



Cynulliad
Cenedlaethol
Cymru

National
Assembly for
Wales

Cofnod y Trafodion The Record of Proceedings

[Y Pwyllgor Plant, Pobl Ifanc ac Addysg](#)

[The Children, Young People and Education
Committee](#)

18/01/2017

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Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynnddi yn y pwyllgor. Yn ogystal, cynhwysir trawsgrifiad o'r cyfieithu ar y pryd. Lle y mae cyfranwyr wedi darparu cywiriadau i'w tystiolaeth, nodir y rheini yn y trawsgrifiad.

The proceedings are reported in the language in which they were spoken in the committee. In addition, a transcription of the simultaneous interpretation is included. Where contributors have supplied corrections to their evidence, these are noted in the transcript.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Michelle Brown Bywgraffiad Biography	UKIP Cymru UKIP Wales
Angela Burns Bywgraffiad Biography	Ceidwadwyr Cymreig (yn dirprwyo ar ran Mohammad Asghar) Welsh Conservatives (substitute for Mohammad Asghar)
Hefin David Bywgraffiad Biography	Llafur Labour
John Griffiths Bywgraffiad Biography	Llafur Labour
Llyr Gruffydd Bywgraffiad Biography	Plaid Cymru The Party of Wales
Darren Millar Bywgraffiad Biography	Ceidwadwyr Cymreig Welsh Conservatives
Julie Morgan Bywgraffiad Biography	Llafur Labour
Lynne Neagle Bywgraffiad Biography	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)

Eraill yn bresennol
Others in attendance

Dr Frank Atherton	Prif Swyddog Meddygol Cymru Chief Medical Officer for Wales
Angie Contestabile	Swyddog Polisi ac Ymgyrchoedd, Sense Cymru Policy and Campaigns Officer, Sense Cymru
Rebecca Evans	Aelod Cynulliad (Llafur), Gweinidog Iechyd y Cyhoedd a Gwasanaethau Cymdeithasol Assembly Member (Labour), Minister for Social Services & Public Health
Vaughan Gething	Aelod Cynulliad (Llafur), Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon Assembly Member, (Labour), Cabinet Secretary for Health, Well-being & Sport
Albert Heaney	Cyfarwyddwr Gwasanaethau Cymdeithasol ac Integreiddio, Llywodraeth Cymru Director of Social Services and Integration, Welsh Government

Denise Inger	Prif Weithredwr, SNAP Cymru Chief Executive Officer, SNAP Cymru
Zoe Richards	Rheolwr Pobl Ifanc a Gofalwyr, Anabledd Dysgu Cymru Young Person and Carer's Manager, Learning Disability Wales
Tim Ruscoe	Swyddog Materion Cyhoeddus Cymru, Barnardo's Cymru Public Affairs Officer Wales, Barnardo's Cymru
Debbie Thomas	Swyddog Polisi ac Ymgyrchoedd, Y Gymdeithas Genedlaethol i Blant Byddar Policy and Campaigns Officer, National Deaf Children's Society
Dr Sarah Watkins	Dirprwy Gyfarwyddwr, Iechyd Meddwl, Grwpiau Agored i Niwed a Throseddwyr, Llywodraeth Cymru Deputy Director for Mental Health, Vulnerable Groups and Offenders, Welsh Government

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

Jon Antoniazzi	Clerc Clerk
Sarah Bartlett	Dirprwy Glerc Deputy Clerk
Michael Dauncey	Y Gwasanaeth Ymchwil Research Service
Sarah Hatherley	Y Gwasanaeth Ymchwil Research Service
Gareth Rogers	Ail Glerc Second Clerk

Dechreuodd y cyfarfod am 09:30.

The meeting began at 09:30.

Cyflwyniad, Ymddiheuriadau, Dirprwyon a Datgan Buddiannau
Introductions, Apologies, Substitutions and Declarations of Interest

[1] **Lynne Neagle:** Morning, everyone. Can I welcome you all to this morning's meeting of the Children, Young People and Education Committee? We've received apologies for absence from Mohammad Asghar, and I'm

delighted to welcome Angela Burns this morning who is going to be substituting for him. Are there any declarations of interest any Members would like to make? No. Okay.

**Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon a Gweinidog
Iechyd y Cyhoedd a Gwasanaethau Cymdeithasol:
Sesiwn Graffu Gyffredinol
Cabinet Secretary for Health, Well-being and Sport and the Minister for
Social Services and Public Health:General Scrutiny Session**

[2] **Lynne Neagle:** Item 2 this morning, then, is a general scrutiny session with the Cabinet Secretary for Health, Well-being and Sport and the Minister for Social Services and Public Health. I'm delighted to welcome Vaughan Gething and Rebecca Evans to our meeting this morning. Can I just ask you to introduce your officials for the record, please?

[3] **The Cabinet Secretary for Health, Well-being and Sport (Vaughan Gething):** Yes, shall we go along—

[4] **Dr Atherton:** Dr Frank Atherton. I'm the chief medical officer.

[5] **Dr Watkins:** I'm Dr Sarah Watkins, head of mental health and vulnerable groups, and working with—.

[6] **Mr Heaney:** Good morning. I'm Albert Heaney, director of social services and integration.

[7] **Lynne Neagle:** Okay, lovely; thank you and welcome to the officials as well. Thank you for coming. We'll go straight into questions, then, and the first questions are on the Additional Learning Needs and Education Tribunal (Wales) Bill, and I've got Llyr first.

