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Audit Committee

Adult Mental Health Services in Wales: A Baseline Review of Service Provision

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THE NATIONAL ASSEMBLY FOR WALES AUDIT COMMITTEE

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Adult Mental Health Services in Wales: A Baseline Review of Service Provision

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Summary

1. Mental illness is a common condition, but typically is not well understood. Historically mental health services have not featured amongst the priorities of service planners and commissioners. Recognising this, the Welsh Assembly Government has identified mental health as one of its health priorities. A strategy for adult mental health services in Wales was published in September 2001 and was followed in April 2002 by the launch of a National Service Framework for adult mental health services which identified standards and key actions aimed at driving up quality and consistency in health and social care provision.

2. On 12 January 2006, on the basis of a report by the Auditor General for Wales,[1] we took evidence on developments in adult mental health services from Mrs Ann Lloyd, Head of the Health and Social Care Department and Mr Philip Chick, the Director of Mental Health in the Welsh Assembly Government.

3. Our examination focused on the steps that are being taken to improve adult mental health services in Wales. In particular we sought to obtain assurances that robust and co-ordinated action is being taken to address the key gaps in service provision identified by the Auditor General.

4. Our conclusion is that whilst there is evidence to indicate that the Welsh Assembly Government is taking positive action to raise the standard of adult mental health services, there are still too many variations in service provision across Wales. The NHS, local government, public health and the voluntary sector need to work together to:

    - strengthen local planning and commissioning arrangements for adult mental health services;
    - address gaps in key elements of service provision;
    - improve joint operational working between the different organisations and teams involved in mental health care; and

[1] Auditor General for Wales report, *Adult mental health services in Wales: a baseline review of service provision*, October 2005.

- seek the views of users and carers when planning services and designing packages of care.

These points are considered further under the following headings.

Local planning and commissioning arrangements for adult mental health need strengthening

5. Despite being one the Assembly's key health priorities, mental health services are not always seen as a local priority and do not feature prominently in all of the 22 Health, Social Care and Well Being Strategies that have been prepared across Wales. We heard that this is indicative of gaps in specialist service knowledge and leadership in some parts of Wales, and also that the assessment of mental health needs which has underpinned some strategies needs strengthening. We note that the Assembly Government is sighted of these problems and is taking steps to address them.

6. Robust local needs assessment should drive the production of clear local strategies for adult mental health services. These strategies need to be developed on a multi-agency basis and encompass a whole system approach. The evidence presented to us indicates that while some parts of Wales have made good progress in this area, others still have some way to go. Continued scrutiny of local strategies by the Assembly Government will therefore be important.

7. The ability to effectively commission mental health services for local populations is being hampered by a lack of staff with specialist skills in this area. Whilst we acknowledge that this is not a problem unique to Wales, it is disappointing to note that neighbouring Local Health Boards have not worked in partnership to develop more "collegiate" commissioning. We have been told that there is impending Ministerial guidance on revised commissioning arrangements and we must hope that this helps address this problem and also the concerns about fragmented commissioning responsibilities highlighted by the Auditor General.

8. Commissioning decisions need to be fully informed by financial and performance management information. We welcome the introduction of new Programme Budgeting arrangements as these should assist commissioners by making it possible to more accurately distinguish spending on adult mental health services within and across local health communities. We also note that performance

management is becoming increasingly systematised within the NHS in Wales. In relation to mental health, we would expect performance management arrangements to be put in place to ensure that the adult mental health action plan is being delivered as envisaged and that the additional investment in services is leading to improvements for patients.

There are gaps in key elements of service provision

9. The Auditor General's baseline review has helped the service and the Assembly Government identify where there are key gaps in adult mental health service provision. A particular challenge that has been identified is the need to give much higher profile to mental health promotion, given that previous activity in this field has been ad hoc and irregular. We heard about the positive work that is underway to develop an evidence based action plan for mental health promotion and we look forward to seeing this come to fruition.

10. Alongside the promotion of mental health and well being, there is a clear need to continue to develop and improve services in a whole system fashion. There are a number of specific service areas that require development. These include mental health services in general practice, which are underdeveloped in many parts of Wales. We note that targets for strengthening mental health services in general practice have been included in the 2006/07 Service and Financial Framework (SaFF), and we would expect these targets to be key drivers for change and improvement.

11. A further challenge will be to develop services which have a greater focus on the prevention and early detection of mental health problems. Although the importance of mental health promotion and early intervention is recognised in much of the Assembly Government's strategic and policy guidance, many service users and carers indicate that they can only obtain access to specialist support if they are experiencing a mental health crisis. This is unacceptable and indicates that work is still needed to bring about cultural and organisational changes in the way services are delivered.

12. The modernisation and re-design of mental health services must include the provision of a range of community based services that provide alternatives to hospital admission. Such services include crisis resolution / home treatment teams, supported housing and assertive outreach services. Access to community mental

health teams outside normal working hours is also vital. The evidence presented to us has been able to identify some encouraging developments in relation to community based mental health services. However, we have concerns that there are still significant variations across Wales in the extent to which these services are available. Some parts of Wales do not have adequate crisis resolution or assertive outreach services. Many mental health patients are housed in accommodation which is inappropriate to their needs and typically community mental health teams only operate during normal working hours. As a result many patients are not receiving the right support at the right time to fully aid their recovery. We note that the Assembly Government has identified performance targets for the development of community based mental health services within the revised NSF and the annual SaFF process. There will need to be close monitoring and scrutiny of performance against these targets to ensure that the required progress is made and that people in all parts of Wales have access to a range of services that can best meet their mental health needs.

13. The needs of people with more complex mental health problems can often only be met by inpatient care. However, we heard that in several parts of Wales the inpatient environment does not support the necessary standards of privacy, safety or therapeutic intervention. Although new inpatient facilities have been built in several parts of Wales, we have been told that the original NSF target of closure of all Victorian type institutions by the end of 2008 is unlikely to be achieved. We would expect to see urgent attention being given to the replacement of out-dated facilities across the whole of Wales. Alongside this we would hope that the new models of inpatient care we have been told about are rolled out across Wales to help ensure the best possible outcome for patients and to make the inpatient environment a more attractive place to work.

There is a need to strengthen joint operational working arrangements between the different agencies and teams involved in mental health care

14. Effective mental health care is dependent on strong joint operational working between the various agencies and teams that provide treatment and support. It is therefore disappointing to hear that very few Community Mental Health Teams have fully integrated management arrangements across health and social care. Local organisations need to be challenged to strengthen their joint working arrangements

and to demonstrate that they have models of mental health care which best serve their communities.

15. Implementation of the new Care Programme Approach (CPA) requires agencies to work together to design and deliver integrated packages of care. We have heard that progress with implementation of CPA has been variable across Wales, despite the fact that full implementation by December 2004 was a SaFF target. We are pleased to hear that the Assembly Government is reviewing CPA implementation across Wales and we would hope that this review will give assurance that full implementation is being achieved and more importantly is leading to improvements in care provided to people with mental health problems.

16. As mental health services are typically organised around separate teams for different age groups of patients, a well managed and co-ordinated approach is needed when people move from one team to the next. Weaknesses have been identified in some parts of Wales with transfer of patients between child and adolescent services and adult mental health services. We have been informed that the Assembly Government has made new funding available to NHS Trusts to develop and strengthen protocols governing the transfer between these two services. Appropriate follow up enquiries will be needed to ensure that the additional funds have been used to best effect.

17. Many people with a mental health condition also have a co-existing drug or alcohol problem. Effective treatment of these patients requires good co-ordination and clearly defined responsibilities between the various specialist teams involved. A need to improve services for patients with a "dual diagnosis" has been recognised and we therefore welcome the fact that the Assembly Government has produced specific guidance and a programme of support to further develop dual diagnosis services. We must however, await further evidence to indicate whether or not this has improved joint working practices between the various specialist teams.

The extent to which users and carers are involved in the planning and design of services varies considerably across Wales

18. The need to actively involve users and their carers in the planning and design of mental health services is clearly recognised within the NSF. Whilst some parts of Wales have made good progress with user and carer involvement, in others users and carers are not as fully engaged as they should be. We have heard about the

requirements for audits of user and carer engagement by local multi-agency mental health planning groups. We would expect local agencies to act on the results of these audits to ensure that the planning and design of services is fully informed by the views of users and carers.

19. Local agencies also need to ensure that mental health users and their carers are fully involved in the care planning process. The Auditor General's report highlighted that this did not always happen and we would expect that the Assembly Government's review of CPA implementation would provide the necessary assurances that care planning is properly undertaken for all service users and that there is appropriate user and carer involvement in the design of individual care plans.

Recommendations

i) The Auditor General's report, *Adult mental health services in Wales: a baseline review of service provision*, represents a comprehensive overview of adult mental health services in Wales and recommends action in a number of areas to bring services up to the standards identified in the NSF. We note that progress has already been made in implementing some of the report's recommendations. **We therefore recommend that the Welsh Assembly Government and local agencies take concerted action to implement the recommendations made by the Auditor General that are still outstanding.**

In light of the evidence presented to the Committee, we would also make the following recommendations:

ii) Mental health needs assessment work requires strengthening in several parts of Wales to ensure that it accurately identifies priorities and gaps in services. **We recommend that the National Public Health Service takes steps to further develop its expertise in mental health needs assessment in order to fully support the production of local health social care and well being strategies.**

iii) Significant expenditure has been and will continue to be made in adult mental health services. Alongside this the Auditor General has highlighted problems with accounting systems which mean that it has not previously been possible to accurately distinguish how much is being spent on adult mental health services within local health communities. **We therefore recommend that the Welsh Assembly Government and Local Health Boards use the new Programme**

Budgeting arrangements to identify differential spends on mental health services and provide assurances that resources are being directed to the areas and services with greatest needs.

iv) A national, action plan is being produced as a mechanism to improve and enhance local approaches to mental health promotion, which to date have been poorly developed. **We recommend that the Welsh Assembly Government accompanies the roll out of the action plan with a programme of work that supports its implementation within the relevant local organisations and which helps them target mental health promotion initiatives at those groups of the population with the greatest needs.**

v) Despite significant capital investments and considerable improvements in inpatient mental health facilities in some parts of Wales, the NSF target of closing all Victorian type institutions by 2008 is not going to be universally met. **We recommend that in parts of Wales where improvements are still required, the local statutory organisations take urgent action to ensure that the quickest reasonable progress is made to draw up and submit strategic outline business plans for replacing old and unsuitable inpatient accommodation.**

vi) There has been mixed progress with the implementation of the new Care Programme Approach (CPA) and the target of full implementation by December 2004 was not achieved in some parts of Wales. The Welsh Assembly Government is currently reviewing progress with CPA implementation across Wales. **We recommend that this review is used to gain assurance that CPA is being fully implemented and is leading to improved services for people with a mental health problem. The review should be informed by the views of those using mental health services.**

vii) At the time of the Auditor General's work, protocols to guide the transfer of patients from child and adolescent to adult mental health services had not been developed in many parts of Wales. The Welsh Assembly Government has provided each NHS Trust with £50,000 to ensure that these and other protocols are brought up to date. **We recommend that the Welsh Assembly Government requests NHS Trusts to demonstrate how this money has been spent and that the required protocols are now in place across parts of Wales.**

viii) Many people with a mental health problem have a co-existing problem with drug or alcohol misuse. Treatment and management of these "dual diagnosis" patients

presents many challenges and it is often not clear which specialist teams have the lead responsibility for their care. The Welsh Assembly Government has developed a framework and associated programme of work to embed better collaborative working practices between specialist services. **We recommend that the Welsh Assembly Government identifies a clear timetable to follow up this work and seeks assurance that the substance misuse framework is leading to improved services for patients with a dual diagnosis.**

Adult Mental Health Services in Wales

Local planning and commissioning arrangements need strengthening

Mental health services are not always seen as a local priority

20. Despite being a key Assembly health priority, mental health services often receive a low priority locally.[2] Mrs Lloyd acknowledged that this has been a concern for her Department and indicated that only 13 of the 22 local health, social care and well being strategies contain any really significant proposals for mental health service development.[3]

21. We note from Mrs Lloyd's evidence that through her role as an accounting officer, definitive steps have been taken to try and ensure that mental health services receive a higher local priority. These have involved inclusion of a mental health component in service and financial framework targets (SaFF), end of year reviews and interventions with Chief Executives, involvement of Regional Offices and on-going scrutiny of local strategies and plans.[4]

22. Whilst we acknowledge that specific action has been taken by the Assembly Government to try to address this problem, we remain concerned that mental health services are still not featuring as prominently as they should in some local health, social care and well being strategies. Mrs Lloyd alluded to the fact that this may reflect the insufficient capacity that some parts of Wales have in terms of competence and leadership in mental health.[5] If that is the case we would expect to see urgent action being taken by both the Assembly and the service address this unacceptable situation.

23. It is also evident that the mental health needs assessment information that underpins local health, social care and well being strategies requires strengthening in some parts of Wales.[6] Mrs Lloyd told us that while assessment of mental health

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[2] AGW report, paragraphs 4.1 and 4.2
[3] Annex A, paragraph 8
[4] Annex A, paragraphs 9 and 10
[5] Annex A, paragraph 11
[6] AGW report, paragraph 4.23

needs have been extremely good in some parts of Wales, in others the assessment was at a very high level making it difficult to identify priorities and gaps in services.[7]

24. This is clearly an issue that requires urgent attention and a key responsibility sits with the National Public Health Service (NPHS), with whom there are service level agreements to produce the needs assessments. Mrs Lloyd told us that she has raised this issue with the Director of the NPHS and that action is being taken to develop more expertise on mental health needs assessment within the NPHS.[8] Accepting that assessment of mental health needs is a complex and specialised task, we are concerned that in some parts of Wales this had not been done to the required level of detail, despite service level agreements being in place.

Funding mechanisms need to support long term service development

25. The Auditor General's report states that current funding mechanisms for mental health services do not support long-term service development.[9] Problems were identified with the short term nature of funding and a multiplicity of funding streams.[10] Mrs Lloyd told us that new, more sophisticated Programme Budgeting arrangements had been introduced which will permit examinations of how expenditure is being matched to the needs of local populations.[11]

26. Mrs Lloyd also highlighted the substantial amount of money that has been made available for service development through Wanless funds, for crisis resolution services and the additional £5million that accompanied the revised NSF.[12] Whilst we would agree that this represents a sizeable expenditure in totality, we are less clear about whether there has been any real change to mechanisms for funding mental health services. There must therefore still be concerns that funding mechanisms are not fully supportive of long term service development.

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[7] Annex A, paragraph 15
[8] Annex A, paragraph 15
[9] AGW report, paragraph 4.29
[10] AGW report, paragraph 4.29
[11] Annex A, paragraphs 19 and 25
[12] Annex A, paragraph 20

More work is needed to develop multi-agency visions of future mental health services

27. Multi-agency visions for future mental health services have yet to be developed in many parts of Wales and there is scope for much more progress with the development whole system strategies and plans for adult mental health services in Wales.[13] We agree with Mrs Lloyd that health, social care and wellbeing strategies are key vehicles in addressing this concern since that is where the partner agencies should come together to plan the necessary changes to services. It is encouraging to know that these strategies are being closely scrutinised by Mrs Lloyd's department given the worrying finding in the Auditor General's report that current strategies in some parts of Wales only have minimal coverage of mental health issues.[14]

28. Mr Chick has told us that a "twin track" approach is important which involves the development of local strategies alongside approaches to promoting good mental well being for the whole population of Wales. He indicated that the revised NSF and the issuing of separate policy guidance in specific areas at key points in the NSF's action plan will provide the service with the support and guidance it needs to develop the necessary models of care, tailored to local needs.[15] The Auditor General's findings indicate the importance of ensuring that this happens. It will also be important to ensure that implementation of any policy guidance issued is closely monitored to ensure that is resulting in the envisaged service developments.

Commissioning arrangements for adult mental health services need strengthening

29. The Auditor General's report indicated that commissioning arrangements for adult mental services in Wales are underdeveloped and fragmented, and that there is a shortage of staff with necessary skills and expertise to commission mental health services.[16] Although we heard that this problem is not unique to Wales, it is nonetheless a worrying finding and it must be hoped that revised guidance on commissioning to be issued by the Minister will help address this.

