with a service. I think that the safety net is pretty much as good as we can make it. We are providing a service for some very distressed people, who will always find some challenges in navigating their way around to get the help that they need. There has been some comment early in the implementation of the Measure particularly as to whether the boundary between secondary and primary care was one that was allowing some people not to be in the right part of the system. It is just a matter of continuing to work at it, and never feeling that there is not a need to keep being sure that all parts of the system are alert to the need to work closely with some people who, by themselves, if they are left to themselves, will always be in danger of not getting the help that is available in the right place and at the right time.

[126] **David Rees:** On that point, I noticed in your paper that you mentioned that there are quite a few task and finish groups, or working groups, based upon the report from April this year. Am I, therefore, assuming that these possible gaps that you have identified will be looked at as part of the lessons learned by those groups?

[127] **Mark Drakeford:** Yes. On the task and finish groups, Chair, there is one for each part of the Measure as a result of the interim report. The interim report identifies issues, as you would expect with each part of the Measure, where practitioners and user groups say that there are things that we need to continue to work on. The interface between different parts of the system is certainly part of all of that, but Dr Watkins could probably tell you a bit more.

[128] **Dr Watkins:** I suppose that I was just going to pick up the point about the universality of primary care, because primary care is there for everybody—everybody has a right to be registered with their GP. They can go to the LHB and ask for a GP, and every GP in Wales can now refer to that local primary care support service. So, there is improved access for everybody. With some people, when they go, their views may be subtly different to their GP's views, but the service also signposts. Some people have very complex needs—they may have financial needs or they may be offenders with very complex needs—and it is about signposting for these people who do not know where to go. We also encourage the local primary care support service, if they do not know where to go, to support them to get there, so that the vision of this universal service is one that does begin to address some of those really challenging individuals that I am sure present to every AM.

[129] **Janet Finch-Saunders:** On that note, certainly in my constituency, and quite locally, in terms of trying to access a GP, you have 10 minutes in a morning to try to access a GP for that day; you cannot book in advance and things like that. That causes a lot of concern. When people have mental health issues, they want to be seen fairly quickly, and I have people presenting who struggle to access any GP support.

[130] **David Rees:** Something for you to think about, perhaps. Lynne is next, followed by Lindsay.

[131] **Lynne Neagle:** I want to ask about children, Minister. How effective do you think the measure has been in improving services for children?

11:45

[132] **Mark Drakeford:** Thank you, Lynne. You, more than me, will remember that when this Measure was going through the Assembly, the Government's original position was that it was a Measure for people aged 18 and over, and that was the position in the first draft of the Measure. The committee at the time, during Stage 1, took evidence from a wide range of stakeholders, including the children's commissioner and so on, who felt that it ought to be an all-age Measure. From Stage 1 onwards, it was always the intention that the Measure should be an all-age Measure, but it did bring a series of issues with it that were not part of the original thinking.

[133] What do we know? We know from a piece of research carried out in Gwent, in the Aneurin Bevan Local Health Board, over the summer that about 20% of referrals to the local primary care service are for people aged 18 and under. So, the local primary care service is reaching significant numbers of young people. There were some tensions in Part 2 between some Child and Adolescent Mental Health Services that did not feel that the care and treatment plans were designed with the views and needs of children in mind. I know from the way in which you structured the inquiry that one of the questions you have been pursuing is whether the legislative process delivered the Measure that we would have wanted. Of course, the eight domains of the care and treatment plan are there, on the face of primary legislation, so some people do argue that it is a bit of a tight jacket around them.

[134] The delivery and support unit that the Welsh Government has, and which has looked at these, actually says that some of the best care and treatment plans that they have seen are for young people and that, when the care and treatment plans are used flexibly and

proportionately, they do a very good job for young people as well. There are some questions that we need the task and finish groups to look at in relation to Part 3 because at the moment, children are not entitled to the protections that Part 3 provide; only adults are able to ask for a reassessment. I think that we are maybe slightly more alert to the United Nations Convention on the Rights of the Child requirements than we were even back in 2010. We have asked the task and finish group to check whether we ought to extend that right to younger people who do not have it at the moment.