[8] **Llyr Gruffydd:** Thank you. Good morning. Clearly, we scrutinised the Minister with responsibility for the Bill last week, and one of the areas, as you can imagine, that's been highlighted to us by a number of stakeholders, and no doubt one that we'll deliberate quite extensively on, is the nature of the duty on health boards in relation to playing their part in identifying and meeting the needs of children with additional learning needs. It goes without saying, I'd imagine, that you had an involvement in looking at section 18 of the Bill—the relevant section in terms of the duty of health boards. I'm just

wondering, really, whether you feel that the provision within that particular section of the Bill generally is sufficient to ensure the meaningful and full co-operation and involvement of health boards in providing the service that we all want to see.

[9] **Vaughan Gething:** Yes, I think the wording is undeniably stronger and clearer than in the previous Bill, and I know that that was one of the particular sticking points and real concerns that stakeholders, both in this place and outside, had. So, I think the Bill is much clearer and it's really clear that there is a duty for the health service to actually meet the need that is identified. And that's what I think we would expect to see.

[10] The one additional thing I'd say, though, is, in addition to the duty and what's there, a large part of the challenge is the practical working relationships that exist in any event around the family, the educational institution, and also what services do exist within health or other care services as well, because I'm sure you will know from your own engagement as a Member that, when these challenges do arise, it is often about the practical working relationships, whether they do or don't work, and whether people talk to each other. So, the new designated education clinical lead officer role that has been created is about trying to make sure there is a key point of contact so that, actually, you can try and make sure that the duty has meaning, as well as strengthening the duty to make sure it will actually have a decent shot at being implemented. And that's the point—to make sure there is a better service and better provision to meet the needs of the child within their own circumstances.

[11] **Llyr Gruffydd:** And are you confident, therefore, that the resources are there in order for the health boards to meet their duties and requirements under the proposed Bill?

[12] **Vaughan Gething:** Yes, we expect health boards to be able to meet their duties under the Bill, assuming this place enacts it. And I think it'd be helpful to have learning from the two pilots that are ongoing and I know the Minister will have outlined to you in his scrutiny with you last week.

[13] **Llyr Gruffydd:** One concern that's been raised with me, and it may be a cynical take on the situation—

[14] **Vaughan Gething:** Surely not.

[15] **Llyr Gruffydd:** Surely not, yes, you're right, but sometimes there are unintended consequences, shall we say. We've seen in England, for example, a reduction in the number of statements over recent years. One of the drivers for that, it's been suggested, is because of the financial climate and, clearly, costs are not being sought, so people are clearly rowing back maybe from some of the responsibilities or expectations put upon them to deliver certain services. Now, in relation to the duty on health boards, clearly, they have a duty to meet the needs identified in the individual development plans but, of course, they also have to approve the contents of those plans. Is there a risk that, in order maybe to avoid some of those additional burdens, that health boards might not be so forthcoming in approving some of the provision required in those plans?

[16] **Vaughan Gething:** I really wouldn't expect that to happen because those individual health professionals have responsibilities, not just as employees of the health service, but their own professional responsibilities and what you'd expect them to do for citizens they have responsibility to care for as well. I think the difficulty is that if we say we're not prepared to trust health professionals to do their job and they will cynically go away and say, 'I will ignore the need for this child because I can see a budget saving to be made'—well, if people really take that view, I don't think there's anything that we could say to persuade them. We either trust health professionals to meet the duties they have, not just in legislation, but their own professional duties to properly care for and meet the needs of whoever the person is, whether a child or an adult, or not. What I think is helpful is the clarity in the duty, the clarity in the requirement to meet the needs that are identified, and we do then need to do perhaps that bigger and more important part about making sure that the duties are real and lead to an improved working relationship that delivers a better service, because we do know that this isn't a perfect situation. If it was, we wouldn't have the Bill with the strengthened duty being created, with a new particular role to make sure there is a key point of contact within health boards to try and make that duty real.

[17] **Llyr Gruffydd:** I agree wholeheartedly with the points you make, although the reality in England is that we are seeing a reduction in the number of statements, and we will be moving in Wales from a position where we have around 30,000 statements at the moment to a hundred and something thousand IDPs. So, you can see that there may be a risk in that sense, but I concur with what you're saying, which is that, surely, we have to trust the professionals. But evidence from England suggest that there are other factors that are playing a part.

[18] Can I then just move on to asking a question around meeting the healthcare needs of children in schools, for example, because we know, again, that the situation is different in England, where there is a requirement to meet medical needs in schools, as opposed to additional learning needs? The Minister last week suggested that he was open to discussion around the potential of extending the Bill in that direction. Would you have a view?

[19] **Vaughan Gething:** I think the point is that the Minister also indicated , I think, that there would be revised guidance coming out, and would want to hear and see what all stakeholders thought of the revised guidance before committing. And I think the point is not to definitively say, 'No, absolutely not; we're not interested in what other people have to say'. There's either a real consultation or conversation about how we better meet people's needs or not. And, in any event, again, health professionals have responsibility to meet those needs. There's a lot of interplay between education and health, about how those medical needs are met in any event that aren't necessarily learning needs, to understand that these are different aspects. But, I too am interested in seeing the guidance when it's produced and seeing what the response is, about whether what I hope will be the strengthening of, and clarity about, how those needs will be met will be sufficient to persuade people that we don't need another statutory duty. All of us know that the main levers we have are how we use money and changing the law, and this admonishing and praise from politicians can be helpful to a degree but, actually, the law and money are perhaps our biggest levers to see change.