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[13] AGW report, paragraphs 4.9 and 4.10
[14] Annex A, paragraphs 29 and 30
[15] Annex A, paragraphs 32 – 34
[16] AGW report, paragraphs 4.11 – 4.13

30. We agree with Mrs Lloyd that LHBs must be more honest about their skills they have at their disposal and get together with their neighbours to pool their resources for more effective commissioning.[17] We are concerned that this sort of collegiate commissioning is not already in place given the obvious lack of mental health commissioning skills within LHBs. Even in parts of Wales where it has been developed we have been told that individual LHBs still want their own individual leads which would appear to be at odds with the overall objective.[18]

31. We note that Health Commission Wales (HCW) are being encouraged to develop closer dialogue with LHBs on a regional basis to revise the way in which commissioning can be undertaken.[19] This will hopefully address the problems identified by the Auditor General in relation to a lack of co-ordinated working between LHBs and HCW when high, medium and low secure mental health services are being commissioned.[20]

32. The weaknesses in the current commissioning arrangements for mental health services in Wales are a real cause for concern. Issuing revised guidance to the service will be a start but there will be a need for very close scrutiny of what is happening on the ground to ensure that effective commissioning models are being put in place and importantly, are leading to the necessary service improvements.

Better financial and performance management data is needed to support commissioning and monitoring of service delivery

33. As noted above, there has been recent sizeable expenditure in mental health services. It is therefore a matter of great concern that the Auditor General's report identifies fundamental problems with accounting systems which mean that is not possible to accurately distinguish how much is being spent on adult mental health services within local health communities.[21]

34. Mrs Lloyd told us that this is being addressed by a new NHS programme budgeting system. We were told that the new system is starting to identify differential spends on mental health services across LHB communities.[22] LHBs must be able to

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[17] Annex A, paragraphs 42, 43
[18] Annex A, paragraph 42
[19] Annex A, paragraph 37
[20] AGW report, paragraph 4.15
[21] AGW report, paragraph 4.25
[22] Annex A, paragraphs 51 and 52

demonstrate that these differences reflect the health needs of the population and that resources are being directed to those areas with greatest needs. More work is clearly going to be needed in this area to provide those assurances.

35. We share Mrs Lloyd's concerns on the views expressed by some healthcare professionals that money released through service re-modelling did not seem to come back into mental health services.[23] It is right that Mrs Lloyd's department is investigating these claims.

36. The Auditor General's report found that performance management arrangements to monitor implementation of the NSF are underdeveloped.[24] We note Mrs Lloyd's comments that performance management is becoming increasingly more systematised but remain concerned that much still needs to be done in respect of specific areas such as mental health. Without a clear performance management framework and supporting performance data it will not be possible to know if Ministerial priorities are being achieved or whether the additional spending we heard about is making any perceptible difference.

37. Good performance is aided by sharing of good practice. We were told that the Action in Mental Health Project being run by the National Leadership and Innovation Agency for Healthcare will have a key role to play by drawing together good practice from across the UK and Europe and sharing it with organisations.[25] Much store is clearly being put in this project and we note that a progress report will be received later this year.

There are significant gaps in key elements of service provision

A greater focus is needed on mental health promotion and tackling the stigma associated with mental health problems

38. The Auditor General's report indicates that local initiatives to promote better mental health and to reduce the stigma associated with mental health problems are generally poorly developed, despite the fact that activities around social inclusion, health promotion and tackling stigma make up one of the eight standards in the

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[23] Annex A, paragraph 53
[24] AGW report, paragraph 4.27
[25] Annex A, paragraph 57

NSF.[26] Mrs Lloyd acknowledged that there needed to be a renewal of efforts in this area, whilst Mr Chick spoke very positively about work that is underway to develop an evidence based action plan for mental health promotion that will help promote mental well being and social inclusion, and challenge the discrimination that many people with mental health problems face.[27]

39. As Mr Chick acknowledged this substantial task will require commitment and co-ordinated action from a broad range of stakeholders. For the action plan to succeed where the NSF has so far failed, it will need to be supported by practical guidance based on what works, as we were told it would be. It will also be critical to identify some tangible measures of success given that the outcomes from mental health promoting activity are likely to be difficult to measure.

Mental health services in general practices will need to be strengthened to meet new targets

40. It is clear from the Auditor General's report that mental health services in general practices need further development in many parts of Wales, and greater clarity is needed on the type of care and support that should be provided within primary care.[28] Many people with less severe mental health problems will receive their mental health care entirely from general practice. For others who are at risk of developing more serious problems, general practice is often their first port of call when problems present themselves.

41. It is encouraging to note that the Assembly Government has responded to these concerns by including targets for strengthening primary care mental health services in the 2006/07 service and financial framework.[29] This means that by March 2007 all practices must have:

- access to psychological support services with a maximum wait of 12 weeks;
- a gateway worker provided from the CMHT to strengthen onward referrals and liaison with other organisations; and

[26] AGW report, paragraphs 1.3-1.12
[27] Annex A, paragraphs 73-78
[28] AGW report, paragraphs 1.13-1.28
[29] Annex A, paragraphs 84-87

- access to training for GPs and practice staff to help them diagnose and manage adults with mental health problems.

42. Performance against these targets will need to be monitored closely as it is clear that practices in many parts of Wales still have quite a way to go to meet the SaFF targets.

43. The new general medical services contract provides further opportunities and incentives to strengthen mental health services in primary care. The new contract's quality and outcome framework requires that all general practitioners keep a record of individuals who have a severe mental health problem. The majority (83 per cent), but not all, of the practices in Wales have achieved this and LHBs must actively pursue the rest. We note from Mrs Lloyd that discussions are on-going with a view to including mental health services in the enhanced services domain of the new contract, although as yet outcomes are unresolved.[30]

A greater focus is needed on preventing mental illness rather than waiting for serious problems to develop before beginning treatment

44. Whilst much of the policy and strategic thinking on mental health services recognises the importance of promoting better mental health and securing early intervention when problems arise, the Auditor General's report has indicated that many service users and carers feel that they have to be experiencing a mental health crisis before they can access specialist services.[31] This is clearly unacceptable and shows that there is gap between policy and actual practice at the ground level.

45. It is acknowledged that there are blockages in the system which prevent people from getting timely access to care. These typically centre around patients becoming stuck in the hospital settings because there is insufficient support in the primary and community care sector to discharge them. This in turn stops other people from getting access to hospital care when they need it.[32] Mr Chick told us that the Assembly Government is tackling this problem by looking at specific elements in turn – namely improvements in primary care, wider introduction of crisis

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[30] Annex A, paragraph 93
[31] AGW report, summary paragraphs 10, 1.39

[32] Annex A, paragraphs 101 – 103

and home treatment teams, refocused models on inpatient care and use of the Action in Mental health project to spread good practice; and that this is part of a drive to strengthen a whole system approach to mental health care.[33]

46. Organisational and cultural change is going to be necessary if we are going to see the improvements envisaged by the policy initiatives Mr Chick told us about. Mrs Lloyd told us that she is confident that the changes envisaged in the revised NSF will take place.[34] There is a need for strong lines of accountability to run alongside the policy initiatives in order to get the improvements in service that are needed. Robust performance managements will therefore be crucial.

There are gaps in community based services that could provide alternatives to hospital care

47. We heard that the development of crisis resolution and home treatment services is a key element in the drive to provide better whole system models of care. These services provide alternatives to hospital admissions and can provide the necessary community based support to facilitate more prompt discharge. Not all parts of Wales have adequate crisis resolution and home treatment services in place, despite it being a SaFF target for March 2006.[35] It is noted that intervention is taking place in the five LHB areas that have failed to meet the SaFF target.[36]

48. There is also a very mixed picture when it comes to the development of assertive outreach services for patients with a developing or established psychosis.[37] Mrs Lloyd acknowledged that in some parts of Wales little progress has been made in developing these services, probably because development of assertive outreach services is not a target until March 2008.[38] More encouragingly we were told that other parts of Wales have begun to look at how these existing crisis resolution teams can be extended to provide assertive outreach.[39] However, this does serve to highlight geographical variations in the way these services are provided across

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[33] Annex A, paragraph 103
[34] Annex A, paragraph 109
[35] AGW report, paragraphs 1.33 – 1.36
[36] Annex A, paragraph 118
[37] AGW report, paragraphs 1.38 – 1.40
[38] Annex A, paragraph 124
[39] Annex A, paragraph 124

Wales. There are associated concerns about safety for patients and the public in areas assertive outreach services are not properly up and running.

49. Mr Chick told us that CHMTS are in a position to manage issues of public safety and that more effective risk assessments are now in place.[40] However, we know from the Auditor General's report that CMHTS only operate during normal working hours, so concerns must still exist. We acknowledge Mr Chick's comment that people with a mental health problem who pose a risk to the public are a tiny minority of those who receive mental health care.[41] However, the risk of individuals with a psychosis being a potential danger to themselves is still an issue and is going to be exacerbated by an absence of assertive outreach services.

50. A potential barrier to the establishment of community based services and treatments is the availability of suitably skilled staff, given that various service developments that are required will place significant strains on the current workforce. We are therefore encouraged to hear of the Assembly Government's plans to increase the range of people working within mental health services, broadening the skill mix and freeing specialist staff to concentrate on therapeutic interventions and assessments that only they can do.[42]

Many parts of Wales still do not have access to the required range of supported housing for people with mental health problems

51. Access to good quality housing with the necessary levels of support is a fundamental part of aiding the recovery of people with acute mental health problems. Yet, many parts of Wales do not have adequate levels of supported housing for people with mental health problems.[43] The Auditor General's report has also highlighted the fact that detailed needs assessments to accurately establish the extent and type of accommodation that is needed have yet to be undertaken in most parts of Wales.[44] Where people cannot get access to the right type of accommodation, they are less likely to make a full recovery, and in many cases their condition may worsen.

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[40] Annex A, paragraph 126
[41] Annex A, paragraph 126
[42] Annex A, paragraph 129
[43] AGW report, paragraphs 1.41 – 1.45
[44] AGW report paragraph 1.46

52. We acknowledge that the revised NSF contains a clear performance target for each area to undertake a gap analysis of supported housing needs and to put plans in place to address the gaps.[45] We heard from Mr Chick that needs assessments and reviews of current accommodation had already been undertaken in some parts of Wales.[46]

Modernised, fit for purpose inpatient facilities are not in place in all parts of Wales

53. The original NSF for adult mental health services contained a target to close the remaining "Victorian type" institutions by the end of 2008, with a range of alternative services to be in place by the end of 2006. The Auditor General's findings indicate that it is unlikely that this target will be achieved, although his report does acknowledge that new inpatient facilities have been provided in a number of parts of Wales over the last 5 years.[47]

54. Mrs Lloyd conceded that it would be very difficult to meet the original NSF target for closure and replacement of old and unsuitable inpatient facilities to be met across Wales.[48] Where further developments are still required, we heard that the Welsh Assembly Government is encouraging organisations to submit outline business plans that can make use of the £120 million of capital funding that is available to modernise or replace out-dated hospital facilities.[49]

55. The need to modernise inpatient facilities is acute in many parts of Wales. Many patients are currently being treated in environments which are inappropriate in that they do not support the necessary standards of privacy or therapeutic intervention.[50] Mrs Lloyd has referred to the "torrid mix" that can often exist within acute wards where some patients are psychotic, some severely depressed, some may have a co-existing drug and alcohol problem and some who may be low secure forensic patients.[51] Managing this mix of patients in an unsuitable environment poses real challenges, not least in ensuring the safety of both staff and patients. It is not

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[45] Annex A, paragraphs 139 and 154
[46] Annex A, paragraph 153
[47] AGW report, paragraphs 1.78 – 1.79
[48] Annex A, paragraph 170
[49] Annex A, paragraphs 171 – 173
[50] AGW report, paragraphs 1.83 and 1.84
[51] Annex A, paragraph 180

surprising therefore to hear that it has been difficult to recruit and retain quality staff to work in acute mental health settings.

56. Mrs Lloyd indicated that the Assembly Government is testing NHS Trusts' approach to managing the inpatient environment and the case mix of patients, within the context of implementation of the revised NSF and use of new capital investment monies.[52] We also heard about the introduction of new models of inpatient care based around better assessment and tailoring of care to the needs of individual patients. We were told that these models are having a positive impact on both patients and staff and are helping to address the problems with recruitment and retention of staff.[53]

There is a need to strengthen joint operational working arrangements between the different agencies and teams involved in mental health care

Very few Community Mental Health Teams have fully integrated management arrangements across health and social care

57. Community mental health teams (CMHTs) play a vital role in assessing the needs of individuals and providing support and treatment. The NSF indicates that these teams should be multi-disciplinary and have well developed joint management arrangements between health and social care. It is therefore worrying to note that there are few examples of genuine joint operational working between health and social care in relation to CMHTs.[54] The positive example set by agencies in Conwy and Denbighshire, where 1999 Health Act flexibilities have been used to establish a joint partnership board, shows that progress can be made where there is commitment to do so.[55]

58. Part of this process must include the development of the multidisciplinary working envisaged by the NSF. The Auditor General's report indicates that there has been good progress in this area, although we also note that psychiatrists are not integrated into CMHTs in some parts of Wales.[56]

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[52] Annex A, paragraphs 179 and 180
[53] Annex A, paragraph 182
[54] AGW report, paragraphs 2.1 and 2.2
[55] Annex A, paragraph 201
[56] AGW report, paragraph 2.2

Progress with implementation of CPA has varied across Wales

59. The Care Programme Approach (CPA) has been introduced as a mechanism of providing co-ordinated management of a person's mental health problem. CPA combines care planning and case management and requires agencies to work together to provide the required integrated packages of care. The 2004/05 SaFF process identified a target of full CPA implementation by December 2004.[57]

60. From the evidence we heard at this session and the Auditor General's findings, it is apparent that there has been variable progress with the implementation of CPA across Wales. Although there was not wholesale failure to meet the SaFF target, it is clear that the full implementation envisaged by December 2004 did not occur.[58]

61. To date there appears to have been much focus on establishing the new documentation and processes associated with CPA implementation and there is as yet no evidence that CPA is making a real difference to the care of people with mental health problems. We were told that the Welsh Assembly Government is reviewing CPA implementation across Wales and we'd expect that this would be the means by which assurance is obtained that CPA is leading to genuine improvements in the delivery of care.[59]

62. We note from Mr Chick that there have been a number of positive examples around Wales of statutory agencies linking up with the voluntary sector and service user groups to strengthen the development of CPA process.[60]

New funding has been made available to help strengthen the transition between child & adolescent and adult mental health services

63. As mental health services are typically organised around separate teams for children/adolescents, adults and older people, a well managed and co-ordinated approach is needed to ensure effective transition from one service to the next. The Auditor General's report has indicated that arrangements for transfer between adult and older people's mental health services are broadly sound.[61] However, the report

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[57] AGW report, paragraphs 2.5 and 2.6
[58] AGW report, paragraph 2.8
[59] Annex A, paragraph 208
[60] Annex A, paragraph 234
[61] AGW report, paragraph 2.18

identified a number of problems in respect of transfer between child and adolescent services to adult services.[62]

64. At the time of the Auditor General's work, many of the relevant organisations in Wales did not have protocols in place to manage the transition between child/adolescent and adult services.[63] Mrs Lloyd told us that £50,000 was provided to each NHS Trust during the 2005/06 financial year to develop and bring up to date these and other protocols.[64]

Guidance and support have been provided to improve the treatment of patients with a "dual diagnosis", although it is not yet clear whether this has resulted in the better collaborative working that is required.