[135] I think that there is some good practical evidence that the Measure is making an impact for younger people. It is always important to remember that the Measure was intended to supplement, and not supplant, services that were already there. So, all of the things that were there before for young people are still there for them, with the extra things that the Measure provides.

[136] **Lynne Neagle:** I have a couple of other questions. Your paper says that a specific plan for CAMHS has been developed, which focuses on the needs of this group. Can you expand on that, please?

[137] **Mark Drakeford:** Yes; thanks, Lynne. I have set out some detail on all of this in the written paper that I provided to the Children, Young People and Education Committee as part of its inquiry into CAMHS. I am referring to two things: some immediate actions that we wish to take following the Health Inspectorate Wales and Wales Audit Office report on CAMHS earlier this year. That includes things like making sure that young people are attended to in wards for young people rather than adult wards as much as possible; that we make maximum use of our level 4 services and that we bring children back into services in Wales from across our border. So far, it is early days—we have only got months, rather than more than that, of evidence—but this year, the figures of occupation rates at our two level 4 units and the number of children who are getting across our border are encouraging.

[138] The second thing that our plan does is to introduce some additional clinical help for our services. Dame Professor Sue Bailey, who is a past president of the Royal College of Psychiatrists with a specialism in child and adolescent psychiatry, is going to come to Wales to help with some rethinking of the CAMHS service to make sure that we try to get a handle on what people providing these services tell me is the current position, where they are spending far too much of their time simply assessing people who have been referred to them and turn out not to be candidates for a specialist service, thereby getting in the way of their ability to provide a service to those young people whose needs are more significant and urgent and ought to be seen by them. So, Professor Bailey will come to help with some clinical and professional help to redesign things.

[139] **Lynne Neagle:** Do you think that the Measure has helped with that problem of people being inappropriately referred into CAMHS? I think that what we all hoped was that people would be dealt with—children and young people—at a primary care level without being pushed into waiting for CAMHS and then sent back out again.

[140] **Mark Drakeford:** I do not think that you could say that. There has been a 103% increase in referrals to CAMHS in the four years since the Measure was passed. It would be very difficult to argue, I think, that the Measure has succeeded in making sure that the right people get to that service. There is a tension here, Chair, is there not? In one way, when you have a new service, what always happens in health is that you provide a new service and a latent demand that you have not predicted will come through the door to use it. So, you think that you have made an assessment of need, but health services do not work in the way that economics work. They work the opposite way. You provide a service and demand rises to meet it. So, there actually may be more people coming into the system as a result of the service that we have provided, which is a good thing if you think that that service is attending

genuinely to a need, but a worrying thing if you think that it is drawing into the net of services people who need not be there.

[141] **Lynne Neagle:** I have just one final question. You have said in your paper that data collected by the Welsh Government do not routinely differentiate between particular age groups, although you obviously have some data that you can refer to, such as in Aneurin Bevan. Do you think that it would help with drilling down into the nature of this problem if we did start to routinely collect data on children and differentiating between them?

[142] **Mark Drakeford:** Yes. I think that I said in answer to Janet's earlier question that one of the things that the task and finish group on Part 1 of the Measure is looking at is whether we ought to refine our data collection measures around Part 1 to ask health boards to send us age differentiated data in relation to the use of the local primary healthcare or the mental health service.

[143] **David Rees:** Kirsty has a specific question on this.

[144] **Kirsty Williams:** Minister, you have repeated this morning the argument that you have made several times in the Chamber that the issue with long waits in CAMHS is due to referral levels that turn out to be, in hindsight, inappropriate. Obviously, people are referring children and their families who are obviously demonstrating some signs of distress. Are you saying that there is no need at all or that the need that is being referred is not a psychiatric need? Does that demonstrate, perhaps, that there is a gap in perhaps psychological services for children and young people that should be looked at to be developed, so that people can refer into those services rather than purely psychiatric services, as is happening at the moment?