[20] But part of the challenge with changing the law is that it can be a blunt instrument sometimes, so we'd want to try and understand, with that guidance, whether that will provide the assurance that I think some people are understandably looking for, but actually the right tools to be able to deliver, again, the right sort of service around that child and their family and the needs they have, whether they're in school or not.

[21] **Llyr Gruffydd:** So, you do recognise that there is an issue.

[22] **Vaughan Gething:** I recognise that there is a debate and there's been a fairly determined campaign by some groups with an interest, and that's completely fair—that's part of the deal of having a generally open society. But when we had the consultation on the draft Bill, my understanding is that this wasn't a significant issue raised in responses to the Bill, but, as I say, the Minister is right in saying that we don't have a closed mind to this. But I think

it is important, as the Minister said, to make sure that we understand and properly listen to the response to that revised draft guidance that he'll be publishing in the near future.

[23] **Lynne Neagle:** Thank you. Hefin, did you want to come in on this?

[24] **Hefin David:** Yes. Llyr's taken us in that direction with regard to the provision of health. I had a meeting with the management team of Trinity Fields School and Resource Centre in my constituency, which provides specialist facilities for pupils aged three to 19 with a wide range of learning difficulties. Albert Heaney, in his previous role, will be familiar with that school. The concerns they raise, in addition to the concerns that Llyr has raised, is that, post 19, their involvement will cease, but the Bill has a duty to the age of 25. And I asked that specific question with regard to health services to the Minister, and he committed additional resources for 19 to 25 and indicated that that's necessary. Can you comment on that and expand upon the needs of 19 to 25, where schools like Trinity Fields would have a lesser role?

[25] **Vaughan Gething:** Those pupils that still have healthcare needs will still have not just a requirement for the health service, but an entitlement to the relevant services to deal with their healthcare need. So, I'm trying to understand what particular point you're making, because if you're talking about whether those pupils go on into higher education and still have needs, again, I'd expect the service to be there. From my own point of view, I had healthcare needs when I was in higher education. It meant that I stopped and restarted my course of study, and I had particular needs. On my path through getting my degree, I had to have additional provision made because of that particular need that existed at the time. That's a normal part of what should happen in any event.

[26] **Hefin David:** So, I suppose I'm asking you to express your confidence, then, that a school like Trinity Fields would offer three to 19, and a great deal of partnership working with health boards would be built up in that time, and you're confident that then, when those pupils that wish to go on further from 19, they will have adequate support.

[27] **Vaughan Gething:** Yes, they absolutely should do. There are always key challenges and transition points—the transition point between different points in education, the transition point from children to adult services within healthcare, but then as people move as well. So, if someone goes to a

different setting and go to a different place to live, there are those challenges too. But I would still expect the service, in its broadest sense—both health, education and care services around them—to properly and appropriately meet the needs of that individual, and I would have confidence that that should be the case in every part of Wales. If it doesn't prove to be the case, then, again, I'd be interested in hearing how the services cope with that and, if not, then what we do about remedying it. Often, those are individual instances rather than, if you like, a systematic problem. But I think I can say that I've got confidence that it should be the case that people will receive the right service wherever they are.

[28] **Hefin David:** Okay.

[29] **Lynne Neagle:** Angela.

[30] **Angela Burns:** Thank you very much, Chair. It's actually slightly building on Hefin's point: would you also say that that would run true, do you think, for people with additional learning needs and vulnerable people going into apprenticeships as well, because the Bill's slightly light on that element? A lot of the concentration is on early years and the primary and the secondary, but, of course, this is to 25 years old. And we've got some people with severe additional learning needs who might, at 22, 23, be able to take some form of employment or some form of apprenticeship. Are you confident that the health system and the social services system will be able to still back them up under the guise of this Bill if required? We accept that you cannot, obviously, legislate for absolutely every contingency, but I just want to make sure that those who are not going into education but are moving slightly into apprenticeship—which, of course, is a form of education—would still receive that kind of support?

[31] **Vaughan Gething:** Yes, for that sort of workplace learning and advanced learning, I'd still expect that the health and care needs would be appropriately met by the services we have. And, of course, this interplays with the duties of the host in terms of making reasonable adjustments for that person, if they're required, to enable that person to actually undertake a course of study or an apprenticeship, or to undertake, if you like, straight employment as opposed to the particular type of apprenticeships that we would want people to still have access to. So, I see no reason why that should not be the case. We have a high-quality, committed workforce who should be able to meet the needs of those people and, as I say, where there are individual instances and where there are challenges and problems, even now,

regardless of into the future, I would expect people to be able to raise them, I'd expect them to be supported and, if not, people in this room have access to the ability to try and help them. But I still expect the usual standard, regular experience to be that people have their needs appropriately met.

[32] **Angela Burns:** Okay. My other question on this, actually, Cabinet Secretary, is just a moment of clarification. You refer in your paper that a health body will refer to local authorities any pre-school age child they believe may have ALN, if the health body is satisfied that doing so would be in the best interests of the child. Of course, that's a great sentiment that we all would cleave to. Could you just give us an example of when you think it might not—. I'm struggling to understand when it might not be in the best interests of a child to get some form of intervention if there's an additional learning need.