65. Treatment of patients who have a drug and alcohol problem together with a co-existing mental health condition poses number of specific challenges. Practitioners in most parts of Wales acknowledged the need to improve services for patients with a dual diagnosis, and GPs in particular have identified it as key priority area.[65]

66. We heard from Mrs Lloyd and Mr Chick that additional guidance to the NSF has been produced for the service in relation to the management of dual diagnoses. This takes the form of a substance misuse framework which contains a component on management of co-occurring mental health and substance misuse problems. The guidance advocates the use of a collaborative approach between the various specialist staff involved.[66] We were told that the production of the framework has been accompanied by work to ensure that the collaborative working required is embedded into practice at the service level.[67]

67. There is as yet no evidence to confirm that it has resulted in any changes in the working practices of the specialist staff involved.

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[62] AGW report, paragraphs 2.16, 2.17
[63] AGw report, paragraph 2.16
[64] Annex A, paragraph 236
[65] AGW report, paragraph 2.34
[66] Annex A, paragraphs 2.47, 2.48
[67] Annex A, paragraph 250

The extent to which users and carers are involved in the planning and design of services varies considerably across Wales

68. Active involvement of mental health service users and their carers in the planning and monitoring of services is recognised as being vitally important in ensuring that services are adequately meeting the diverse and complex needs of people with a mental problem.[68]

69. The approach to engaging and empowering users and carers varies considerably between different parts of Wales.[69] Mrs Lloyd acknowledged that historically, users and carers had not been sufficiently involved in the planning and design of services.[70] We were told that the situation has improved since the Auditor General's work was undertaken, although the extent of this improvement will not be quantifiable until a formal audit has been undertaken by local multi-agency mental health planning groups. That audit will need to assess progress against wider requirements for user and carer engagement set out in the "Stronger in Partnership" guidance produced by the Welsh Assembly Government.[71]

70. It is also unacceptable to learn that some service users and carers felt that they had not been adequately involved care planning, and worse still that some people with a serious mental problem or complex needs do not have an up to date care plan.[72] The Assembly Government's review of CPA will no doubt throw light on whether the situation has improved since the Auditor General's work was undertaken.[73] From what we have already heard about the challenges associated with full implementation of CPA, we cannot be overly optimistic that user and carer involvement in care planning will be as comprehensive as it should be. We would expect urgent action to be taken by the Welsh Assembly Government and individual local organisations to rectify any problems that the review of CPA identifies.

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[68] AGW report, paragraphs 3.1 and 3.16
[69] AGW report, paragraphs 3.17 – 3.21
[70] Annex A, paragraph 260
[71] Annex A, paragraphs 262 and 263
[72] AGW report, paragraph 3.14
[73] Annex A, paragraph 264

Annex A

Cynulliad Cenedlaethol Cymru
Y Pwyllgor Archwilio

The National Assembly for Wales
The Audit Committee

Dydd Iau, 12 Ionawr 2006
Thursday, 12 January 2006

Cofnodir y trafodion hyn yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir cyfieithiad Saesneg o gyfraniadau yn y Gymraeg. Mae hon yn fersiwn ddrafft o'r cofnod. Cyhoeddir fersiwn derfynol ymhen pum diwrnod gwaith.

These proceedings are reported in the language in which they were spoken in the committee. In addition, an English translation of Welsh speeches is included. This is a draft version of the record. The final version will be published within five working days

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Aelodau o'r Cynulliad yn bresennol: Janet Davies (Cadeirydd), Leighton Andrews, Mick Bates, Alun Cairns, Mark Isherwood, Irene James, Denise Idris Jones, Carl Sargeant, Catherine Thomas, Rhodri Glyn Thomas.

Swyddogion yn bresennol: Phillip Chick, Ymgynghorydd Iechyd Meddwl, Llywodraeth Cynulliad Cymru; Jeremy Colman, Archwilydd Cyffredinol Cymru; Ann Lloyd, Pennaeth yr Adran Iechyd a Gofal Cymdeithasol.

Gwasanaeth Pwyllgor: Kathryn Jenkins, Clerc; Liz Wilkinson, Dirprwy Glerc.

Assembly Members in attendance: Janet Davies (Chair), Leighton Andrews, Mick Bates, Alun Cairns, Mark Isherwood, Irene James, Denise Idris Jones, Carl Sargeant, Catherine Thomas, Rhodri Glyn Thomas.

Officials in attendance: Phillip Chick, Mental Health Adviser, Welsh Assembly Government; Jeremy Colman, Auditor General for Wales; Ann Lloyd, Head of Health and Social Care Department.

Committee Service: Kathryn Jenkins, Clerk; Liz Wilkinson, Deputy Clerk.

Dechreuodd y cyfarfod am 1.32 p.m.
The meeting began at 1.32 p.m.

Cyflwyniadau, Ymddiheuriadau, Eilyddion a Datgan Buddiannau
Introductions, Apologies, Substitutions and Declarations of Interest

[1] **Janet Davies:** I welcome the public, witnesses and members of the committee. I will outline the usual housekeeping issues. The committee operates bilingually and headsets can be used to listen to the translation of Welsh contributions or to hear the whole proceedings more clearly. Please turn off any mobile telephones, pagers or any other electronic devices as they interfere with the broadcast and translation systems. If there is an emergency, please leave by the nearest exit. There are two exits, one on each side—I feel like an air stewardess doing this—and follow instructions from the ushers. We have had apologies from Jocelyn Davies, and Rhodri Glyn Thomas is substituting for her. Welcome to your first Audit Committee, Rhodri, I hope that you will enjoy it. Do any Members have any declarations of interest? I see that they do not.

1.33 p.m.

Gwasanaethau Iechyd Meddwl i Oedolion yng Nghymru: Adolygiad Sylfaenol o'r Gwasanaethau a Ddarperir
Adult Mental Health Services in Wales: a Baseline Review of Service Provision

[2] **Janet Davies:** The report that we are considering this afternoon is 'Adult Mental Health Services in Wales: a Baseline Review of Service Provision', which was commissioned

by the Welsh Assembly Government and the work was initiated by the Wales Audit Office's predecessor body, the Audit Commission in Wales. The Wales Audit Office has now brought it before committee. It was intended to inform policy development and was not part of the auditor general's value-for-money studies programme. It has therefore not been subject to the usual signing off by the relevant accounting officer. I remind Members of Standing Order No. 12.4, which states that:

[3] 'the Committee shall not question the merits of the policy objectives of the Assembly'.

[4] This afternoon, we are discussing the substantial changes that face mental health services in Wales, in one of the Assembly's stated health priority areas. The report shows that much still needs to be done to improve mental health services for adults in Wales and I would hope that we could use this session to obtain some assurances that the necessary steps are being taken to improve services to help meet the needs of adults in Wales who have mental health problems. We will take evidence today from two witnesses, whom I ask to introduce themselves.

[5] **Ms Lloyd:** I am Ann Lloyd, head of the Health and Social Care Department and the chief executive of the NHS in Wales.

[6] **Mr Chick:** I am Philip Chick, the director of mental health in the Welsh Assembly Government.

[7] **Janet Davies:** I will start with some general questions, as we usually do in these sessions, and Members will then come in with more focused questions. Paragraphs 4.1 and 4.2 highlight the fact that despite being a key Assembly health priority, mental health services often receive a low priority locally. This question is to Ms Lloyd first. Why is it that mental health services receive this low profile in some part of Wales, when the Assembly itself has clearly stated that mental health is one of its key priorities?

[8] **Ms Lloyd:** This has been a key concern for us. When we asked the local health boards to develop their health, social care and wellbeing strategies, we scrutinised their proposals in terms of mental health services very carefully. Quite a lot of work had been done looking at the way in which the standards for the treatment of those with a mental illness had been managed within Wales, the sort of quality of accommodation that was available to them, and whether the organisations concerned were getting to grips with developing a more community-orientated responsive service. When we received those strategies, we discovered that only 13 of the 22 had any really significant proposals for mental health service development for the future. Therefore, as part of the role of the regional directors and the regional offices, they have been discussing with the local health boards, and their partner organisations, including the voluntary organisations, precisely what their plans for mental health services are for the future. We took a deliberate step in pressing them on that question and also by ensuring that the service and financial framework targets contained a significant mental health component. As you have seen from what we have tried to do over the past three years in particular, we have tried to look at crisis resolution; this year we are looking at general practice, and next year we will be looking at assertive outreach. Although developments in all those areas are going on within Wales, we want to ensure that there is quality improvement, and also access improvement, so that there are no more inequalities.

[9] I have just written to the service, given the results that we had at the third quarter for how the organisations were getting on in meeting their service and financial framework targets, particularly for mental health this year, to remind them that the mental health targets are not of a 'Well, we might do them' type, and not a continuous improvement target anymore, but a target that must be met. We have tried, because this is one of the Minister's

primary priorities, to ensure that sufficient attention is given to improving mental health services in Wales. As an accounting officer, there are definitive steps that I can take to ensure that organisations comply with the Minster's policy, and that is what we have done so far. However, this report is a very helpful adjunct to that work; the organisations have now received their local plans on how they have managed individually against the national service framework, and we, at the end-of-year reviews, through the regional offices, will be testing them on their proposals in order to make improvements.

[10] **Janet Davies:** Thank you, Mrs Lloyd. You referred to the national service framework and to the various steps that you are taking to try to ensure that the local plans fit into that framework and meet the targets and that there is action to achieve what is needed. How confident are you? You sounded to me as if you are working very hard on it, but you are perhaps not entirely confident. What degree of confidence do you have that you will be successful?

[11] **Ms Lloyd:** I must have confidence, because it is critical. It is a critical service, and it is one of the Minister's main priorities. Through my interventions with chief executives—and my colleagues discussed this whole issue with chief executives this week again—we must continue to impress upon them that this is very important. It was for that reason that I asked NLIAH, the National Leadership and Innovation Agency for Healthcare, to institute the Action in Mental Health (AIM) project, so that there could be a real galvanising of best practice and best results for patients through that initiative throughout Wales, and that is going on at the moment. I have also been testing organisations on the competence and numbers of individuals who are there to manage the mental health service, whether or not they have kept up to date with latest practice, and what the quality of the leadership in mental health in Wales is. To me, that is very important.

1.40 p.m.

[12] **Janet Davies:** It would be fair to say that you have some concerns that these services are not featuring as prominently as they should be in some, but not all, local health and social care wellbeing strategies.

[13] **Ms Lloyd:** Yes. That is why we scrutinised those strategies well. Also, given the results that we are obtaining on how well they are doing in terms of the crisis resolution teams, there are still some that are showing up as red on our balanced scorecard. They are being helped to improve the services and to think through the way in which they are going to be able to deliver for their population.

[14] **Janet Davies:** Right. Underpinning these local strategies and plans are the mental health needs assessments. Is work being done to strengthen them and what sort of work is it?

[15] **Ms Lloyd:** Yes, indeed. You may or may not know that we have service level agreements with the National Public Health Service for Wales. When we looked at the needs assessments—and I have discussed this with its director—some of them were at a very high level, and the interpretation of what you then had to do, what the priorities really were and where the gaps were was difficult. So, as part of this year's and last year's needs assessments, it has been developing further its expertise in mental health needs assessment.

[16] The National Public Health Service is also taking part in looking at the outcomes of mental health promotion work. It is engaged in a UK group that is looking at developing a methodology to be able to track the improvements in outcomes, given the various initiatives that it will be promoting through its portfolio. Dr Cerilan Rogers is mindful of the need to improve the quality of the assessment processes, some of which were extremely good. So, we have been sharing the good practice around that service too.

[17] **Janet Davies:** Carl will take things into more detail in one field.

[18] **Carl Sargeant:** Good afternoon, Ms Lloyd and Mr Chick. I take you to paragraph 4.29, on the funding of services. Does the Assembly have any plans to change the way in which mental health services are funded to ensure sustainable service developments, because, obviously, problems have been identified in long-term planning that come along with long-term funding? Do you have any plans? Could you please enlighten us on that?

[19] **Ms Lloyd:** As you know, we have instituted programme budgeting in the Welsh Assembly Government, and the programme budgets show that, at the moment, we are spending more per head of the population on mental health services than England. Nevertheless, we have tried, wherever possible, to provide additional resources, particularly given the comments that are made frequently that it is difficult to change a service unless there is pump-priming. That goes for all services, but particularly for mental health services.

[20] Over the past couple of years, we have provided £1.8 million for Wanless, which was recurring, to ensure that the more community-orientated programmes could take place. A sum of £1.2 million has been provided for instituting crisis resolution. On the issues of transitions between adult care and elderly care, and children's care and adult care, we have provided £50,000 for each local health board, to help them to institute better procedures for that. Given the relaunching of the revised national service framework, the Minister made available £5 million, and, again, this was to pump prime the changes that are required within the NSF. Given the NSF and the local plans that are now available from the Wales Audit Office for each locality, we will be discussing with them how they are going to use that additional resource to start to make the changes.

[21] We have seen some real improvements in some places. This is just anecdotal, I am afraid, but I was talking to the chief executive of Cardiff and Vale NHS Trust the other day about crisis resolution and the effect of some pump-priming money and how that has enabled him to start taking out some of the old accommodation given that crisis resolution teams are coming on-stream. He was hopeful that, given the start that he had made, he would, with the second crisis resolution team, be able to take down another ward, thereby complying with the policy direction of the Welsh Assembly Government.

[22] **Carl Sargeant:** To follow up on that, we would all agree that quite a substantial amount of money has gone into service delivery, but I would say that one of our concerns is long-term delivery. Are you confident that you can deliver on the long-term service planning and funding with provision as it is?

[23] **Ms Lloyd:** We would always like more money.

[24] **Carl Sargeant:** Would not we all?

[25] **Ms Lloyd:** Everybody would. At the moment, £470 million goes towards mental health services in Wales. Given the increasing sophistication of programme budgeting, we will look at exactly how that money is focused on the population, given updated needs assessments, and we will discuss with each local health board and their partners how best that money might be used. The sort of evidence that has come out of this baseline service is fundamental to having that sort of discussion.

[26] **Denise Idris Jones:** Paragraphs 4.9 and 4.10 demonstrate the lack of progress on developing local multi-agency visions and strategies for mental health services. In fact, paragraph 4.10 states that

[27] 'At the time of the baseline review explicit multi agency visions for future mental health services had not been developed for most parts of Wales'.

[28] If that is the case, Mrs Lloyd, what more can you do to support local agencies to develop the whole-system strategies and plans for mental health that are clearly needed?

[29] **Ms Lloyd:** I do not know whether I would agree with the statement that most places have not developed positive examples of service redesign, but some have not. That is why we have scrutinised their wellbeing strategies thoroughly, because that is where the partners come together to start to describe how they will change the service to meet their needs. I am hopeful, given the reports that we are getting from the national leadership agency, that the Action On programme, in terms of looking at mental health development, will produce much better practice throughout Wales, because one of the problems with all services throughout the UK is getting a handle on the evidence to support what does and does not work in mental health. Critical to that is the need for partners to engage with those who use the service, which is why we have done a great deal of work on pushing out better guidance on how to engage users and carers effectively. The Health and Social Services Committee, as you know, has just undertaken a review of that, which, again, is helpful, and I think that the Minister made a statement on that yesterday. I know that that committee will discuss it on 8 March.

[30] We must ensure that we scrutinise the proposals that come forward, particularly given the current reconfiguration debate. It is not just about acute services, but about the whole system in which people live in a community. We should be looking particularly carefully at what plans there are for mental health services, particularly where different commissioners are commissioning different parts of that service, and asking to what extent they join up, and to what extent is the service seamless from the point of view of the user and the carer. I think that we are very mindful of the fact that, throughout the UK, for many years, mental health services have been somewhat cinderella-like, but it is nothing like the low-priority areas that it was many years ago. There are many strong lobbies to improve those services, and rightly so. We must listen to those lobbies and pay attention to the way in which care can be delivered for the future, and test the local health boards and the trusts on the quality of the product that they are giving to people within their communities.

1.50 p.m.

[31] **Denise Idris Jones:** Do you want to come in, Mr Chick?

[32] **Mr Chick:** I think that the issue that I would pull out of that is that the twin-track approach is very important in mental health services. This covers the development and improvement of services, which is about the development of local strategies, not leaving aside the importance of dealing with the mental wellbeing of the total population of Wales, which involves improving the mental health of those people who do not have a problem but are at risk, as we all are, of developing one, while improving and promoting the mental wellbeing and social inclusion of those who have a mental health problem. We are dealing with both tracks and making clear the vision in the revised national service framework on how to take both of those strands forward together.