[145] **Mark Drakeford:** Thanks for that, Kirsty. My basic anxiety is to make sure that we avoid the over-medicalisation of the struggles that some young people face with growing up. I do not believe that drawing large numbers of those people into specialist mental health services is the right answer for them. What I am equally clear about in my mind, however, is that saying to someone, 'This is not the right door to come to', has to be accompanied by saying, 'What we can offer you is this'. It is not just a diversion approach in which you do not offer people anything. So, we have to find other things that we can offer families and young people who are going through tough times in their lives, but if we help them in the right way they will grow through it, get past it and be able to carry on with the rest of their lives. It is not an argument for neglect; it is an argument for the right service. It is an argument that I think is quite difficult to put to some of our workers, which is that you have not discharged your responsibility to the young person in front of you simply by referring them to somebody else. These young people are in touch with a lot of professional workers through schools, the youth service, counselling and things like that. We have to better equip those people to give a positive response to the young people and their families who need that sort of help, and ensure that they do not feel that if they fill in the form to send to them to CAMHS that they have done their job. They have a continuing responsibility to work with those young people and their families and to provide for them. Equipping them better through mental health first aid courses, through the investment we are making in a wider range of psychological therapies and so on, is definitely part of that.

[146] **David Rees:** There are questions from Lindsay and then John.

[147] **Lindsay Whittle:** Minister, we all know that there is an increased demand for mental health services. I have noticed that my caseload is increasing. I just wanted to ask you about the progress in meeting mental health training needs for GPs and primary care staff. Also of particular concern to me is whether that training—this comes up a bit later on in some of the other categories, but I will take this opportunity—is being taken out to education staff and in

particular to the people who deal with homeless people, because there is a real issue on our streets.

[148] **Mark Drakeford:** Thank you, Lindsay. When the Measure was introduced, as far as GPs were concerned, in 2012 a new direct enhanced service was agreed with the General Practitioners Committee Wales. This is the extra service that GPs are paid extra money to provide. That direct enhanced service is about training for not just GPs, but the wider primary care team. I got in trouble with the Royal College of General Practitioners for something I said in front of this committee a little while ago, when I said that I think that professional workers in the field have a professional duty to keep themselves up to date with changes in legislation, new forms of treatment and so on, as well as Government having a responsibility to make sure that they are supplied with the wherewithal to do that.

[149] I think the evidence on the whole is more promising than not. We have a group of GPs who work together as specialists in mental health in primary care. It has produced a training programme for the whole of the primary care team. It is quite onerous—it means that you have to find a way of getting everybody together for an afternoon to go through it all—but between a quarter and a third of practices across Wales have now completed this training. It is very good stuff, if you ever have a chance to look at it. It is designed to make sure that the requirements and the possibilities of the Measure are fully understood, not just by the GP, but, as we have probably said here before, in relation to dementia, for example, it is often the receptionist who is the first person who has contact with somebody and who needs to be alert to the signs that someone who they have known for many years may not be as on top of things as they used to be. So, it is a holistic training package.

[150] I will ask Sarah or Andrea whether they want to add anything more generally, but I will just say one specific thing in relation to homeless people and hard-to-reach groups. The approach we are taking there is to try to work through third sector organisations, rather than to do it through the services themselves, because, on the whole, we think they are more likely to be able to make contact with groups that do not feel comfortable, necessarily, in their involvement with services. It cannot be easy for street homeless people to present themselves at a GP surgery, so Gofal, which is one of our big third sector mental health organisations, is doing some work on our behalf with some hard-to-reach groups to try to make sure that the Measure is as available to them as it would be to anybody else.

[151] **Dr Watkins:** Very briefly, in terms of working with schools, for example, we do try to work very closely with school counsellors in particular, but also school nurses. You are right that, in order to manage some of the demand, the way to do it is to make the people who are working with children anyway feel more comfortable, because it does create anxiety within professionals, it is fair to say, when they have a distressed child before them.

12:00

[152] Sometimes they are referring to CAMHS when, actually, a week later all of those problems have disappeared because that is part of being young, being adolescent—your mood and how you feel about your friends and other issues can vary very rapidly. So, training people up and the school counselling initiative and the £5 million recurrently that other parts of the Assembly have put into that have made services more robust. However, they also need to feel supported by CAMHS so that they feel that they are making the right decisions, and that applies whether it is in youth justice or other services. The only way this is going to work is for everybody to work together and support each other in this.