[33] **Dr Watkins:** I suppose the tension is that it has to be a health need. So, I think that the issue for the health service is that some things might be perceived by other professionals as a health need whereas, actually, the intervention might be more in parenting skills or other areas. So, health should meet the health needs, and I think there wouldn't be any pullback from that. But the tension may be that, actually, sometimes, the need is identified by somebody who doesn't have that expertise and understanding of where there are evidence-based interventions that will make a difference.

09:45

[34] **Vaughan Gething:** I think this goes back to the point about partnership and understanding that it isn't simply saying, 'I don't want to deal with this'. But it is about, 'Well, here's what the evidence says, and look at this person as a whole'. A more appropriate intervention may not be in the service but it might have a medical aspect to it. It's really about looking at the whole person and how you help them. That's why I go back to working through the duties in law, and then, in practice, how you actually meet the needs of the child in their whole context.

[35] **Angela Burns:** I can understand that from a clinical excellence point of view. I totally get it. But, of course, one of the drivers of this Bill is to resolve areas of conflict that arise between parent and provider, between the services, and also between education, health and social services. There are lots of areas of conflict. We all have case loads that groan with that kind of thing. So, firstly, I just wanted to put a little bit of meat on that particular

bone, because, whilst I accept totally your argument, do we need then to look, or do you believe that the Bill actually gives the follow through that says, 'Oh, by the way, if you think it's health, but health don't think it's health, where do they go then?' Because what we're trying to do is iron out those areas of conflict so that the parent in particular, or the carer, has a very clear pathway of where they may go, because, at the moment, they are always hitting so many cul de sacs. So, I'd just like your view on that.

[36] **Vaughan Gething:** I think part of the challenge here is that I don't think you can legislate out some of those particular challenges. That's the point about how a whole team of people to look after the health and care needs of that child within their whole context have to be able to talk to each other, and to the parent as well, and to the child. I accept that part of the difficulty, if everyone says, 'It's not my problem. It's not my responsibility', is that you potentially have the child and the family saying, 'Well, actually, everyone says we've got a need for some support, but no-one's prepared to do it'. That's part of the point about trying to understand this whole thing of having a more integrated service, and having teams that go across particular organisational boundaries. That's part of going back to a whole scheme of Government progress, from the Social Services and Well-being (Wales) Act 2014 to where we are now with this Bill and the way in which the duties have changed. We recognise that, actually, if you don't have a genuine attempt to work across the different parts of Government, then you're likely to see people fall through. So, I couldn't tell you, and I couldn't say, 'I can guarantee that this new piece of legislation will mean there won't be some of those challenges'. There will be, inevitably, and there are some times when parents and service providers just don't agree, and often they're the most difficult things. I know that you'll probably have instances where you have a constituent telling you, 'This is outrageous—this school, and the health service aren't helping me', and you may get a response that says, 'Well, it isn't quite like that. We just disagree about what the right way through is'.

[37] Now, you can't legislate those out. What we can do, though, is to make sure that we have the best prospect of those whole teams working properly together and working with a child and their family. That's what we're really trying to do, and to make sure that the law enables that and that the duties are pointed in that direction to make clear how we want people to work. And actually, fundamentally, most professionals want to work in that way as well. The resistance is very rarely the front-line staff, as you'll know.

[38] **Angela Burns:** So, my last question, very quickly, then, on that, would

be: every team needs a leader, so would that team leader always be the designated education clinical lead officer, or does the team leader actually sit within education, and the DECLO comes in, and then if the DECLO says, 'No, this isn't a health intervention requirement', they'd step out? Because what I want to make sure of is that whoever is the team leader always stays as the leader of that team. So, if the default is that it's always going to be education, then that team leader has to be education, surely.

[39] **Vaughan Gething:** I don't think the scheme is that the DECLO will always be the leader of the team. Sometimes that will surely vary around the child, and the needs that exist, and seeing the whole child and what their needs are. I think the point is that you need the involvement and engagement of all the different services, but from the individual's point of view, I think there's got to be clarity about who's taking a lead, and who they can go to and speak to. But I don't think that then means there must always be a scheme where you have one particular officer from whatever sector saying, 'I will be the lead for however this particular assessment works', because you need to understand the individual needs that will present in that case.

[40] **Llyr Gruffydd:** Sorry—how many DECLOs are there going to be? Was it just one strategic lead per health board?

[41] **Vaughan Gething:** Yes.

[42] **Llyr Gruffydd:** So, getting involved is going to be very difficult for that individual because that will mean getting involved with potentially tens of thousands of children and young people.

[43] **Vaughan Gething:** Well, the point is about making sure that there is a proper strategic lead—someone with an oversight. So, it could be a different health professional involved in each case—whether it's for speech and language needs, whether it's about—. Just as an example, where we know that there are needs that affect a child's ability to learn, potentially, you might not have any other health need identified that affects their ability to learn, and that might not be the biggest learning need that exists, but, equally, it may be the prime one, and so that's why some of the challenge exists about who should be the strategic—. When it's about the operational delivery of a service and support around that child, it will vary as to who is the lead person taking control of that and having responsibility, which I think is appropriate.