[33] I think that we have also assisted the service by setting out very clearly our priorities by using the service and financial framework over the last few years. The baseline was to introduce the care programme approach and to enhance service user engagement, both of which were reflected as a requirement in the report. We have also used the service and financial framework to be clear about what the priorities are. So, the development of improved in-patient environments and the crisis resolution home treatment teams this year, and the focus on primary care next year, is really giving vision to the service regarding how you develop the different elements within the whole system in order to improve it.

[34] Finally, we have already produced policy implementation guidance to support the service and to give it that strategic vision to set out exactly what is required. So, in terms of crisis resolution home treatment, policy guidance came with that target to say, 'These are the fundamental components that need to be in the service'. We have a string within the action plan of policy guidance that will be issued to the service as we progress through the action plan to ensure that people are clear about what we are trying to achieve and what models they should develop. We are not overly prescriptive in terms of the form, because we know that, given the mixture of very urban and very rural areas in Wales, the models that are needed differ greatly. You do things very differently in rural Powys than in central Cardiff or Swansea. We are producing policy guidance that sets out the framework within which those services should be developed. I think that that gives that sense of vision and detail with which the service can be assisted.

[35] **Janet Davies:** Thank you. Mark, you want to continue with the issue of fragmentation and information.

[36] **Mark Isherwood:** Paragraphs 4.11 to 4.13 tell us that the commissioning of mental health services is fragmented, that there has been slow progression and development of joint commissioning across the NHS and local government and that there is a shortage of staff with the appropriate skills in health commissioning and service provision. What plans do you propose to deal with this?

[37] **Ms Lloyd:** The Minister will be producing revised commissioning guidance in March, which will include a section on the commissioning of mental health services. In terms of where commissioning might be split for particular services, such as forensic services and secure services, we are encouraging Health Commission Wales to sit down on a regional basis with local health boards to revise the way in which commissioning can be undertaken, given their needs assessments. So, it goes across high, medium and low-secure services, with low-secure services being commissioned by local health boards.

[38] In terms of some of the very sophisticated services, local health boards have to get together. That is what we have already encouraged them to do, not just for forensic services, but for general adult mental health services, because there is an absence of expertise, not just in Wales, but right throughout the UK. So, you will find that in primary care trusts in England, one commissioner will commission on behalf of five or six health boards, because it is a very specialised regime. The national leadership agency is putting on training programmes to ensure that commissioners are adept at commissioning for mental health services and using needs assessments in a better way for the future. So, we are mindful of this problem, and those are the sorts of initiatives that we have put in place.

[39] **Mark Isherwood:** Will this be on a planned and reviewable basis? Will it be monitored with measurable action points in the future?

[40] **Ms Lloyd:** Yes. The commissioning guidance from the Minister will be clear about what is expected.

[41] **Mark Isherwood:** What actions would you expect the various local agencies to take to ensure that they have staff with the necessary skills that we have talked about?

[42] **Ms Lloyd:** A degree of honesty is absolutely essential; they have to admit whether or not they have the effective mental health commissioners in the first instance. It has been easier in Health Commission Wales, because it has always commissioned sophisticated services, and has therefore developed that expertise. We have been pleased to see that, for example, in the old Dyfed area, the three local health boards have grouped together to

commission as a collegiate, and that is being promoted throughout Wales, although I was a little disconcerted to find that they still wanted their own individual leads. I sense a little insecurity about that sort of move, and we have now encouraged them to pool their resources.

[43] They also have to have the right sort of professional advice, and we have some excellent professional advisory machinery, in terms of medicine, social services and the other professions that are required to deliver care. They can use the policy advice of the Welsh Assembly Government, and that is why we have been keen to push out proper guidance on how to do this and on how services should look. We talk to the commissioners of the local health boards consistently to ensure that they are getting the skills that they need to do the job properly.

[44] **Mark Isherwood:** You talk about what they can do and how they can do it, and you talk to them about what they could do, but how are you managing that change to make sure that it happens?

[45] **Ms Lloyd:** That will come through the commissioning guidance from the next financial year onwards. From April, we will be scrutinising very carefully how they commission their services and the sorts of models that they use. We will evaluate their commissioning against the guidance that we have already provided for them. We will ask the National Leadership and Innovation Agency for Healthcare to make sure that there is no block to people acquiring the necessary skills to commission more effectively.

[46] **Mark Isherwood:** Moving on to paragraphs 4.25 to 4.28, why do you think that there are significant gaps in financial and performance management information? I will quote briefly:

[47] 'it is often not possible to identify the costs of individual service elements…it was not possible to accurately distinguish spend on adult mental health services from other categories of mental illness…a transparent accounting system is needed to demonstrate each statutory agency's spend on mental health.'.

[48] Paragraph 4.27 states:

[49] 'The NSF acknowledges the need to develop a performance management framework for adult mental health services…multi agency performance management for adult mental health is generally poorly developed'.

[50] Why is that the case, and what action will you take to deal with it?

[51] **Ms Lloyd:** We have already taken action on this by developing programme budgeting, which reveals much more explicitly the amount of resources spent on each element of the service. We have not yet had the figures for 2005-06, but we have scrutinised the 2004-05 figures on the spend per health community on mental health and all of the other programmes, to look at the extent to which they are spending to match their percentage of population and to match their health needs assessment.

[52] There is already some evidence of a differential spend on mental health services throughout the LHB communities, and we are talking to them about the reasons for that. It is possible that it reflects the health needs of the population, but LHBs need to be sure that, on average, they are using their resources wisely to meet the greatest needs within their communities.

[53] I was disconcerted to read the comments somewhere in this report—I think that it was in paragraph 4.35—that professionals expressed concerns anecdotally that where service

remodelling took place the money did not seem to come back into the service. That is one of the priorities, and is another thing that we will be tracking. I cannot see justification for that comment in the evidence that we have to date. However, I am willing to look at it critically, because this is a priority and we have put additional resources into it. There will be serious questions to be answered if we find that money is being moved around when the Minister has made considerable efforts to increase the potential spend for mental health services, only for it to be redirected elsewhere. That is not what is shown in the figures that we have to date over the past three years. We are investigating that.

2.00 p.m.

[54] **Mark Isherwood:** I am sure that it is agreed that there is a difference between people wilfully countering the directions received and those innocently doing things that perhaps they were not necessarily aware of. This is where performance management takes effect. I am sure that you will agree that, without effective and documented performance management, there can be no legal accountability or, ultimately, there can be little sanction against the people who are not performing appropriately. Can you assure us that that performance management will be systematic and properly documented?

[55] **Ms Lloyd:** Fortunately, the systematisation of performance management has increased considerably over the past three years. When I came to post, in 2001-02, there was no perceptible performance management, so we have had to do a lot of hard work to institute a performance management system. It is growing by the year—hopefully not too bureaucratically—but it is trying to highlight where the balance is within communities, in terms of their capability and capacity to deliver against the priorities set. As a priority of the Minister, performance management will be scrutinised thoroughly by the regions and then by us, when it comes up to me, as accounting officer.

[56] **Mark Isherwood:** What action is being taken to share and harness good practice in mental health services in your remit?

[57] **Ms Lloyd:** That is being managed largely through the aAtion In Mental Health project. Staff have been drawing together best practice, not just from Wales, but throughout the United Kingdom and Europe, to share with the organisations. They have been visiting the organisations to see the current state of play, and they have a suite of techniques that they will be using with those organisations, which will continue until August or September this next year, will it not?

[58] **Mr Chick:** It will be at least until August or September.

[59] **Ms Lloyd:** We are considering, given the progress report that we will receive by then, whether to extend that programme further.

[60] **Janet Davies:** Could I just bring Rhodri in? I think that he wanted to ask about the collegiate scheme.

[61] **Rhodri Glyn Thomas:** I want to go back to the commissioning process and some of the things that you said about it, which were interesting to say the least. You were suggesting that there were some concerns that certain local health boards did not have the necessary expertise to commission these services. You also said that there were concerns that perhaps these services were not best commissioned locally, but that they should be commissioned regionally—and you referred to Dyfed, an area that I obviously know well. You also mentioned concerns about the fact that, although they were working together, each of the LHBs wanted to keep their lead person in terms of commissioning these services. Those are major concerns about how mental health services are commissioned throughout Wales.

[62] On Tuesday, we heard an interesting interpretation by the First Minister of the relationship between your regional offices and the LHBs. If these services are not being commissioned with sufficient expertise, and if they are not cross-border services, should your regional offices not be stepping in? Indeed, if these services are not being provided to an adequate level in those areas, should the regional offices not consider taking over the commissioning processes of those services?

[63] **Ms Lloyd:** The regional offices are there to monitor, not to direct and not to do. They are there to provide advice to the local health boards, but that is in the context that they happen to be my operational branches. They are not a tier or a level; they are my operational branches because we needed to improve performance management. I think that there is evidence that commissioning is not as expert as it could be, but that is not unique to Wales, and we are having to look carefully at how we can ensure that the best advice and commissioning expertise is available to all. We have to be pragmatic about it because there are not a lot of expert commissioners in mental health services throughout the UK. If we have to share that expertise over a wider geographical area than that of the local health board, that is the advice that we would give to local health boards. However, we must not lose the local contact.

[64] The critical work that is done between voluntary organisations, local government and local health boards on a community basis is very important, because otherwise you will lose those local links, and you will also blur the ability of carers and users to participate actively, not only in determining what the planning and the scope of the services should look like, but the outcome that they require. So, where we can do commissioning better and with greater expertise over a wider area, we should consider that. However, we must not lose that local link, or we will handicap carers and users for being appropriately involved in what is vital for them. We have just got to be pragmatic about it.

[65] **Rhodri Glyn Thomas:** It is not so much a matter of being pragmatic; it is a matter of ensuring that those services are available throughout Wales to everyone, irrespective of where they live, and that they are provided in the most efficient way possible. If you are telling me that you have concerns about the expertise of local health boards to commission those services in some areas, and that they would be better commissioned on a regional basis, but are still commissioned on a local basis, and that, in that situation, all that the Government of Wales can do is advise local health boards as to what would be best practice in their view, but that local heath boards may carry on with those practices, irrespective of your advice, then that is not an acceptable situation when we all know that there is a deficiency in the standard of mental health provision throughout Wales.

[66] **Ms Lloyd:** I am not here to answer on behalf of the Minister; what he does with his commissioning guidance is his decision. I am saying that it is very important that mental health services are commissioned effectively, and that we use the best experience and expertise to do that commissioning. It is no fault of local health boards that all 22 of them might not have exactly the same degree of experience in mental health commissioning. If mental health commissioning can be improved by local health boards joining together to commission over a wider area, then that will be encouraged. However, we shall certainly point out to them where we feel that local health boards are not commissioning effectively or not commissioning against best practice.

[67] It must be recognised that local health boards have to undertake a major commissioning task. Before they came into being, there was a consideration about whether health authorities were just handing money over to providers or whether they were starting to commission more effectively. Since local health boards and Health Commission Wales have come in, we have tried to ensure that there is an evidence base for the commission, that we

get a proper needs assessment against which there can be commissioning, and that we will identify and use the expertise that is required to ensure that there is an equality of commissioning throughout Wales. The reason that we established Health Commission Wales was because, for some of these very sophisticated services, you need a very sophisticated commissioner. It can be done only on a regional or national basis, which is why Dyfed—it came up with the idea—was encouraged to try the experiment of commissioning mental health services across the wider area, with interlinks and networks. As you have seen from some of the cancer and cardiac networks, the best commissioning—when there is agreement, and when we do not lose the local links—can be undertaken on a wider network base.

[68] **Rhodri Glyn Thomas:** Surely that was the way in which the service was previously commissioned by the former Dyfed Powys health authority.

[69] **Ms Lloyd:** No, not necessarily, because it does not include Powys.

[70] **Janet Davies:** I do not think that we can get into a situation of looking at what the organisation used to be; we are talking about what the organisation is now.

[71] I wish to go back to section 1, which talks about gaps in key elements of service delivery. I will ask Denise Idris Jones to start.

2.10 p.m.

[72] **Denise Idris Jones:** Yes; we are going to look at the gaps in key elements of service delivery and, specifically, at paragraphs 1.3 to 1.12. These paragraphs highlight the fact that local initiatives to promote better mental health and to reduce the stigma associated with mental health problems are generally poorly developed, even today in 2006. Activity in this field is typically ad hoc and irregular. Why do you think that such limited progress has been made in relation to promoting better mental health and reducing the stigma associated with mental health problems?

[73] **Ms Lloyd:** As the expert, I think that Mr Chick could answer that question. However, it has been appreciated that there needs to be a renewal of the dual approach. We must ensure that mental health promotion is given a much higher profile. That is why the chief medical officer's department is currently producing policy guidelines, which will be produced by March 2006, looking at mental health promotion and practices. The National Public Health Service is looking also at the outcome of mental health promotion practices, so that the two things can go together. I think that Mr Chick will be able to answer that.

[74] **Mr Chick:** It is an extremely difficult area in terms of finding the outcomes from health promoting activity—the promotion of mental health and mental wellbeing. The other issue that I think is fundamental in this area is that promoting mental wellbeing is not solely an issue for health and social care services. That is something which, I think, has taxed services across Wales and the UK, and internationally. The wider determinants of mental wellbeing often lie outside of the remit of health and social care. It is about housing, access to leisure, and access to employment. To sum it up, people need someone to love, somewhere to live, and something to do. We know that they are the things that make people mentally well.

[75] There is a remit that is specific to mental illness services, and a great deal of work has been going on to improve the recovery approach in the voluntary and statutory sectors, looking at the holistic needs of a person so that their financial, social and medical needs are met. That work is going on and will continue within the mental health promotion action plan. But, we also need to encourage all partners across the divide—in Government and outside Government, employers, trade unions, people who provide leisure facilities, whether they are local authority or otherwise—to engage in looking at how we promote the mental wellbeing

of the total population. Because of that, we are developing a health promotion action plan that is much wider than the NHS and social care. It will be from the cradle to the grave so that it is not just about adults of working age—it is about children, young people, adults and older people. It will engage the much broader range of stakeholders that we need to engage in promoting the mental wellbeing of people with a mental health problem and the whole population.

[76] We have also developed a cross-Government network within the Welsh Assembly Government to look at activity that is currently going on and the assets within services. Therefore, for instance, programmes such as Sure Start, targeted at improving parenting, will impact, in the long term, on the mental wellbeing of the population. We are putting a great deal of effort into looking at where those assets lie, finding gaps, filling those gaps, and then doing the difficult task of trying to establish what impact that makes in the long term. This is very much a long-term goal, but it is fundamental to taking it forward.

[77] For that reason, we will be seeking local services, not to develop strategic plans in terms of promoting mental wellbeing within their social care and healthcare local mental health strategic planning groups, but for them to be focusing on the health, social care and wellbeing partnerships so that we get the corporate body of local authorities attending to this with our local health boards and other stakeholders. That is very complex. Commissioning mental health and promoting mental wellbeing is complex in terms of the number of stakeholders that we need on board.

[78] For that reason, we are developing a national action plan that will be based on the evidence of what works in terms of promoting mental wellbeing. It will tackle the social inclusion of people with mental health problems, and it will deal with attempting to challenge the discrimination that many people with mental health problems face when they look for work and further education, so that they can be aided in their recovery. Therefore, it is a big programme, which is partly to do with the NHS and social care, but lies in a much broader stakeholder group than that.

[79] **Denise Idris Jones:** Do you feel quite positive about this?

[80] **Mr Chick:** I am excited about mental health promotion, because it reflects, in the twenty-first century, where we were in the nineteenth and early twentieth centuries in understanding the relationship of the wider determinants of physical health—the awareness of good drinking water, how our children worked in factories, and how we educated our population—in improving people’s physical wellbeing. We are now on the cusp of seeing the same approach in terms of how we take care of our population’s mental wellbeing. There is a groundswell, internationally, around that, and we, in Wales, are grasping that. Much of the corporate approach in terms of the twin-track approach for dealing with health is encouraging—we are seeing that it is not just about treating illness; it is about promoting wellbeing and seeing wider stakeholder sign-up to the promotion of physical and mental wellbeing.