[153] **Lindsay Whittle:** Could I thank you for that? I am aware that certain mental health issues, such as bipolar disorder and schizophrenia develop in late teenage years and the early 20s, so I hope that some work is being done with universities as well. I am just wondering

about work through the medium of the Welsh language for those areas where Welsh is the predominant language.

[154] **Mark Drakeford:** Thank you. Both of those are important questions. I think that I said a few moments ago that I was in Aberystwyth a week ago today and went to meet a series of mental health services there. They were very keen to talk about both of those issues. They have had an influx of students over the past few weeks. They are always alert to the fact that there will be a certain number of young people who, faced with new surroundings and the significant pressures that can come with those, will experience an acute exacerbation of mental health conditions that tend to have onset in later teenage years and the early 20s. They were certainly working with the university authorities to identify those things. They felt, they said to me, that when young people come to university with a physical health need, that is very clearly signalled up in advance—the university is alert to it and there is good liaison around those things—but that with young people who have a mental health condition it is less clearly brought to the surface as part of that young person's arrival at the university. There is a bit of catching up that has to be done to discover their histories when it becomes an issue that needs attention.

[155] On Welsh language services, in that part of Wales you can imagine that there was a lot of discussion of that. There is definitely more we have to do. At certain levels of professional intervention—with nurses and community psychiatric nurses—they were confident that they had people who were able to carry out interventions at that level through the medium of Welsh for the local population. When you get to the more specialist end, the consultant psychiatrist end, we do not have sufficient people able to provide the specialist service. So, we are exploring—well, Dr Watkins really is exploring—with those people who are able to do that whether we can, through video links and other things, make them more available in places where there is not a service that we are currently able to provide in that way.

[156] **Lindsay Whittle:** Thank you for that. I am pleased that it is on the agenda at least. I appreciate your earlier comments. You do not know what is coming down the track anyway—none of us does—but at least it is on the agenda, and that is good news. Thank you.

[157] **John Griffiths:** In terms of local primary mental health services and the range of availability, some evidence that this committee took suggested that psychological therapies are not always as available as they should be. Sometimes, that results in GPs prescribing antidepressants where they otherwise would not if there were greater availability in terms of alternatives. I just wonder whether you could say a little bit about consistency across Wales in terms of the provision of psychological therapies and how the Measure has helped to achieve progress.

[158] **Mark Drakeford:** Well, Chair, if there is a single area where we need to be able to do more than we have been able to do in the past, it is in investment in psychological therapies. We are putting £680,000—

[159] **Dr Watkins:** It is £650,000.

[160] **Mark Drakeford:** We are putting £650,000 of new money into psychological therapies across Wales this year. I am sure that if we were better off for money, we could spend more than that and spend it usefully, but in the current circumstances, £650,000 is a significant new sum of money to do that. As a result, there is a growth in psychological therapies, and there are new forms of therapy like mindfulness, which we have discussed in front of the committee previously, that are being added to the repertoire of services that can be provided in Wales. However, I am not going to suggest here that this will mean that we are able to do everything that we would like to do as far as psychological therapies are concerned.

[161] Medication and drug forms of therapy in mental health have been a very important part of what we have been able to offer people, which we were not able to offer before, so they will always have an important part to play, but we have a big experiment just about to start in the Cwm Taf area, where, using money from the WCVA on a social impact bond basis, it is going to be able to provide a new range of psychological talking therapies. The idea is that, over three years, these things will pay for themselves by a reduction in the routine prescription of antidepressant drugs. Cwm Taf has one of the highest levels of primary care antidepressant prescribing of any part of the United Kingdom. Sometimes, there are people who are prescribed those drugs over very long periods of time. There is evidence that much shorter forms of talking therapy interventions do better in people's lives and leave them better equipped to go on managing without forms of intervention. So, Cwm Taf has been given the money by the WCVA. The idea is that, over three years, it will demonstrate that these new services pay for themselves and will allow Cwm Taf to pay the money back that it borrowed in the first place, in the way that social impact bonds are meant to do. We will learn a lot, I think, both about whether that is an innovative way of trying to fund new services in difficult times, but also, in answer to your question, John, as to whether or not those extra talking therapies really do displace people from routine antidepressant prescribing into something better.