[44] **Angela Burns:** Yes, and I totally take Llyr's point and I accept the point you make that it's just ensuring—you always need one person, whoever that person might be, who has got enough stripes to be able to pull together all of those different teams. And that's what parents say: that they can't find the person with the stripes, and so they're off having to chase up all the different people who they need to have as part of their child's health and learning care.

[45] **Vaughan Gething:** Well, that's part of changing where we are and having revised duties. It should make it clearer. And some of this is to make sure that people can't say, 'This isn't my responsibility'. It's about what your share of responsibility is.

[46] **Lynne Neagle:** Okay. We'll move on, now, then to mental health. I know we've got quite a few questions on that, given the committee's interest in child and adolescent mental health services. If I can just start with a general question. We're two years, now, into the Together for Children and Young People programme, but we're still seeing a lot of children waiting longer than they should be, albeit against the backdrop of increasing referrals. How confident are you that, by the time we reach the end of these three years, we are going to see the step change that we want to see, and is it your intention to keep this programme going?

[47] **Vaughan Gething:** There are two different points in the question, the first about whether, by the end of the three-year programmes—we've got about a year left of the Together for Children and Young People programme—we'll have seen the step change. I think we can have some confidence in that, because of the progress that is being made, albeit we'll know much more over the next calendar year—whether we really are seeing the step change delivered. And the challenge for me will be not just whether we get to various points in 2017 where we can say the situation is continuing to improve, but how much confidence we can all have—myself and officials here included—that the change is sustainable and of a sufficient nature to give us the confidence that children with real needs are being provided with the right sort of support and service.

[48] I start pretty much from where we were in the last committee meeting, Chair, which is that we have made real progress. You're right; there are more people still being referred into the service. We still think a significant number of those referrals are inappropriate. But we are actually seeing people more

quickly. We're starting to eat into the waiting times that people have for their assessment, but there are still too many people waiting too long. Some of that is about the number of staff that we now have in, which is why we are making progress, following the significant investment that my predecessor announced. That's having a real impact. But I think what would give us the confidence is whether we have the full staff complement in place; where there are parts that are difficult to recruit to, whether we're able to provide staff that mean that a proper service is still being provided, even if we need to tweak the model that exists to make sure that they are properly supported and seen; and whether, as I said, we can have confidence that that is being sustained properly.

[49] That leads into your second point, Chair, which is: will the programme continue? Well, I think to answer that, we need to review and understand how successful the programme has been and whether we consider the programme has been successful but we still haven't dealt with all of the things we would want to do to deliver that sustainable change. So, do we continue the programme or do we say, 'Actually, we think that there's a different way to do this that would be more helpful'? And I couldn't really give you a straight and honest answer to that until further into this year when we've got more evidence about the nature of the change that is being delivered. But, in all of this, as we sit here and now, for all the progress that really has been made over the last year—and it's pretty significant—there is still much more to do, and I wouldn't try to look you or any other Member in the eye and say that everything is fine now, because it isn't, because we know we still need to do more.

[50] **Lynne Neagle:** Okay. Thank you. And one of the issues the committee has had is with the transparency of the data. I know that you're looking at publishing the referral-to-assessment times for each health board; can you actually tell us when that is likely now to be routinely published in the public domain? But also, there is an issue then with the time that young people are waiting between assessment and treatment. I think it would be useful if that was also published, as it is for adults. Are you able to give us your views on that?

[51] **Vaughan Gething:** The information is published on the StatsWales website on a regular basis. I guess the visibility of that in terms of making sure that people are aware about how regularly that goes up and what it contains—. And it does contain data by health boards. So, those data should be visible and we'll have to send a note about confirming how often those go

up and where they can be found. But with the challenge about referral to assessment or referral to treatment, part of the challenge in this service is that it isn't quite as simple as having the referral to assessment and then you agree in the first appointment what the definitive treatment is. Sometimes, you need to see a child more than once and part of the intervention or the process can start through those initial assessment appointments as well, and it would depend on the needs of the child. So, part of our challenge, in publishing useful information about referral to treatment, is that we'd have to separate out and indicate at what point we think that treatment is starting.

[52] The difficulty with that would be having different definitions going with each child and their need. I'm not sure that that in itself would be a hugely helpful exercise in the way that we use our data, but I recognise that there's something about providing assurance that there are aren't significant gaps that are taking place between the assessment and treatment actually starting. But I'm not sure that we'll be able to create a referral-to-treatment architecture that would be a good use of our resources. But it is something that is in my mind in terms of how we do provide the scrutiny that we'll understandably have and the desire for assurance that people understandably have as well—that people aren't being seen and then going into another long wait to then have their needs actually met. Sarah, we had this conversation earlier, so it might be helpful to give some practical examples of what that might mean in terms of the different needs and how they might be met—to give a practical example of that challenge about how you could have a referral to treatment or not.

[53] **Dr Watkins:** When a child is seen in the service, they'll have varying needs. So, they may be acutely ill; they may be suicidal or they may have a psychotic illness. They would actually need immediate treatment and would go into that pathway at once. Many other children, within CAMHS, are seen, but the first assessment will be undertaken quite sympathetically. It's lengthy—it's normally an hour. Some therapeutic intervention will take place then. They would then, if they needed therapy, have their next appointment when they would start that work. It isn't like an orthopaedic process, where you're seen and then you're on a waiting list for an intervention. So, the length of time will depend very much on the need of that child.