[81] **Denise Idris Jones:** Are we going to target this to the people who really need it? That is what we must ask ourselves. Are we marketing Sure Start to the parents who will benefit from this?

[82] **Mr Chick:** There has to be targeting to those people who need it. We know that there are communities in Wales where the determinants of physical and mental wellbeing are a real issue in terms of the quality of the housing, access to employment, and access to skills. Therefore, we need to look at communities as being a target group, with regard to this. I have talked about total population, which is important and significant when we are looking at promoting mental wellbeing in Wales, but we also need to target those people who are most

discriminated against in mental health, namely people with severe and enduring mental health problems. We need a mental health promoting strategy that encompasses our whole population, but we need to target those people who are most discriminated against and whose mental wellbeing suffers the greatest because of the discrimination that they suffer in the wider community, in work and in accessing leisure and other facilities.

[83] **Irene James:** Paragraphs 1.13 to 1.28 highlight the wide variations of mental health services provided in general practice. Key areas for attention are training for GPs and practice staff, and support for general practitioners from specialist services. What can the LHBs and the Assembly do to ensure that mental health services in general practices are strengthened?

[84] **Ms Lloyd:** The service and financial framework for 2006-07 has just been published. In that, the Minister has highlighted the importance of strengthening the primary care services available for those suffering from a mental illness, or trying to improve their mental health status. Therefore, what has been included in that as a target for March 2007 is that the mental health service will be strengthened in primary care on three levels. First, all general practitioners and primary care communities must institute what is called tier 1 mental health services—therefore, they have to widen their scope of managing mental health services for their communities. Accompanying that is the necessity for increased training. You have seen from this report the variability of recent mental health training for general practitioners and their practice staff. Therefore, additional training resources are being provided there.

[85] We have also included an improvement to the psychology service. We have increased the number of psychologists working in the service considerably over the past few years, but now we have said that we expect that individuals who have been assessed will start to receive psychological therapy treatment within three months. So, that is another thing that has gone in.

2.20 p.m.

[86] Thirdly, and very importantly, all practices will have what are called gateway workers to ensure that there is a link between voluntary organisations and the individual; referral through to secondary care, which is more appropriate; and a relationship with the community mental health team. That will strengthen the ability of the primary care practice to manage someone with a mental health issue more effectively in future.

[87] This is part of a threefold approach to improving the community orientation of the service. The first part comprised crisis resolution, which is a response, and home treatment services, which are a target for this year. General practitioner improvement is a target for the next financial year. We then move into assertive outreach, although that is going on already to some extent. People are looking at their crisis resolution teams to see how they can institute assertive outreach, because they know that it will be a target for March 2008.

[88] It is quite a determined approach to implementing a policy of having a more proactive community resource. We consulted local health boards and trusts on the possible targets. They were content that this was the way to go, and they are now signed up to delivering those.

[89] **Irene James:** Is there any emerging evidence to suggest that the new general medical services contract is driving forward improvements in mental health services?

[90] **Ms Lloyd:** The quality framework requires that all general practitioners keep a record of individuals who have severe mental health problems. We know from the results that we have obtained so far from the first year of the quality and outcomes framework and the new GMS contract that 83 per cent of practices have already done that. We are now encouraging

and telling local health boards to pursue the rest. That means that at least we have a much more stable record of where the major problems may be occurring and of the sort of additional care and treatment given to people suffering from severe mental health problems.

[91] At the moment, we are discussing with general practitioners and local health boards an enhanced service connected with improved mental health services and access at primary care level to see whether we can use the GMS contract more constructively for mental health intervention. Until now, they have been rather concerned with diabetic management and other issues, which are important, but we would now like to target an enhanced service on mental health. That discussion is going on at the moment.

[92] **Irene James:** So, that discussion is going on, but, at this moment, there is no emerging evidence.

[93] **Ms Lloyd:** The only evidence that we have is what was required from the quality and outcomes framework—this first stage of the GMS contract. As you probably know, discussions are ongoing on a UK basis about what the next step for the GMS contract might look like. We in Wales are pushing the enhanced service for mental health support.

[94] **Catherine Thomas:** In a previous life, through my work for a Member of Parliament representing a Cardiff constituency, I dealt with a number of individuals with acute mental health problems. Several of them found themselves in a situation where they also had profound physical health issues. However, because of the mental health problems—and often because the GP was overwhelmed by the mental health issues that the patient presented—in some cases, patients were sent from one GP to another. For three or four months they would be on the books of one GP, who just could not deal with the situation, and another GP in the practice would therefore deal with the patient. Eventually, the patient would see most of the GPs in that practice, and would then be sent to another practice. In one case, a particular lady more or less exhausted all the practices in Cardiff North. Her mental health deteriorated, as did her physical health. It was an extremely sad case because the support was not there for her. She also went from one community mental health team to the other. It is very challenging, and it is not an easy situation to deal with, but there were examples of particular individuals whose mental and physical health was deteriorating because the patient was being failed at the point of access to a GP.

[95] **Mr Chick:** You raised a number of issues there. I will start with the systems that have been introduced recently: the care programme approach and the unified assessment process. For a long time, the systematic means by which people’s physical and mental healthcare was assessed and plans developed was weak in Wales. The care-programme approach was instituted with an implementation target of December 2004, so we are beginning to see compliance with the care programme approach across Wales. That focuses very much on the assessment of a person’s needs, the development of a care plan for that person’s needs, and the appointment of a care co-ordinator, who should prevent the kind of breakdown in communications that you talked about, with people being moved from pillar to post. That is an issue, and I think that the care-programme approach will bear fruit in ensuring more robust communication between different parts of the system.

[96] At the moment, we are also seeing the drawing together of the unified assessment process, which is much wider than the care-programme approach. The unified assessment process applies to all people whose needs need to be met, and it take a more holistic view of a person’s needs—his or her physical healthcare needs, social needs, housing needs and so on. It is the drawing together of those processes that should mean that we get a more rounded view of the needs of a particular individual. Those processes, and the appointment of care co-ordinators to ensure that the process is robust and that everybody that needs to be involved is involved, are now rolling out in Wales.

[97] With regard to the step that we are taking in terms of development, you may have heard about crisis resolution home treatment, about which there has been discussion today. We in Wales are clear that the community mental health team should remain the hub for those people with severe and enduring mental health problems whose needs should be met in secondary community services. While we will add crisis resolution home treatment and, perhaps, assertive outreach services, they will be retained within the context of the community mental health team. They may operate over and above one CMHT, but they will fit with the CMHT, and we are clear that we will not create artificial divides between elements of the service, which I think was also something to which you alluded. So, we are very clear that we have to have care pathways that are clear and understandable to patients, and that we have a system in place that ensures that their needs are properly assessed, their risks are properly assessed, and that plans are properly developed and shared with all the people that need to have them, including the GP. They should be identified in the care-programme approach, and they certainly should be getting copies of the needs assessment, whether they are plans that have been developed in the community, or whether they have been developed in hospital facilities. So, the care-programme approach will incorporate general practice, and teams will work across CMHTs and across boundaries to ensure that there are robust processes to tie people together with care co-ordinators with responsibility for that.

[98] On the other issue about people's physical health, we have undertaken work recently with the Disability Rights Commission, which has been looking specifically at this issue of physical and mental health. It has looked very specifically at the physical health needs of people with a serious mental health problem and a learning disability. We are looking at that with them, and we are looking at physical health checks for people with mental health problems being made substantial, and we will work very closely with the Disability Rights Commission to ensure that we take forward that tying together of physical healthcare and mental health care in the future.

2.30 p.m.

[99] **Rhodri Glyn Thomas:** In paragraph 1.39 and in summary paragraph 10, there is an emphasis on the need for early intervention, which I think we would all accept is the best way of providing the service. The report also says that users and carers were giving evidence that they were finding difficulty in accessing services, and I know that the Health and Social Services Committee last year took a lot of evidence where people were saying that they were having difficulty accessing a service and users and carers were telling us that we have crisis management in terms of mental health provision in Wales. It is treating the illness rather than trying to prevent it. I was very encouraged by what Mr Chick was saying, but the reality out there, at the moment at least, is very different to that. We should be doing it but it is not happening. Is that based on a lack of resources or is this the culture in terms of the way in which we provide services for people who have mental health problems in Wales?

[100] **Mr Chick:** There are probably aspects of all the things that you have suggested. We certainly have to reform the culture in mental health services. We have to move away from a reliance on secondary care services, and an over-reliance on hospital-based care, towards community services. That is what lies behind the strategy in the national service framework and some of the specifics that we have been developing recently. However, that means that you have to take with you the hearts and minds of the people providing the service, and sometimes the people receiving the service, in terms of where they expect their service to be provided. So, there is a cultural move, as you have highlighted.

[101] However, there is also, fundamentally, an organisational change that we need to implement. One of the issues in terms of the community mental health teams is that they

have, since their inception, following the first mental health strategy for Wales, become all things to all people. They have tried to deal with delivering interventions for people with long-term, ongoing mental health problems, and they have tried to be responsive to general practice in terms of undertaking assessments on large numbers of people that come through. It is very difficult to get that balance between providing therapeutic interventions for people with long-term needs and the short-term requirement to be responsive to people who may have a flare-up of a common mental health problem or a major relapse of a serious and enduring mental health problem and need to get through the front door into the mental health system. Several of the things that we have spoken about today are focused on improving the processes that make that care pathway smoother.

[102] The development of crisis resolution is one of those components, which means that the services will be much more responsive than primary care in terms of doing an assessment and dealing with that person's problem and will perhaps hold that person outside the secondary care community service, so that they get brief intervention and are then perhaps aided back into work, school, further education or into services provided by the voluntary sector. Alternatively, they may be fast-tracked to community mental health teams. So, the development of that element of our programme is crucial in dealing with that issue of how we get the right person to the right place in the system. Strengthening primary care will also facilitate that, because more people with a common mental health problem that can be managed in primary care will be managed there. Those people who have a stable mental health problem and who were in the community mental health team or in hospital will be facilitated to go back to primary care.

[103] The AIM project that has been talked about, which is focused on developing care pathways, is looking at where blockages currently lie, because we have to move people through that system so that the people getting ill can get from their general practitioner into secondary care or hospital if they need to, and come back out. Traditionally—and this again is not a Welsh problem; this has been a UK problem—we have had blockages with people getting into secondary care, the community mental health team or into hospital, and then, because the support is not there to help them out, they do not move, which means that the people who need to get into that system are being blocked. So, these steps that we are taking, namely improving primary care, introducing crisis resolution and home treatment, introducing the Tidal and refocusing models on in-patient wards and the AIM project to look at how that system works, are targeted at doing just what you said. However, it is not a matter of one size fits all and there is no quick fix. It is about looking at the whole system and taking bite-sized chunks, which is what we have done, developing the system in primary care and secondary community in-patient care and moving the people through those processes most effectively. That is the approach that we have taken. It will take time to bed in, but we have taken a variety of steps that will impact on that very real issue. So, we are trying to move away from community mental health teams being all things to all people to having a clear focus on the different functions that it will fulfil in ensuring that we get people to see the right person, at the right place, at the right time.

[104] **Rhodri Glyn Thomas:** Again, I am very encouraged by what you are saying, but when you look at the reality of the situation in Wales, it is very different from that. However, if that is what we are aiming to achieve, it seems that we are talking specifically about changing the culture, but there is a resource issue there where you are going to have to invest more money, and we certainly need to develop more expertise in terms of practitioners on all levels. The problem sometimes is that the only answer given is, 'Oh, we are investing so many millions of pounds in the service'. That, in itself, will not meet the needs in terms of mental health provision in Wales. How do you respond to the comments of the Children's Commissioner for Wales, who said about mental health provision for children and young people in Wales that the situation at the moment was totally unacceptable, and that it was not so much a matter of Government saying that—

[105] **Janet Davies:** Rhodri, this is about adult mental health services.

[106] **Rhodri Glyn Thomas:** I accept that. In terms of developing the services in the way in which you are talking about, with the mental health legislation that is going through Parliament at the moment, there is a fear in Wales that that new legislation will be based, to a large extent, on the national strategic framework. You have told us that the NSF in Wales has certain weaknesses. Would you accept that it is less developed in Wales than in England? Is that going to be a major problem in terms of changing the situation that you are talking about, and getting the step change in terms of the way in which the services are provided? Is there a danger that this new legislation will prevent you from doing that?

[107] **Ms Lloyd:** There are two things. I do not think that I said that the NSF has weaknesses. One of the reasons why the Minister asked for this whole baseline review in the first place was to look at the progress that had been made following the strategy that was produced in 2001, to look at the changes in practice that had taken place since then, to look at the consequences of the mental health legislation that was being discussed at that time—as you know, it has been deferred by the UK Government—to put into context the new baseline for the NSF compared to where we had got to with the old one, and to look at how it needed to be altered. It is substantially the same, but there are a couple of differences, particularly in respect of housing and probably user participation being highlighted as a key issues in the new one. However, that was to try to anticipate any changes in legislation so that we give to the service a clear view of the direction of travel for the improvement of mental health services over the next five to six years. That was one of the reasons why the Minister asked us to take a look at the NSF as it stood.

[108] **Rhodri Glyn Thomas:** And you are confident that those changes can take place?

[109] **Ms Lloyd:** I am confident that the changes that are described in the NSF will take place, and that is why, as Mr Chick says, we have had this phased approach to changing the traditional model of mental health service delivery to putting into place the support mechanisms for the staff and the patients that are necessary to change a culture. As you will be well aware, mental health services throughout the United Kingdom have been criticised over past years for being too medically orientated.

2.40 p.m.

[110] It is absolutely vital to get a good medical base, but there are different ways of providing the sort of service that is required for those suffering from a mental health problem, or those who are likely to, other than the very medically orientated, institution-orientated service that we knew 20 years ago.

[111] **Janet Davies:** I have one issue to raise that looks at some of the problems that Mr Chick has described. To get someone out of secondary care, there are blockages on the pathway. Would one of those blockages be a problem in that, if that person's condition necessitated them going back into secondary care, there could be some hold up or waiting time, and, therefore, there would be some degree of nervousness and concern about moving them out and moving them on?

[112] **Mr Chick:** No.

[113] **Janet Davies:** You do not think that it exists?

[114] **Ms Lloyd:** No, I do not think so. When I was a chief executive and in charge of some mental health services, we always used to monitor how long it took for people to get

admission to an acute ward for assessment. We were always acutely aware that you could not delay a discharge out of fear that you could not get someone back in. Anyway, the follow-up after discharge has to be good; you must risk-assess the patient very well indeed so that you can estimate what the possibility of the need for readmission would be. That is why it has been important to extend the roles of the community mental health teams into crisis resolution, so that you get better risk management of an individual on discharge.

[115] **Janet Davies:** It is not that I am personally aware of anything like this, but it just struck me, while you were speaking, that it might be possible.

[116] **Leighton Andrews:** I apologise for my late arrival, but the Minister for Health and Social Services was laying the first stones of the new Rhondda hospital.

[117] I take you to paragraphs 1.33 and 1.36, just to follow on from the questions that Rhodri Glyn started. Mr Chick mentioned that crisis resolution and home treatment services were being developed in the context of community mental health teams, but, from the report, there is clearly a lot of work to be done. At the time of the report, only nine out of the 22 local health boards had crisis resolution/home treatment services in place. Has that situation improved?

[118] **Ms Lloyd:** Yes, it has. The field work was done in 2004. This is a target to be met by the end of March this year. There are five areas—several are in north Wales—that we are not at all happy with yet, and the regional director is pursuing with them how they are going to achieve this target. I have written to the service again in the last couple of weeks to remind it of the importance of achieving this target. We have sent in the experts to assist these five areas, to try to see what the blockages to them achieving this are and to try to help them to overcome them.

[119] **Leighton Andrews:** Are they all in north Wales?