[162] **David Rees:** Have you identified whether there is any correlation between prescription and the lack of talking therapies available in pockets around Wales?

[163] **Mark Drakeford:** I do not know whether I could say, but I would be surprised if there was not. The real correlation is between deprivation and prescribing, as you would expect.

[164] **Kirsty Williams:** Could you tell us how the £650,000 will be allocated and what you expect to be able to get for that investment? I acknowledge that there has been a significant improvement in compliance with targets set for assessment and intervention, but despite the improvement—and there has been over 20% in the space of a year—we are still not meeting your targets with regard to compliance with assessment and then intervention. Local health boards have been asked to provide you with plans by next month as to how they will reach those targets. Could you tell me whether you believe that it is a realistic proposition to hit those targets and whether you believe that those targets are still meaningful?

[165] **Mark Drakeford:** If I could try the second question first, and then I might ask Dr Watkins to give you the detail on the £650,000. I think that the approach that we have tried to take to targets with this new piece of legislation is to have targets that are stretching, but achievable, and not to have targets that are so beyond being achieved that they become demotivating and stop people from trying, because they think, 'We'll never manage that, so why bother?' So, we started with a 56-day target from referral to assessment, managed to achieve that, and, therefore, we reduced it by half, so it is now a 28-day target from referral to assessment since October of last year. The pattern has improved over the year. We are over 70% compliant with the 28-day target now.

[166] We want to keep pressure in the system, nevertheless, to do even better, and that is what those plan requirements are: to say to people, 'You are doing well and things are heading in the right direction, but we don't want you just to stand back from it, we want you to do even better'. We have a 56-day target following assessment to intervention. The figures are better than the ones that I gave you in my written report—at least the September figures are a further advance on August, so we are now up to 85% against a 90% target of achievement there. The question that I know I will get advice on sometime in the next few months is whether we now reduce that 56-day target to something shorter in order to continue the journey of reducing the time from referral to assessment and then from assessment to

treatment. So, it is that balancing act between wanting targets that are stretching and lead to improvement, but not having targets that are so beyond achievement that actually they have the opposite effect to what you hoped they would have.

[167] **Kirsty Williams:** Since you took over as Minister, you have said that you are looking at whether targets are effective, whether we are measuring the right things and whether they are being measured in a way that actually makes a difference to patients rather than just statisticians. Under this system, somebody could wait, if they are seen within target, 84 days before they actually begin treatment. Is there any evidence to suggest that that is clinically appropriate or whether that is too long? If somebody arrives in their GP surgery today in a distressed state, is it clinically appropriate for them to wait that time? I am just wondering whether we can expect to see a continuation of this or whether, in a couple of weeks' time, you will say, 'Well, actually, this doesn't make a difference to patients, so we need to measure it in a different way'.

[168] **Dr Watkins:** I would expect all services to respond according to clinical need. So, if you have an urgent need anyway, our targets in mental health are four hours for emergency, 48 hours for urgent, and 28 days for routine referrals for assessment. However, that means that you are assessed at either four hours, 48 hours, or 28 days. So, you are assessed according to need and then that assessment tells you how long you can wait before treatment. Some people who are seen, whether in the primary care service or in the secondary service, may need to be seen very soon; other people may have very long-term conditions that are distressing to them—I do not want, in any way, to underestimate the distress to them—but have been around for a long time. An anxiety disorder is a good example of that. Sometimes, they are horrible experiences for people, but they may have been having that experience for a year or so and so actually putting somebody in an anxiety management group when it starts next within that time frame is reasonable, whereas, if somebody is seriously depressed, they may be one of the one in 10 people who are referred on urgently and are treated immediately. So, any service has to respond to the patient's needs and not to the target. So, it is important that those are in place. However, that does not mean to say that having the 28-day target is not helpful, because we need services to know that people need to be seen in a timely fashion, whether you count it as an urgent referral or less urgent. Everybody needs to be seen in a timely manner.