[54] We were also mentioning the example that Gwent gave us—that a third of their children were seen and assessed and had one further appointment, with high satisfaction rates. That was the intervention. So, it is difficult, because if you averaged the 24 hours that you might need for a

child who was suicidal with the month or six weeks when most children would then have their follow-up appointment and start that further exploratory work or therapeutic intervention, you'd come out with two or three weeks, but that wouldn't mean very much for either child. It is the same measure with adults. We do measure the time to assessment rather than to intervention, because you need the right treatment for that individual at that point.

[55] **Vaughan Gething:** If we try to, say, count something different like the time to a second appointment, well, again, you'd still have the same issue with accounting activity, which again probably isn't the most useful thing to do, as opposed to understanding how soon someone is seen to have a proper assessment and then how that need is properly dealt with. I'm keen to have measures that have real meaning and a genuine debate with those across the whole service. I think, on trying to introduce a referral-to-treatment architecture here, if we don't think that we can do it in a way that would tell people something useful, I'd much rather not do it. I'd happily—[Inaudible.]—the right thing to do. If we found a different way to do that, to provide a broader meaning, well, we can look at that again.

10:00

[56] **Lynne Neagle:** Thank you. Darren, then Llyr, on this.

[57] **Darren Millar:** Just on this specifically, and I've got some other questions later on, if that's okay. Can you explain to me, if someone's referred, they're assessed, and they receive some sort of therapeutic intervention, presumably, that immediately triggers the referral-to-treatment activity, yes? So, when you've got people who are waiting in excess of 18 weeks, that implies that they have been referred and not assessed. Sarah, would I be correct in saying that?

[58] **Dr Watkins:** That is the position now, which is why we're moving to a 28-day expectation. That was the position and there are still too many children who have been in that position, but the service is clear and has accepted that we should—. As with adult mental health problems, there is still three levels. So, if a child needs an urgent emergency assessment, it's four hours; an urgent assessment is 48 hours; but if it is a routine assessment, we now have a clear target of 28 days, which we are working out very clear definitions for, because you need to make sure that, across LHBs, they're comparing similar cases, not doing it subtly differently so that, when

you get the data, it doesn't mean anything.

[59] **Darren Millar:** What concerns me here though is, obviously—it would be very interesting for the committee to know why certain individuals are deemed to be okay to leave for 18 weeks without even being assessed, because that's the implication of what you're telling us.

[60] **Vaughan Gething:** No, it isn't. We're talking about having 28 days as the standard expectation, to provide data on, to get to that first assessment. The people who are currently waiting longer than that—we accept they're waiting too long and that's why the investment has gone in, to try and make sure that isn't the case. That's the progress we are seeing. But, as I said at the start of this round of questions, too many children still wait too long, which is why there'll be more activity and, I accept, much more scrutiny until that position changes.

[61] **Darren Millar:** It would be interesting to me to see a note of how many of those waiting over 18 weeks for treatment have actually been assessed—and when they were assessed.

[62] **Dr Watkins:** They won't have been. They are referred by their GP and they will not have been seen until they are seen. That is why we've had to bring in a much tighter 28-day target. That's been the case for many years in adult mental health, that expectation. It wasn't the expectation—it was actually 16 weeks for a long time. That's why we've changed it with this programme.

[63] **Darren Millar:** But those data aren't routinely published or available.

[64] **Vaughan Gething:** They are; they're routinely published on StatsWales, and we'll provide a note to the committee about how and when that's published. But it is routinely published and that's why we've made the change. The time-to-assessment target and expectation is much shorter now, and rightly so, but getting ourselves to the point where the service is meeting that is why we've had the investment. On the Chair's initial question about 'When you will be satisfied that it's made the step change that we need it to with the programme, will the programme continue?', we need to understand, over the rest of this year, whether we actually get on top of the whole thing and don't have the numbers of children and young people who are waiting far too long, because this Government accepts that far too many children wait far too long to be seen.

[65] **Darren Millar:** I understand that. The point I'm making is that the impression you've given the committee today is that all of those children who are waiting in excess of 18 weeks are likely not to have been seen at all. We don't know what their condition is, whether it's worsening or what level of risk they may pose to themselves or others.

[66] **Vaughan Gething:** There are different things here, Darren. People who wait too long are waiting too long to get their CAMHS assessment—that's where we go into the challenges about who's referred it and how we deal with inappropriate referrals so that those who really do need to be seen have a better prospect of being seen. That's part of the whole picture. Those people who are waiting too long are waiting too long, but it does not mean that they're not having any form of support because they still have access to their normal primary care team. But, the challenge is how they get to the CAMHS assessment to properly access that part of the service. That's why we've changed the target and made it a more stringent one.

[67] **Darren Millar:** And just on the recruitment issue, if I can, one of the challenges that Carol Shillabeer identified as being a major concern was the ability to have a full complement of staff for these teams, to ensure that they have the capacity to be able to deal with the patient demands being placed upon them. One thing I was very concerned about was the fact that around half of the recruitment has taken place so far, and we are obviously quite late into the programme, to date. But in terms of the other half, when you look at the individual health board websites, there are very few posts actually being advertised for. Are you satisfied that the health boards are actually making sufficient effort to recruit those members of staff the services need? It doesn't appear that they're making much of an effort if you look at the way that they are advertising and the frequency of their advertising.