[120] **Ms Lloyd:** Not all of them. Two of them are in south Wales.

[121] **Leighton Andrews:** Okay. Are the problems that they are facing similar or are they facing a wide range of issues?

[122] **Ms Lloyd:** There is a different range of issues in each area, which is why we have given them individual attention.

[123] **Leighton Andrews:** Okay. I turn to early intervention and supportive outreach for patients with developing or established psychosis. Again, at the time that the report was compiled—this is in paragraphs 1.38 to 1.40—these schemes, which are obviously very important, were only in place in six areas in Wales. Has there been an improvement on that?

[124] **Ms Lloyd:** I do not wish to be pedantic, but it depends on how you define an area. People automatically associate that word with local health boards, when, in fact, we have always looked at assertive outreach on a trust-by-trust basis, so we are talking about 12 areas. It has improved slightly, but assertive outreach is not a target until we get to March 2008, although progress has been made in many of the areas to establish assertive outreach. Some of them are looking critically at what they do with their crisis resolution teams and how they could extend those to provide assertive outreach as well. However, there are some areas in Wales where little progress has been made, because they have got some time to get there and it is best practice. I do not like to see people go to the wire to achieve the target, but to get it in place in good time. We are discussing with them how they might improve or start to deliver an assertive outreach system much sooner than March 2008.

[125] **Leighton Andrews:** I would hope so, because that is two years away, and there are real concerns here in terms of safety, both for patients and the public, if these services are not in place.

[126] **Mr Chick:** I believe that our CMHTs are in a position to work to manage issues of public safety. As I mentioned earlier with CPA, they have developed more effective risk-assessment approaches in terms of capturing risk where risk may exist. However, I always like to take the opportunity to stress that those people with mental health problems who pose a risk to the public are a tiny minority of the people who receive mental health services. That cannot be overstated. However, we have taken another step that is running alongside these other initiatives, which is that our academic base, through the Caswell Clinic, is developing a curriculum of evidence-based risk-assessment tools that will be offered to trusts to develop in whole teams. So, that would be crossing the health and social care divide to look at that very issue of assessing and, importantly, managing risk where risk becomes an issue.

[127] I believe that assertive outreach methodology helps to improve the management of risk, but it is not an absolute fundamental in terms of that happening. We have been managing people, for example, using section 37/41—a hospital order with restrictions under which people are conditionally discharged—for many years without this specific methodology being in place. It will help; it is an aid, but I would not want to overstress it as being absolutely imperative and a missing piece. It is about us taking those steps forwards and improving the quality of our service and the functionality of our CMHTs, but it would not be appropriate to say that we cannot do that work without these new methods of working being in place. We want them and we are setting targets for them to be achieved, but it would be inappropriate to say that we cannot deliver a mental health service without them. I think that they are about developments and improvements.

[128] **Leighton Andrews:** Are there specific obstacles to the other areas getting their services in place? Funding is mentioned in the report as being a problem in some cases.

[129] **Mr Chick:** We talked earlier about culture and developing services, but we also need to look at our skill mix. We are doing work in the Assembly that looks at improving the skill mix within our community mental health teams. As you will know, developments are taking place in relation to mental health in Wales and across the border. They are placing big strains in terms of the available workforce, because we are making developments. It is sometimes a question of whether we have enough people to do the work and, because of that, we recognise that we need to increase the range of people within mental health services who are looking at developing a competence-based, non-professionally-affiliated workforce. These are people who are not necessarily occupational therapists, social workers, psychologists and doctors, but people who are competent to work in mental health and who can deliver effective interventions for people with mental health problems rather than doing the planning. That frees up our professional staff to do what they should be doing in terms of delivering therapeutic interventions and undertaking those assessments. So, that is another important strand of what we are taking forward.

2.50 p.m.

[130] One of the obstacles to moving services forward sometimes is recruiting the right people, particularly in some of the more rural areas in Wales. For that reason, we are looking to have a much broader skill mix, with professional staff being free to use the skills that they have and having staff who they can direct to do the doing in terms of the plans that are being developed. That should not be overlooked as an issue in terms of how we take this forward. We have two streams in place at the moment, with policy guidance about to be issued to the service to facilitate that change in terms of looking at new roles in mental health, and we have also commissioned NLIAH to take that work forward, and it is working with us on that

programme now.

[131] **Leighton Andrews:** Who have you commissioned?

[132] **Ms Lloyd:** The National Leadership and Innovation Agency for Healthcare.

[133] **Leighton Andrews:** Thank you. What about the funding question?

[134] **Ms Lloyd:** Additional resources have gone in to increase the numbers in training. An allocation is also given each year to postgraduate education for non-medical and medical staff. We are testing the trusts in particular because they have that resource, and the deanery, in terms of how they are producing their workforce plans for their pregraduate and postgraduate staff to ensure that they are maximising the use of the resource that they have already, which is increasing year on year.

[135] The other issue—and it is helpfully pointed out by the auditor general in this report—is the use of the healthcare assistant role. We commissioned Health Professions Wales to undertake a piece of work for us on the healthcare assistant of the future and how they might be trained, what they need to do and how they need to have continuous development. That work is being showcased in around three or four weeks' time, and that again will be part of the guidance that we will be providing to the service at the end of March on the evaluation of the capabilities of different types of individuals to support their professional staff, particularly in the community.

[136] **Janet Davies:** Thank you. We will be continuing for a little bit longer with this section of the report. Mick?

[137] **Mick Bates:** Paragraphs 1.41 and 1.47 show that many parts of Wales do not have adequate levels of supported housing for people with mental health issues. Furthermore, I am sure that you would agree with me, Mrs Lloyd, that appropriate accommodation is a key element of successful community care for many patients with such issues. Do you also agree that the problems identified with the provision of supported housing are indicative of poorly developed joint working between health and local government bodies?

[138] **Ms Lloyd:** It is quite difficult for me to answer that, because an awful lot of that relates to local government, and, fortunately, I am currently not accountable for that, although I know that it is doing an excellent job in many parts. The report highlights some of the innovative and creative supported housing initiatives that have been developed in Wales, which I am sure that you will all have seen.

[139] As part of the new NSF, one of the new key actions relates specifically to housing and supported housing, and to improvements in the way in which such housing will be provided. That is being promoted at a local level. I think that the planning and development, through those health and wellbeing strategies, for the whole range of services, and the way in which the NSF has been developed to cross cut right through housing and the social justice agenda, is an important milestone in terms of placing an emphasis on the fact that health cannot just plan on its own, and neither can local government, when you are dealing with the complex needs of those who have mental health problems. So, we will be testing this again when we see the revised health, social care and wellbeing strategies that come forward from the partners within the next year, and testing whether or not the emphasis placed on the NSF for joint planning and joined-up planning is being taken seriously by local health boards and their partners. We have placed an emphasis on the necessity for this.

[140] **Mick Bates:** While your first remarks may have been factual, they betray one of the key issues that has led to what you earlier called a 'cinderella' service. Given your first

remarks about not controlling local government, if you were presented with this health issue and if you could see a solution that may concern improving accommodation, because you know that that is a key element, would you leave it because it is not your area of responsibility?

[141] **Ms Lloyd:** I am sorry; I do not mean to be rude, but that is a slight misinterpretation of what I said. Technically, I cannot speak on behalf of local government. I am not the accountable officer. That is the technical part of why I am here today. If, however, we are looking at how health and local government can join together, then we have the health flexibilities budget, which came from the health vote, and is used flexibly between local government and the health service to solve problems that can be solved mutually. Much of the health flexibilities budget has been used on supportive housing, telecare, telemedicine, on trying to ensure that people can stay safely in their homes. Great things have been achieved in Blaenau Gwent in the area of assistive housing, and will continue through the work of the health organisations, the voluntary organisations and local government. However, I cannot, technically, answer on behalf of local government and I, technically, cannot direct them. That is what I meant.

[142] **Mick Bates:** Thank you very much. However, you are, essentially, responsible for resolving the health issue, which I consider to be the element of this whole baseline report about adult mental health services.

[143] **Ms Lloyd:** That is the point of the partnership arrangement.

[144] **Mick Bates:** That is right. However, the figures presented in these paragraphs bear out that there has been very little integration of approach to resolve issues of accommodation. What do you see as the way forward towards assessing needs in a better way?

[145] **Ms Lloyd:** The health needs assessments are being revised now. We will continue to look at the proposals coming forward from the partnership against those health needs assessments to see whether they are using all of the opportunities available to them to meet those needs in the best way possible.

[146] **Mick Bates:** Thank you for that first part. How would you then work together to get an assessment of the needs for supported housing, apart from the health issue?

[147] **Ms Lloyd:** The health needs assessment will show the sorts of accommodation, care and treatment and care pathways that are necessary for the population. I know that the Minister has put additional resources into the telemedicine services in Wales, because we have a reasonable telemedicine service, but it needs extending. The Minister is also considering a paper on telecare and its future.

[148] **Mick Bates:** Thank you. Returning specifically to the business of assessment, I draw your attention to paragraph 1.46, where the issue is identified, but it goes on to say that very few authorities

[149] ‘have undertaken any detailed needs assessment to accurately establish the type and extent of accommodation that is needed’.

[150] Given what you have just said, this must be well known. I have referred previously to the lack of robust data to enable planning, and this appears to be another area of weakness. What are you doing to resolve the particular issue identified in paragraph 1.46?

[151] **Ms Lloyd:** We are taking the proposals from each of the organisations and testing them. We are looking, through the Action In Mental Health project, to roll out best practice

and to assess where the gaps are, and that will include the housing and supportive housing element. Within the national service framework, there are distinct key actions that will be taken by the partners in terms of the provision of supportive housing. As I said, the Minister is about to consider a paper on telecare, which is fundamental to supportive housing.

[152] **Mick Bates:** You could, therefore, produce the data on which your statement and the NSF are based, the data on what is needed for that supported housing?

3.00 p.m.

[153] **Mr Chick:** There is a range of things taking place. A number of areas have undertaken very specific needs assessments about their accommodation. There have been accommodation reviews in a number of our local health board/local authority areas already.

[154] I draw your attention to key action 9a in the national service framework. In response to the issue about supported accommodation—again, I go back to what I said earlier about the wider determinants health—this is about local authorities and local health boards working together around the health, social care and wellbeing strategies to focus on accommodation. However, in the NSF, it is quite clear now that there needs to be a gap analysis in response to the Wales Audit Office baseline review of local supported housing needs, and that is to be undertaken in 2006-07, that a strategic plan needs to be developed in each local authority area, and that supported housing developments are to be developed in response to those local plans. There is clearly a programme within the action plan in the revised NSF that is identifying this very issue that was raised in the Wales Audit Office report, and is placing the requirement on local areas to analyse their gaps and their needs and to develop a locally agreed plan of action, with the local authority and the LHB working in partnership to take those initiatives forward.

[155] **Mick Bates:** Thank you very much for that, but currently you do not have any data on which anyone is basing future need, do you?

[156] **Mr Chick:** Local areas will have undertaken their local assessment of needs which, as I say, is something that will have been taken forward by individual local authorities and local health boards. As far as I am aware, we do not collate data nationally on local accommodation provision. That is a local authority issue that, I think, was set at the very beginning of the debate.

[157] **Mick Bates:** On that point, do you not think that it might be a responsible action to collate the data to identify areas of weakness?

[158] **Ms Lloyd:** It is very much a local issue. They are local organisations that are held to account for the way in which they can deliver a national service framework. I do not know what added value it would give to collate it nationally. The important thing is how the local organisations are delivering care locally and how appropriately. It is they that will be held to account for ensuring that the needs of their populations are met as best as is possible. I cannot see that collating it nationally would add value to the local situation.

[159] **Mick Bates:** I will just add to that by saying that it may help to identify weaknesses of delivery to which you could respond.

[160] **Ms Lloyd:** I think that we would be able to identify weaknesses of delivery at a local level. All these organisations are held to account locally for the way in which care is being delivered. They all have to give their response to the national service framework on an annual basis. You will see quite clearly where action needs to be taken. They have to be held to account locally for some of this.

[161] **Janet Davies:** Catherine wanted to come in with something.

[162] **Catherine Thomas:** Yes, I will be very quick. It involves accommodation again. As Mr Chick said earlier, I think that the holistic approach is fundamental. I think that housing—appropriate housing—is absolutely central to this. Do you share my concerns about situations in which individuals with acute mental health illnesses are not able to secure supported housing, but are actually accommodated in temporary accommodation such as bed-and-breakfast accommodation, which is often completely inappropriate? It can actually worsen their mental health, perhaps because of joined-up thinking and communications between a community mental health team and the local authority and, because of a breakdown in communication, that individual with quite acute problems is inappropriately housed.

[163] **Mr Chick:** Yes, I think that what you have said is absolutely right. Access to good-quality accommodation is fundamental as part of the programme of helping someone to recover when they have an acute mental health problem.

[164] Going back to the points that we have just debated, that is why it is so important that there is an assessment of need locally. A join-up between the local mental health strategic planning group with local housing agencies, whether the statutory agency of the local authority or housing associations, is crucial to the delivery of a full range of mental health services and accommodation, for all the reasons that you have pointed out.

[165] We need a range because we have floating support schemes, and the Supporting People initiative increased significantly the amount of support being offered to people with mental health problems. It might just be worth focusing on what that was about. Floating support, which was very much taken forward under Supporting People, which was the move from the housing benefit care element to dedicated schemes, has meant that, instead of the person having to move out of supported accommodation when they no longer have that need, the support is moved. Floating support is important in terms of those elements.

[166] We also need a range whereby you have higher levels of support for the local authorities, mainly, to have supported accommodation that is developed. Developing that range and having plans developed at the local level—to pick up on just those issues that you raised—are vital. In terms of having that within the action plan, we would certainly be seeking to have local authorities and the NHS working collaboratively to plan that and to make sure that the responsible agencies are developing a range of accommodation services.

[167] **Catherine Thomas:** Unfortunately, people are still slipping through the net. That is my concern. I know of constituents in my area—and I am sure that other committee members do—who are slipping through the net and who are in those situations. That means that they are a risk to themselves, as well as to wider society.

[168] **Janet Davies:** We will finish this section with a question from you, Rhodri.

[169] **Rhodri Glyn Thomas:** Moving to in-patient services, under paragraphs 1.76 to 1.93, there are concerns about certain aspects of those services. There is reference there to mixed-sex wards, rehabilitation, lack of facilities, lack of stimulation and, specifically in 1.79, there is a reference to the NSF target to get rid of what are called 'Victorian-type institutions'. I will not ask you exactly what a Victorian-type institution is, and whether you have a definition of it, but I note that you have a target to get rid of those by 2008. Is that achievable, and, if not, why not?

[170] **Ms Lloyd:** It is going to very hard to achieve that. There has been a considerable improvement in accommodation, particularly over the past five years, but we have some way

to go. As you know, the Minister has provided considerable additional resources in the capital programme for the next three years, and over the past five, to tackle this problem of Victorian institutions, or, indeed, other accommodation that is no longer suitable. It is not a prerequisite that all old buildings are absolutely hopeless; some new buildings with a more modern approach are also found to be not as good as they might be, and they might be only 10 years old. So, at the moment, we are waiting for a final proposal to come forward from Cardiff and the Vale. As you know, it has just had one new unit, which has allowed some of the old accommodation at Whitchurch to be closed, but more needs to go. The resource is there to support it, and so, hopefully, that will be done by the end of 2008.

[171] We are waiting for a few more what we call 'strategic outline cases'. They have to tell us precisely what they are going to do and what the model of care will look like. Many of the replacement schemes for Victorian accommodation actually describe a very different model of care that better fits the modern circumstances that we have discussed today.

[172] I think that it will be extremely tight to get to 2008 and see all the old accommodation shut and the patients moved out, but, certainly, in all of them, the buildings should be in the process of being built to get there, because a huge amount of resource is being put in. Over the next five years, about £120 million, , will go in to replace unsuitable accommodation.

3.10 p.m.