[169] Shall I move on to the psychological therapies? Some £100,000 of that is going to veterans to manage psychological interventions for veterans with post-traumatic stress disorder, and £45,000 is going in response to our analysis of psychological therapies in Wales and their provision in order to understand better the gap analysis and to develop a plan to address those gaps. So, someone within the NHS is going to do that piece of work, working across Wales, to make sure that the plans in each LHB are to manage better psychological therapies. The remaining money is going into training current staff in order that they are better skilled to be able to deliver evidence-based psychological therapies. It is all seven LHBs and Velindre NHS Trust, because we felt that it needed some money, too, to do psychological interventions, for example, with children. We were very keen that there should be a bit more consistency about what was provided. So, we have said it must be all ages, it must be evidence-based and we gave examples of the sorts of things that we expected to see. The bids have all come in and the money has now gone out to LHBs. People have already started, for example, in cognitive behavioural therapy training on the Cardiff University course.

12:15

[170] **Kirsty Williams:** Thank you very much.

[171] **David Rees:** Gwyn is next.

[172] **Gwyn R. Price:** May I just touch on this? The committee has received written evidence suggesting that the Measure has created an unnecessary barrier between primary and secondary mental health care in prisons, where multi-disciplinary teams work. Have you done any work on this to implement the Measure in the context of prisons and the specific needs of prisoners with mental health problems? Certain things in my constituency lately have shown that failure can result in horrendous consequences.

[173] **Mark Drakeford:** Thank you, Gwyn. Obviously, the specific incident in your constituency will be investigated by the Ministry of Justice, around, in many ways, exactly the issue that you have identified: whether information flowed across systems in a way that made sure that someone's needs were properly identified and could be prepared for.

[174] The issue of the needs of prisoners was discussed during the passage of the Measure. It is not an easy issue at all. Lots and lots of people with a mental health need who come back to live in Wales are not in prisons in Wales at all; it is a very dispersed and scattered population. Lots of the people that we provide a service for in Cardiff and Swansea are not Welsh residents themselves, and will be going back to somewhere else. However, what we have done—I think it was an undertaking given by the Minister at the time—is that we have prepared and published specific guidance for prison health services and other prison employees on the mental health needs of their population, how they are best met and the relationship between that and the Measure. We launched that guidance earlier this year, and I went with Gwenda Thomas, the Deputy Minister at the time, to Swansea prison to discuss with its medical and senior staff how that guidance could help to make a difference to the way that they were providing for the mental health needs of their population.

[175] **Gwyn R. Price:** Thank you.

[176] **David Rees:** Minister, the regulatory impact assessment that was undertaken, and we are looking back at the Measure now and therefore the consequences of the Measure, did it actually—? We have heard evidence that the resourcing side of issues as a consequence of the introduction of the Measure was queried. Did that assessment actually underestimate the resourcing requirements as a consequence of the Measure? I will highlight one example. You talked about the impact on under-18 year olds who are in the system and the increasing numbers as a consequence of that. Has that put an extra demand upon the system, and therefore were the resourcing requirements not actually reflected properly?

[177] **Mark Drakeford:** I have read quite a bit of the evidence that the committee has received from other organisations, and I have seen that suggested by a number of them. I think it is important to be clear that the Government's original proposal was for a Measure that would deal with people aged 18 and above. The amendments that were brought forward to the Measure to make it an all-age Measure were as a result of the Stage 1 report that the committee of the time produced, which strongly advocated making it an all-age Measure. However, therefore, that was known from quite early on in the legislative process; it was known from Stage 1 onwards. It was not a sudden amendment to the Measure at the very final stage; it was identified strongly from Stage 1 onwards.

[178] The regulatory impact assessment that the Government of the time published in October 2010 said very clearly that the precise resource implications of the Measure were difficult to be sure about, partly because of some of the questions that committee members have raised this morning to do with the way in which, if you provide a service, a latent demand that you just simply are not able to anticipate may rise to meet it. So, I think that you could argue that the Act has been successful beyond what was originally anticipated in the demand that it has discovered in primary mental health services in particular. I do not myself believe that the inclusion of children within the Measure has been detrimental either to them,

or that it has, by itself, been the cause of large unexpected costs to those services implementing it.