[68] **Vaughan Gething:** Well, the last returns we had in September, which weren't available to Carol Shillabeer when she gave evidence, showed that about seven in 10 of the posts are filled. So, there is progress being made, and, yes, I expect further progress to be made again. I said at the start of this section of questioning that I expect that we will see staff teams at, or near, full complement. But in many of these areas, as I'm sure you will appreciate, Darren, there are some areas that are difficult to recruit to on a UK-wide basis. Part of our challenge will be: if health boards really cannot recruit to some of those posts, then do we need to think about alternative staff to try and make sure that there is a model that can support children and

provide them with an appropriate form of support? But I think that you will see, throughout the rest of this financial year, more recruitment taking place. I expect to report back on that to this committee. At my next appearance, I expect there will be more questions on this, and rightly so. But, yes, we are making further progress, and I don't think it's a fair criticism to make to say that the health boards aren't trying and aren't making much effort. Like I said, you will see from the returns that we had in September, nearly seven in 10 posts have been recruited to, and that's the reason why we are actually making progress on reducing the times that people are waiting to be assessed—because there are more staff in posts to a new model. It's not about waving a magic wand; it is about those staff coming into the service and delivering a service.

[69] **Darren Millar:** If I can just be clear, I wasn't criticising the health boards, I was just asking: are you confident that they are making those efforts? We are two years in, and you have suggested that there are still 30 per cent of those posts that are unfilled. That is still a concern, is it not, if we want to achieve the capacity within those services to deal with those coming in? The other issue, of course, that Carol Shillabeer raised was variability—that some areas are more difficult to recruit to than others, and that means that there are warped waiting times for some young people in certain locations in Wales, which is clearly unacceptable. I'm okay on this.

[70] **Lynne Neagle:** Okay. Llyr.

[71] **Llyr Gruffydd:** Just a very quick one on data, really. How do we ensure the comparability of data over time? There is a tendency to publish statistics in a certain way for a few years, and then the focus changes and we publish them in a different way. Is there not a danger, then, that we don't have that long-term take in terms of comparable data?

[72] **Lynne Neagle:** Before you answer that, Vaughan, Carol Shillabeer told the committee in writing that the data on the assessment waiting times were not routinely published. So, it would be helpful to have some clarity on that.

[73] **Vaughan Gething:** Yes, no problem at all. I'm happy to do that. With the data that we have and the changes in them—. Going back to Sarah's point earlier about interrogating the data, some local health boards were proving returns that included access to primary healthcare, as opposed to the specialist part of CAMHS as well. So, there's a challenge there about understanding that they are providing the same returns. So, that's part of

interrogating them, to make sure that we are comparing like for like internally. Then, as you go in to one year to another to another, well, there's something here about wanting to have a data set that does make sense. We would want that for our own purposes, frankly. From the Government's point of view, we would want to know whether the investment we are making is actually delivering a significant return and whether we are seeing a reduction in people's time to assessment. We would then need something a bit more qualitative about understanding what the impact of that is, too.

[74] But there will be points in time when we look at our data and ask, 'Are they really telling us something useful again?' Any time that the Government announces a change in the way that data are collected, analysed or published, there will be the usual thing about, 'Are you moving the goalposts? Is this at your convenience? Is this really the right thing to do? How on earth can we compare things? And you've done this deliberately to make my job more difficult in scrutinising you?' Well, that goes with the territory, doesn't it, a bit? It's our job to try and be upfront about the reasons why any data changes would be made, and that there is a point and purpose to them. Look at ambulances, as an entirely different area: we changed the way that the targets worked, and the data then reflected that. You either accept that that was the right thing to do or you don't. But ultimately, there is a stream of data that is published and made available on a regular basis. In this area too, we want to make sure there are regular data made available to the public, so they can see where we are. I couldn't give you a cast-iron guarantee about data collection in the future because I can't tell you what will happen in five or 10 years' time.

[75] **Lynne Neagle:** Okay. Julie, was it on the stats?

[76] **Julie Morgan:** No.

[77] **Lynne Neagle:** All right. Okay, I've got Angela, then, next.

[78] **Angela Burns:** Thank you. Can I just move away from the statistics for a minute and actually ask about the, sort of, delivery of the services? I've always found, if I'm honest, trying to negotiate my way through CAMHS extremely difficult. I understand the four steps. I understand that if a young person presents, for example, at their GP with eating disorders, then they would not necessarily go to CAMHS if there was an eating disorders clinic that that person could go to. I get all of that; it's totally, totally appropriate. What I don't understand are the numbers of people who we've had evidence

from, both at this committee and also in my own constituency, where people have come with young children or young people who have what appear to be horrendous issues. Sometimes, they may or may not have a physical disability involved as well, but they will have multiple problems wrong with them, and they've consistently been told by CAMHS that they're not suitable for CAMHS because their needs are too complex.