[173] But, we are urging organisations; we have employed, as part of the capital programme team, individuals who can assist them to more quickly develop their strategic outline cases, their outline business plans, so that I can get them through the capital investment board quickly, and so that there will not be unreasonable delays. Everything is being done to get there, but it is a big task. As you walk around Wales, you will see why it is a big task.

[174] **Rhodri Glyn Thomas:** I agree that it is massive task. It is encouraging to see that there is a programme of modernisation, based on the suitability of buildings.

[175] **Ms Lloyd:** Yes.

[176] **Rhodri Glyn Thomas:** As you say, some older buildings can be even more suitable than some newer ones.

[177] **Ms Lloyd:** Not many, though.

[178] **Rhodri Glyn Thomas:** No; I accept that. However, it remains a fact that a number of patients will still receive their in-patient treatment in buildings that are not suitable. What are you doing in those circumstances to ensure that the level and quality of services are improved? Obviously, people working under those conditions are finding it very difficult. There are barriers to the kind of treatment that patients should be receiving. What are you doing to improve those conditions?

[179] **Ms Lloyd:** The first thing to do is to work with the staff to ensure that those unsuitable environments are improved and to ensure that they understand that there will be new accommodation coming. One of my great fears about the whole movement to a much more appropriate, community-orientated service has been that we have seen a big increase in the number of staff working in the community, because it is seen to be more desirable, but, at the same time, we must maintain the morale, skills and interest of people who are still working in old accommodation or on an in-patient basis. So, there has been a lot of work done to ensure that we work much more creatively with staff who will have to stay, and manage patients, in possibly not ideal surroundings, and to engage them much more effectively in

planning for the future, looking very carefully at the sort of skills mixes that are required for the patients who are coming in, to try to ensure that there is a proper risk assessment of that accommodation. It talks about mixed-sex wards: we have learnt a great deal from the problems that can arise with mixed-sex wards. There are requirements that, if you must have mixed-sex wards for very much longer, they are properly risk assessed, that there is privacy for patients and that staff can manage adequately the type of patient that we have there.

[180] We are looking at, and testing, the organisations on the case mix of the patients. Often, on acute wards, you can get a mix of patients, some of whom are psychotic, some of whom are highly depressed, some of whom might have a drug-related problem and dual diagnosis, some of whom might be low-secure forensic—that is a torrid mix. How do you manage that sort of case mix of patients if you are stuck with a certain environment? How can you improve an environment to render it safe for both patients and staff? We are testing the trusts, particularly, on how they are safely managing their environment for staff, and how they can make sure that they retain their really good quality staff to continue to manage on an in-patient basis. That is being tested, and is, again, re-emphasised in the NSF and in the strategies. But, every effort is being made to ensure that the environment in which we expect patients to be managed is as modern and as appropriate as possible; hence the huge capital investment.

[181] **Rhodri Glyn Thomas:** Given the importance that you place on an appropriate environment, and the fact that patients in both the past and the present, to an extent, have been treated in unsuitable locations, has that had an effect on staff recruitment and retention? Has it been a problem to recruit and, more so maybe, retain highly qualified and motivated people to carry out these services? Is it the hope that, as the environment inproves and as buildings improve, people will be attracted to working within the system?

[182] **Ms Lloyd:** From my own experience, when community mental health teams first started, it was a tremendous problem to retain staff to manage in-patients on the wards, because the community mental health team was regarded as being a more desirable form of employment. That has diminished in its effect over the years, as more and more effort has been placed on training and developing staff to really manage the sort of case mix of patients that I have just described and to more actively engage them in the ways in which care can be provided to train them and give them training opportunities. Largely, the new techniques of managing patients on an in-patient basis—the Tidal and refocused care models—have allowed the highly developed staff almost more latitude and a greater role of managing patients in a much more proactive way than the more traditional models of management. There was a tremendous problem at one time; it is not so prevalent now and it is not showing through in the numbers that we are able to retain on the wards. Nevertheless, we cannot take our eyes off this. This is an ongoing problem. We must ensure that we can create an environment that staff are going to be happy with and content to work in, and give them lots of opportunities to train and develop. At the end of the day, that is what motivates staff, and we must ensure that we are putting in a proper skills mix so that the trained and highly experienced staff are doing that which only they can do and that they are not being dragged into different types of work. One of the key skills of chief executives is to retain the motivation of their staff—it is absolutely vital.

[183] **Janet Davies:** Thank you. We will take a short coffee break now before we go on to the second part of the report.

Gohiriwyd y cyfarfod rhwng 3.18 p.m. a 3.37 p.m.
The meeting adjourned between 3.18 p.m. and 3.37 p.m.

[184] **Janet Davies:** Welcome back. Mick, it is your question next.

[185] **Mick Bates:** In the section on integration and co-ordination of adult mental health services, in paragraphs 2.1 and 2.2, you can see that there is great variation in the extent of integrated working within community health teams. Mrs Lloyd, why is joint working and integration between the various agencies providing mental health services better developed in some parts of Wales than others?

[186] **Ms Lloyd:** That goes back to the issue of culture that Mr Chick spoke of earlier. Some parts of the country, because they embraced community working earlier, got off to a much better start in terms of establishing their community health teams and their role and responsibilities. That has been seen from their responses to the extended roles of crisis resolution and assertive outreach. So, they are all required to produce community mental health teams that meet the needs of their populations. How they do that has been a matter of choice of the trust that is providing the care. However, we are evaluating the effectiveness of the interventions that are undertaken by the community mental health teams, because, on the face of it, it is difficult to understand why, in some places, the psychiatrists or the social workers are not part of them. We have to test with local organisations whether or not that is the best way to serve their communities and whether that is the best way to provide these extended services.

[187] This is an incomplete picture, because, to look at what makes up the community mental health team, you have to understand what the rest of the range of services might be in a particular location, and that is what Mr Chick is running through with them and that is what the AIM project is also highlighting—where the gaps in these individual communities are.

[188] **Mick Bates:** I take your first point about the lack of representation. However, that is exacerbated by the fact that there is a lack of psychiatrists, for example; I think that there are 26 per cent psychiatrist vacancies—

[189] **Ms Lloyd:** That is better than it was.

[190] **Mick Bates:** Is it better than it was? I am pleased to hear that.

[191] **Ms Lloyd:** Yes, it is much better than it was. Shall I tell you what it is now?

[192] **Mick Bates:** Please do.

3.40 p.m.

[193] **Ms Lloyd:** In terms of pure numbers, the number of old age psychiatrists has risen by 25 per cent over the last three years, as has that of forensic ones—there were only two, but there are now four. For general psychiatrists, what has happened now is that the numbers employed have slightly increased but the number of vacancies has dropped to 8.4 per cent, which is a great improvement. One of the areas highlighted in the report, where there has been a significant recruitment problem, is Dyfed. That has had some good success in recruiting substantive psychiatrists over the past year. So that is good news, but we are mindful that throughout the UK, in terms of the number of psychiatrists employed, there are a lot of vacancies throughout the country. That is why we have been testing the workforce plans coming forward from the organisations to ensure that they can recognise the growing needs of this group of staff and we are looking at their recruitment processes to ensure that they are targeting properly to try to ensure that there are not any vacancies, particularly for sectioning purposes.

[194] **Mick Bates:** Thank you, that is encouraging. What about opening hours? There are some large gaps there in terms of access.

[195] **Ms Lloyd:** Opening hours for—

[196] **Mick Bates:** Sorry, for the CMHTs.

[197] **Ms Lloyd:** Do you want to take the question on opening hours?

[198] **Mr Chick:** The issue of the availability of contact with mental health services has been around for some time. There is, and always has been, a responsibility to provide around-the-clock, 24-hour assessment under the Mental Health Act 1983. The local authorities have a duty to provide them through their approved social worker service and also for psychiatric services to be available to assess under the Mental Health Act 1983 where that is required. However, for more proactive interventions, there is an issue in terms of the availability of CMHTs. They have tended to be available from nine to five, five days a week, which is why, in the development of the crisis resolution home treatment teams, one of the core issues with those is that they are available outside normal office hours and at weekends. There is no evidence to say that you should have people sitting and waiting for the phone to ring 24 hours a day. Sometimes people see around-the-clock services in that way. Where services were developed in that way in the past, they were not felt to be best value for money or an effective way to deliver the service, so in the policy guidance on crisis resolution/home treatment, we are requiring that they be available between the core hours of 9 a.m. to 9 p.m. at weekends with on-call during the nights so that, if a crisis were to develop beyond the opening hours of those core services, a response could be made. We see those as being fundamental to expanding the activity and availability of CMHTs.

[199] We are also seeing developments in many of our voluntary sector services with day activity services being available at weekends and in the evenings. That is becoming much more a part of the culture of activity services—people used to call activity services day care, but I am against calling that because that sounds like a paternalistic approach to providing it. It really is about providing people with therapeutic activities. Clearly, those do not need to be available nine to five, five days a week. We are encouraging services to develop into the evenings and weekends, both in terms of core CMHT activity and activity services outside of that.

[200] **Mick Bates:** That is very positive. So what actions do you have planned to encourage the type of joint working that you have just described between health and social services?

[201] **Mr Chick:** We have set a requirement in the national service framework for the teams to become multi-disciplinary and to ensure that there is greater joint management between health and social care in the delivery of CMHTs. If you look at Conwy and Denbighshire, they have used Health Act 1999 flexibilities to have a partnership board so that the NHS trusts and the local authorities have formally signed up to a joint partnership board to encourage not just joint commissioning, but joint provision of services. We would certainly support that and look for other areas to follow suit. We would encourage that as a development so that we can see much closer joint operational working between health and social care.

[202] Something that we have not discussed in a great deal of depth this afternoon is the fact that we are doing a review of the strategy from 1992 of mentally disordered offenders and secure mental health services. As part and parcel of that root-and-branch review of services, we will be looking for joint operational working, not just between health and social care, but between the criminal justice services, which include the police, the prison service and the probation service, so that those elements are also tied in. It goes beyond just health and social care. We are encouraging that and seeking developments, such as the crisis resolution home treatment, to be multi-agency and multi-disciplinary. We are also seeking this broader base around the interface with the criminal justice services around mentally

disordered offenders.

[203] **Mick Bates:** I note that your list of agencies does not include housing or planning departments. Will they also be part of that?

[204] **Mr Chick:** Very much so. Housing, as we have mentioned, is crucial to this. There is reference to the fact that we would seek to see housing departments represented on local mental health strategic planning groups because of the importance of housing being part and parcel of that. There is specific reference in the action plan to the need to develop local plans on accommodation services. The other issue is the cross-Government network, which I mentioned earlier. Housing is a very significant player in that in terms of looking nationally at how we can encourage local authorities to take stock of their role in terms of accommodation services and mental health. So, we would be seeking a high-level approach to that as well.

[205] **Mick Bates:** Finally, when would you like see that whole-system vision that you just described actually implemented so that you will not be able to identify the lack of multi-agency working?

[206] **Mr Chick:** I would like to see it implemented now, and I think that in some areas I do see it now. All that we can do is continue to encourage services to work in this way. As we mentioned earlier, some of this is about organisational and structural issues, and I think that we have seen some of those obstacles move away with the Health Act 1999 flexibilities in recent times. However, it also comes back to this issue of culture. We all know that cultural change can be slower to progress, because it is not just about providing people with policy guidance; it is about people making the change themselves. We are working with colleagues in the profession to make this significant shift. I think that the work that we are doing at the moment on reforming the workforce, and looking at the fundamental roles and responsibilities of different professionals, will facilitate that cultural change.

[207] **Alun Cairns:** Mrs Lloyd, you and Mr Chick have placed great emphasis on the care programme approach in your answers to many of the questions raised by colleagues. How would you assess the progress made in developing the care programme approach, up until the time the document was published in October 2005?

[208] **Ms Lloyd:** First, we had to ensure that it was being implemented, and that there was consistency across the units of management to ensure that that was the case. We were finding, in our quarterly reviews, that, in some areas, they were only applying the CPA to new patients and, therefore, we had to redress that balance to ensure that all patients received a care plan based on a CPA and unified assessment. I think that Mr Chick is just engaged in a review of how each of the organisations has responded to CPA, because they have had sufficient time now as it was supposed to be in by December 2004. We all appreciate the problems that they have had in terms of IT systems and sharing information, but many of those problems have been overcome and we have a way forward for the IT solution, because I think that we have to admit that it is onerous to do some of CPA properly using the current systems. He is undertaking a review of the consistency of application across Wales at the moment. From that will flow the discussions with individual clients about their outcomes and their perception of the improvement or otherwise of the services that they have received, given this different approach.

[209] **Alun Cairns:** My question was about how you would assess it. Would you assess it as being good, mediocre or poor?

[210] **Ms Lloyd:** Sorry, I misunderstood.

[211] **Alun Cairns:** That is okay. As you rightly said, it was part of the service and

financial framework target to be implemented by December 2004. It says within the document that the CPA for homeless people exists in only two areas. How would you assess the progress up to October 2005?

3.50 p.m.

[212] **Ms Lloyd:** I think that it is mixed. That is from the reports that we are getting from the regional directors and from Mr Chick, as well as our lead director.

[213] **Alun Cairns:** Let me press you, then. Let us commend the two areas that had CPAs for homeless people; they are good. Therefore, two are good, but maybe all of the others were not so good and then some were poor. Is that what you mean by 'mixed'?

[214] **Mr Chick:** I would say that when you have trusts and local authority areas with the responsibility to implement, there will be people who have been early up-takers and who will be further down the road than others. Where they have developed it, some elements will have been developed very strongly in some areas, and less so in other areas. I will give you some examples: where we have areas where there are significant populations of homeless people who perhaps travel to use accommodation services developed for them, you are more likely to see an approach that focuses on meeting the needs of homeless people. That is not being defensive. Equally, I would say that where there are good quality IT systems in place, they will have the electronic version of CPA. Therefore, different places have developed different elements of CPA at different paces. That is not surprising given the fact that a number of organisations are taking this forward.

[215] **Alun Cairns:** Your answer does not quite stack up, because you said that areas with particular difficulties with homelessness might develop CPAs, but I can easily think of more than two areas that would have a problem with homelessness. In reality, therefore, are we not being polite? Has not the progress of the CPA been pretty poor up to October 2005, bearing in mind that they had had 10 months in which to have it up and running, because it was part of the target for the previous year?

[216] **Mr Chick:** Many areas have made significant progress, and will continue to do so. The issue with the care programme approach is that it is a process; it is not simply ticking a box on a form. It is about engaging service-users, developing care plans and making sure that those care plans are shared by those who have a responsibility for developing care. That means that, as those processes come on-stream, we will see more effective delivery of CPA. I think that we will see a maturity of CPA over a number of years. England introduced CPA many years ago, and is continuing to review and reform its CPA process. It has gone from having three tiers of CPA to two. We have learned from that and we have two tiers of CPA. I am sure that, when we are talking about embedding a care-planning process that involves service users, their carers and all of the agencies involved, that we will see continued improvement in its application over time. Systems have been established by all trusts. They have CPA systems in place with their local authorities now. People who were on care plans under the old regime are being brought onto CPA, and people have been prioritising those on enhanced CPA where they have complex needs. A multi-disciplinary approach is being applied, and those people are being prioritised to come onto CPA. We will see CPA continue to embed and it will continue to be reviewed by organisations and will be underpinned, as time progresses, by an IT system that makes it much more effective, much more efficient and much easier to audit in the future.

[217] **Alun Cairns:** I am grateful for your answer, and I have no doubt that the CPA will continue to evolve to ensure improved care as resources allow and as skills improve. I have no doubt about that. However, paragraph 2.6, Mrs Lloyd, is specific in that it says

[218] 'with a target for full implementation by December 2004.'

[219] Is it part of the culture within the NHS that we set a target and say that as long as the structure is set up or a little progress is made, then that is okay? Is that what has happened in this instance?

[220] **Ms Lloyd:** No, I do not think that that is acceptable at all. The target was that the CPA should be in position by the December 2004 timescale. When we reviewed the progress made by the organisations in about September or October 2004, we found that some had already instituted the process. Some would get there by December and a couple of them—although I cannot remember which ones—would not get there until January or February. That was the process.