[179] **David Rees:** In the sense of legislation, is it therefore a consideration that we should have that when we look at pre-legislative scrutiny rather than at Stage 1 to give that more time for such considerations before a Bill is laid?

[180] **Mark Drakeford:** There are people in the room who are better equipped than I am, I think, to reflect on some of that and who were here in the Assembly when this piece of legislation was going through its processes. In some ways, I think that it is important to recall that this was a very particular piece of legislation. It had already gone through the legislative competence Order process, so there had been a whole round of discussion and debate about it as powers were drawn down to the Assembly. At the time, I remember quite a number of Assembly Members arguing that an LCO process, followed by a Measure process, was very repetitive and led to going over a lot of the same ground. So, you could argue that, in effect, there was a pre-legislative phase to this Measure. It was also a piece of legislation promoted by a backbench Member rather than by the Government itself, and it was promoted at a time when there was quite a lot of political commitment, it seemed to me, to demonstrating that the new system could work successfully. So, the Minister of the time, I think, although it was not her piece of legislation, provided a significant amount of support to ensure that the legislation was in proper form and could do what it wanted to do.

[181] I am sure that there are lessons to be learned from it, but I do not think that they are very easily simply picked up from the context within which this Measure was put on the statute book given the very different set of legislative capacities and ways of doing business that the current Assembly has.

[182] **David Rees:** The reason that I am asking is that, clearly, I believe this is the first post-legislative scrutiny that has existed here and we just want to see whether there are lessons to be learned and whether those lessons are being transferred into current legislation.

[183] **Mark Drakeford:** Well, Chair, I think that there are lessons to be learned. As I say, there are others here who went through the whole process, who would have views that are more informed than my own in looking back. However, when I look back at it, and have talked obviously to Dr Watkins and others who were involved in it, among the lessons, it seemed to me, was that there was very, very strong engagement with the sector, and the third sector in particular, in the formation of this legislation, and that is part of its strength. I see in the replies that you have had from those organisations that they all speak highly of the opportunity that they had to help to shape the Measure, and I think that that is a strength of it.

[184] There is always a tension between the ambitions that we all have to make services better quickly and the capacity of the service to absorb change. It is about trying to make sure that, in the implementation side of the Measure, we are prepared sometimes to hold back a bit of our impatience for change to allow services to be built up to absorb new work and to do things in different ways against a timetable that is actually achievable for them, and allows you to continue to take with you that quite wide-ranging coalition, from consultant psychiatrists at one end of the spectrum to small, local third sector organisations at grass-roots level, and to keep that coalition together through the implementation phase as well as the formation phase.

[185] **David Rees:** Okay. Thank you. Are there any further questions from Members? There are no further questions, Minister, so I thank you for attendance this morning. You will receive a copy of the record to check it for factual accuracy, as usual. So, thank you very much.

12:25

**Papurau i'w Nodi
Papers to Note**

[186] **David Rees:** We have some papers to note. The first item is the additional information from the Minister for Health and Social Services in relation to the Welsh Ambulance Services NHS Trust's recruitment plan. The second item is the additional information from the Chief Medical Officer for Wales regarding the primary care plan. The third item is the additional information from the Minister for Health and Social Services regarding our committee's inquiry into the national health service's complaints process. I do not think that it is just additional information; actually, it is in response to our letter to him, in which he does identify that a more detailed statement will be made in the near future. The fourth item is our forward work programme for January to March 2015. Are you happy to note those papers? Yes. Thank you very much for that.

12:26

**Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd
Motion under Standing Order 17.42 to Resolve to Exclude the Public**

[187] **David Rees:** I move that

in accordance with Standing Orders 17.42(vi) and 17.42(ix), the committee resolves to exclude the public from the remainder of this meeting and for the first item of the meeting on 26 November 2014.

[188] Are all Members content with that? Yes. Thank you.

*Derbyniwyd y cynnig.
Motion agreed.*

*Daeth rhan gyhoeddus y cyfarfod i ben am 12:26.
The public part of the meeting ended at 12:26.*