[221] As Mr Chick says, the important factor is the outcome of that process in terms of the type of care that can be delivered to patients. I do not find it acceptable that if we set targets, they are just ignored, which is why, as I said previously, for things like crisis resolution, the service has been reminded that this target is not an optional extra; it is not one of the continuous improvement targets that were set in the last two years, but it is one that must be achieved. They are required to ensure that the priorities of the Minister are implemented. This is one of them, as is the CPA.

[222] **Alun Cairns:** I am grateful for that robust answer, Mrs Lloyd. However, going back to your first answer about the assessment being mixed, I think that that is pretty kind, is it not?

[223] **Ms Lloyd:** We are not dealing with wholesale failure here. They do have CPA, which, in itself, was an achievement. We now have to adjudge the outcome of that process being there.

[224] **Alun Cairns:** I do not want to get bogged down in it but, looking forward, what progress has been made since the document was published in October 2005?

[225] **Ms Lloyd:** Since this has been published?

[226] **Alun Cairns:** Yes.

[227] **Ms Lloyd:** The number of patients that have been subject to the CPA, particularly the extended CPA which is a much more complex process, has improved enormously. More patients have been reviewed and more patients have been included more appropriately in care plans. As I said, Mr Chick is undertaking a review of the precise progress that has been made by each of the organisations concerned. He will be presenting that to the Minister, I think in May, as part of an update on where we have got with the national service framework and with his targets.

[228] **Alun Cairns:** Up until now, is there clear evidence that the implementation of the CPA is really making a difference to the care of those people who are most vulnerable?

[229] **Ms Lloyd:** I think that that is difficult. I have not seen the evidence yet. I do not know whether Mr Chick has seen sufficient evidence yet.

[230] **Mr Chick:** I think that we can reflect on the fact that service users who have been engaged in the CPA often report that they have valued the process of the CPA being introduced. What you are actually asking is: does everyone who has been assessed under the CPA value it? We could not possibly give you that answer. I can say that where we have had reflective responses from service-user groups, they are valuing the process of being engaged

in the care programme approach, and they are valuing having a care plan that is clear and in which they have been engaged in developing. Therefore, I would argue that that is an improvement and is the kind of improvement that you are asking for. However, it would be dishonest of me to give an absolute ‘yes’, because it is about asking service users and engaging with them on how that process has occurred. That is an issue that we need to consider in terms of our audit of CPA implementation.

[231] **Alun Cairns:** I am grateful for your frank answer, but paragraph 2.9 states quite clearly that there is more focus on the documentation. I can understand that drafting the plan, in the very early days, clearly means getting it on paper, agreeing it and having the process in place. Are you worried by that statement and that that is much of the interpretation?

[232] **Ms Lloyd:** This report’s evidence was collected in the implementation phase of the CPA, and I think that people were really concentrating on trying to get the process right and consistent, and then establishing to what extent the care programme could be met within the resources available. We are now asking them, as part of the evaluation, to look at the outcome of care and to look at the user and carer satisfaction elements of the outcome of care. I am afraid that it is too early for me to be able to present you with the evidence to support an argument either way.

4.00 p.m.

[233] However, that evidence is certainly being collected, and it will be evaluated, because it is fundamental. We know that, in England, when they established CPA, a number of research and evaluation projects were undertaken to assess the improvement in care, which is why the CPA process was tweaked, as Mr Chick has described. So, there is historic evidence now that CPA improves the outcome of care, and it certainly improves client and carer satisfaction, but we need to be able to prove that in Wales, too.

[234] **Mr Chick:** The only thing that I would like to add to that is that we have seen, in Wales, a number of initiatives, and what is really good is how service user groups and voluntary sector groups have embraced the care programme approach and have been assisting in its development. Hafal, a major voluntary sector mental health provider, has developed a CPA guide. We have supported it in developing that guide, and we have been very supportive in receiving it. Also, in Rhondda Cynon Taf, for instance, something called ‘The Only Way Is Up’ has been developed. This is a service-user programme to improve engagement in the CPA process. So, we have not just seen initiatives taking place in the statutory sector, but the voluntary sector and service-user groups are also getting on board with this as a means by which care can be planned, and that join-up between statutory sector, voluntary sector and service-user groups in Wales is really helping to strengthen the CPA as a process. Service users must engage in the process as well as those people who conduct the assessment process from within our statutory sector services.

[235] **Alun Cairns:** Thank you. The report also highlights that half the organisations have protocols in relation to the transition of children with mental illnesses to adult care. Why is it the case that only half have such protocols?

[236] **Ms Lloyd:** We were really concerned about some of the protocols that were not available in some of the organisations. As a result, we gave £50,000 to each trust in this current financial year to ensure that their protocols are brought up to date. So, by 31 March, all organisations must have in place protocols to deal with transition and other areas—I think that it says in 2.12 that protocols relating to non-compliance and missed contact is another of the protocols that simply must be put in place.

[237] **Alun Cairns:** That is clearly good practice, but was that part of the SAFF target as

well?

[238] **Ms Lloyd:** No, it was not.

[239] **Alun Cairns:** Thanks.

[240] **Ms Lloyd:** But we did highlight it as a gap.

[241] **Alun Cairns:** But was it part of the SAFF target originally?

[242] **Ms Lloyd:** No.

[243] **Alun Cairns:** No. Thanks.

[244] **Janet Davies:** Thank you, Alun. Leighton?

[245] **Leighton Andrews:** Paragraph 2.33 looks at the issue of dual diagnosis patients, which GPs have rated as one of their top-three priorities. What is currently happening to strengthen services for people who have drug and alcohol problems as well as mental illness?

[246] **Ms Lloyd:** We put out guidance and a protocol in, I think, November 2004 on the management of dual diagnosis. Mr Chick will be able to tell you precisely what that entails. However, again, this is a difficult area, and many of our patients have a dual diagnosis, and it was considered that, in terms of implementing an NSF, we needed to produce further guidance for the service on the management and the protocols surrounding people with a dual diagnosis.

[247] **Mr Chick:** In the substance misuse treatment framework, one of its components was this issue of co-occurring mental health and substance misuse. We have put out the treatment framework for co-occurring mental health and substance misuse, which includes a preferred model for mental health and substance misuse services. It reiterates the fact that, in the strategy, where a serious and enduring mental health problem exists, mental health is the lead agency, and it also sets out the requirement for services to develop training programmes around mental health and substance misuse services and around substance misuse in mental health services. It introduces a care pathway, which allows for everything from shared care arrangements between substance misuse and mental health, to encouraging consultancy, where that is required, from either of the services, so that people who do not require shared care can have direct consultancy. For example, you could have consultancy from a substance misuse service, if you have a patient in the mental health service with a problem that does not require dedicated substance misuse intervention, but for whom the advice and guidance of the substance misuse service would facilitate a better outcome.

[248] We also require, where there is a significant misuse problem, that it is identified in that person’s care plan whose role and responsibility it is to develop those elements. In support of that work, and in support of the development of local protocols and the implementation of those protocols, resources are being given to the service and a programme is rolling out across Wales of engaging key elements of the substance misuse and mental health services under the trust areas where substance misuse services are provided, with all the relevant stakeholders within them, to make sure that this treatment framework is embedded in practice.

[249] **Leighton Andrews:** Okay. I can see how that could work in areas where the substance misuse frameworks are working, but the report points to a lack of facilities and specialist staff across Wales. You say that it is ‘rolling out’, how far—

[250] **Mr Chick:** What is rolling out is a programme to engage the staff who work in the specialist services to work together. When we looked at this, and engaged a group of clinicians from within mental health and substance misuse services in primary care, and looked at the outcome of the work that was undertaken in the National Public Health Service for Wales, there was a strong sense that we did not want a hybrid service for people with a co-occurring mental health and substance misuse problem. The evidence was that a collaborative approach between specialist mental health and specialist substance misuse services was the best way to deliver an integrated approach to people with a co-occurring problem. That was the outcome of that consultation, and that is the substance of the framework that was produced. We have undertaken this work and are progressing that. There has been a significant development of specialist substance misuse services in recent years, and, in this treatment framework, we are seeking to bring together those two specialist areas so that they work more effectively together to deliver the sorts of outcomes that we require. We know that this is a major issue in mental health services.

[251] **Leighton Andrews:** There are specific problems identified in paragraph 2.33: a lack of agreed protocols; a lack of clarity and resources and appropriate services; problems with the availability of services in some areas of Wales; and a lack of knowledge and training among staff.

[252] **Mr Chick:** All of those are addressed in the treatment framework as being required to be developed.

[253] **Leighton Andrews:** They are being addressed in the framework. Therefore, what you are saying to me is that you have a framework; you are not saying that the problem is being addressed yet. You are saying that the need for the problem to be addressed has been identified and put into a framework. Do you have a timescale for when you think that things will improve, or what?

[254] **Mr Chick:** What I am saying is that there is a framework, and we felt, for the very reasons that you have raised, that it was not sufficient to simply put out a framework and say, ‘This is what you should do’. What we have done is put a framework out there and provided input from, I believe, the Welsh Institute for Health and Social Care, to go out and work with the service across Wales to develop protocols and to ensure that they are embedded into practice. So, it has not just been about giving people a document; there has been a programme along with that to bring together the substance misuse and mental health services so that they embed that into their practice. That is the important element that was followed up with a roll-out of this programme. It has been a three-fold programme, looking at the arrangements prior to this work being undertaken and the development of a protocol, and then there is to be a follow-up, so that people go back and look at how it has impacted on practice in those areas.

[255] **Leighton Andrews:** When is the follow-up?

[256] **Mr Chick:** There is not a date for the follow-up in Wales. What has happened is that, as the programme goes out, people have been doing the stocktake, then the work. They were going back several months after the first two sessions so, as it rolls out across the different trust areas that deliver substance misuse services, the follow up is—I think, off the top of my head—three months after the first two phases. So, it is a rolling programme that will run out across Wales.

4.10 p.m.

[257] **Leighton Andrews:** Are you satisfied with the outcome of the follow up?

[258] **Mr Chick:** At this stage, I think that it is too soon to tell. We will be working with

the Assembly's Community Safety Unit, because it has been facilitating this programme on the substance misuse side, to ask it to look at the outcomes that it has seen. It is a programme that has been significantly commissioned and the follow-up, therefore, is something on which we will be working very closely with it to look at ensuring that it has the desired outcome. However, it is too soon to tell at this stage.

[259] **Catherine Thomas:** I would like to ask quite a lot of things, but, because of time constraints, I think that the Chair would appreciate it if I was as brief as possible. In paragraphs 3.17 to 3.21, we are looking at the extent to which users and carers are involved in assessing and planning services. Can you tell us why you think there is such variation across Wales in the extent to which service users and carers are involved in planning and shaping services? I also draw your attention to paragraph 3.19, where we see that there is major concern that some areas are yet to formally gather the views of users and carers on their satisfaction with services and their priorities for future development. Paragraph 3.18 makes it very clear that the involvement of carers and users is very important at all levels of planning if services are to succeed.

[260] **Ms Lloyd:** There have been improvements since this baseline research was undertaken, in that all the organisations and all the trusts now have user groups and carer groups particularly because, often, the carers have been marginalised in the past. As part of the resource given to the service for protocols, one area that was highlighted was that they simply must have proper protocols and proper established networks for ensuring that users and carers are appropriately included in the planning and design of services. Certainly, many of the trusts had already set up user groups, where they would sort through the issues of how to enable users to participate in such groups, and what sort of protocols they could use to ensure the active engagement of users and their carers. However, this is again one of the areas in which you must constantly strive for an improvement. The more we can engage users and carers in the planning and design of services, the better. We will be, particularly in the capital investment board, testing the organisations that have come forward with their proposals on the extent to which users and carers have been engaged and involved. It is really important because, for so long, users and carers were marginalised, and it is down to us to ensure, at a local level, that people are more actively engaged and have an active say, which is acted upon, on the type of service that they wish to have.

[261] **Catherine Thomas:** How do you measure that improvement? I was also concerned to read paragraph 3.14, which indicates that not all service users with a serious mental illness had received an up-to-date care plan. How do you measure that? It is not acceptable that individuals with acute problems find themselves in that situation.

[262] **Mr Chick:** There are two elements to this. One thing that I would like to mention here, because it is important and it has been extremely well received by service users and carers, is the 'Stronger in Partnership' guidance that was issued. That was policy guidance that went out from the Assembly reiterating the need, as you said, for service users to be involved at all levels, from strategic planning right down to the engagement in their own care plan. What went out as part of that document, and something that was particularly valued by the service, was a self-assessment checklist, which asked and stipulated different elements of the engagement of service users. In order to answer the questions of 'How much improvement has there been?' and 'How well engaged are service users and carers?', there needs to be a fundamental audit of those processes.

[263] That is why, in the action plan for 2006-07, we are requiring a formal audit to be undertaken of the compliance with the 'Stronger in Partnership' guidance that has been issued. The only way in which we will get robust evidence on improvements in service user and carer engagement is by the local mental health strategic planning groups asking the fundamental question, 'How well are we doing?'. For that matter, our national

implementation advisory group needs to ask the same questions, as well as ask service users how well they feel engaged against the criteria set out in that checklist, which was developed with service users by the Welsh Assembly Government. So, on user engagement, we need to undertake that formal audit process. That will need each local mental health strategic planning group to take that action.

[264] On the other issue of how well our service users are involved in their care planning, that goes back to the review that we are undertaking of the care programme approach, and looking at how well service users have been involved in undertaking the plans and having the plans shared with them, because a fundamental part of the care programme approach is user engagement in that process and the engagement of their carers.

[265] **Catherine Thomas:** Linked to that, do you feel that there is sufficient training for health and social care staff to ensure that users and carers are enabled? How would you monitor that in terms of the training of staff to ensure that they are equipped to do what we want them to do, and what they should do?

[266] **Mr Chick:** As a social worker by trade, I can speak from experience and say that it is embedded in social work training. Enablement and engaging clients in their own care is fundamental to the training. The approved social work course fundamentally underpins service-user engagement and anti-oppressive practice as a required competency. Nursing, equally, is about engaging service users in their own care. However, I am also aware that we are all human, and how we integrate that into our practice is variable. We have to encourage this culture shift towards enablement and recovery, which is what has been coming through in mental health services for the last few years—moving away from a paternalistic model of care where we seek to work with people, almost in a 'doing for' way, towards a recovery-biased model of care.

[267] We have talked about the Tidal model and the recovery model in in-patient settings, but the application of that methodology across the service is vital. You are right that we need to ensure that all professions continue to look at their training programmes to ensure that those principles of recovery and enablement are fundamental to their care. However, in my own experience, as well as to the background to nursing, social work and psychology training, that is fundamental to those models of care.

[268] **Janet Davies:** I will now draw this session to a close. Thank you for your answers, Mrs Lloyd and Mr Chick. I can confirm that you will receive a draft transcript of the meeting. It has been an interesting session. ** WE WENT OUT HERE – WE WERE NOT PARTY TO INTEREST OF THIS SESSION AND THIS SHOULD BE MADE CLEAR **

[269] Just before we move to the other items on our agenda, I wonder whether Members would like a session on this report from the other end—what we call a double-headed session—where we could invite trusts and local health bodies, and possibly local government here. Would you be interested in that? If you are, I will ask the auditor general how feasible that would be, but I would first like to know from Members whether they would wish to do that.

4.20 p.m.

[270] It can be illuminating, but it would also push the whole timetable back a meeting. I see that the answer is 'no'. Jeremy, do you have any advice on this?

[271] **Mr Colman:** No, Chair. I am very happy to be guided by the committee. If Members had wanted another session, it could have been accommodated without displacing other meetings too much, but there is not much enthusiasm for it.

[272] **Alun Cairns:** If the Auditor General has a strong view that we maybe should look at it from the other angle because of experience and advice from his staff, then that is fine. Otherwise, although I cannot speak on behalf of everyone else, I am pretty satisfied with the quality of today's investigation.

[273] **Janet Davies:** We should note that I believe that the Health and Social Services Committee will also look at this, clearly from a different, more political, point of view, but there is also that to consider.

4.21 p.m.