[79] So, my question to you really is: where would those people go, or do we need to actually look at expanding the kind of young people and children that CAMHS will take on? And I particularly refer to our inquiry into adoption that this committee did in the last Assembly, when we met many adoptive parents who had taken on children with multiple needs, and were finding it impossible to access CAMHS and were being refused by CAMHS. And I kind of thought that CAMHS was there to deal with all the children whose needs were so complex that that they needed to have that kind of support. So, we had these individuals with multiple needs, but with no direct ability to access any kind of mental health service, or any kind of support from social services either, and weren't able to follow the adult pathway. The psychosis people say, 'Well, it's more than psychosis, it's this and that', and somebody else will say, 'Well, it's learning as well'. So, could you just kind of clarify for me where those individuals go? I'm sure this committee would be able give you that evidence, because it was not just one or two, it was a multiplicity, and I've had it my constituency. In fact, I'll give you one quick example: young boy in a wheelchair, self-harming, then tried to commit suicide, then started to hear voices, but CAMHS turned around and said, 'No, you are not suitable for CAMHS, we're a crisis service.' And the parents had nowhere else to go. So, it's that kind of example. Where else do these young people go, if not to CAMS? Sorry, that was such a long-winded question.

[80] **Vaughan Gething:** There are a couple of different things, and part of the challenge is about responding to what is a general point, and many individual instances as well. There is always a challenge where children present with complex needs, and who needs to be involved to deal with them. And often you can't just say the CAMHS service will be the one that should be taking a lead, or whether that means that there must be a CAMHS need. In the individual circumstance that you raised, I couldn't honestly tell you what the correct response should or shouldn't be. There's something here about clinicians doing their job and being trusted to do their job, but at the same time, there being a proper review process if people are unhappy with that decision. But in lots of things we talk about—where lots of the referrals go into CAMHS, there is real need that exists for that child and that

family. And it's about how we actually deal with and support people around that. In fact, previously, I've met with adoption support groups who made a point about access to CAMHS, and they said they were concerned about the challenges that you are more likely to see with adopted children. And there was something about wanting to see a general improvement in CAMHS rather than giving special access to CAMHS for adopted children and their families.

[81] So, it's about where that is support provided and how it is most appropriately done. That's why we've invested in support in primary care for children and young people as well. But I think for me to be able to give you the most helpful answer, it would be helpful to be clear about the particular needs that you're talking about. Otherwise, I think we're just going to talk in general terms, but I don't think it is likely to satisfy the particular point you're making about the level of complexity and how it's dealt with, because I think that really comes down to the individuals and the nature of the complexities and how they present. And often that'll be whether the right judgment been made on whether there is a mental health need, and that really is about the specialist CAMHS service being part of helping to deal with that, but equally that person will have other needs and how those needs are dealt with as well, because, you know, you can't really say that dealing with one part will necessarily resolve all others. So, that's why I think it's really good to talk in specific terms, not just talking in very general ones. Like I said, I think it would helpful for me to try and say, 'And I can tell you lots more about it', until we have some of those particular examples of the level of complexity, how that's dealt with, and who people should go to for their support, because it goes across our portfolio and into others as well. So, it's where that support will be provided and wrapped around the child and their family.

10:15

[82] **Lynne Neagle:** We're going to have to speed things up a little bit, so I've got Julie next. If I can appeal for brief questions and brief answers, please.

[83] **Julie Morgan:** Thank you very much, Chair. I guess I wanted to ask about the provision for deaf children within CAMHS. I know that care pathways have been developed to provide for deaf children, and I know there is still some concern about whether the monitoring and resources are there, so I wondered if you could tell us how that provision is being developed, and how it's actually going, because, obviously, it's the communication issue

that's so crucial in this.

[84] **Vaughan Gething:** Well, on the general points about the service being able to meet and understand and deal with the needs of children and their families who come through the door, obviously a deaf child will have particular needs that I would expect the service to be able to cope with. I'll ask Sarah to come in, because a couple of years ago we had a particular review in this area, but also there is a development coming forward that should help us to understand the nature of children with disabilities within the service as well.

[85] **Dr Watkins:** In some ways, as you say the National Society for Deaf Children worked with the service to develop an agreed pathway for every LHB. So, that is in place, and as far as we're aware, that is running, and those children's needs should be met if they're referred. But in terms of the data, we don't have ready access to those data. However, there is the WCCIS, which is the Welsh community care information system, that is being gradually introduced across Wales, where, at the outset, things such as disability will be inputted. So, in future, as that rolls out, getting much more detailed information across all of health and social care—because it's a combined system—will become much easier. So, you would be able to pull out the data that the child has been seen by CAMHS, and had a disability, and the type of disability. So, that would be the vision for the future, but I can't say that we would have readily accessible data. My colleagues in CAMHS tell me the level of demand is not very large, but I can't give you anything more than that as a—

[86] **Julie Morgan:** So, when would the data be likely to be available?

[87] **Dr Watkins:** It's being rolled out, so Powys will go live later this year. Bridgend has gone live, and incrementally over the next two to three years, that is going live and being piloted. That's my understanding of the IT—it's not my area, but that's my understanding of it.

[88] **Vaughan Gething:** And it's a really important development—much more than CAMHS, but actually a genuine shared information centre for health and care, and we'll be the first nation that we're aware of to be able to have that proper informatics system to share those data and information. So, it's a really important development across a whole range of health and care needs.

[89] **Lynne Neagle:** Thank you. Darren.

[90] **Darren Millar:** I just wanted to ask you, if I can, about the inpatient capacity around Wales. One of the problems that has been presented to me, and to other Assembly Members, I know, is the fact that, very often, young people are placed in inpatient facilities that are many miles away from their home, sometimes at a significant cost to health boards as well. There's a flagship CAMHS centre in my own constituency, at Abergele, but it's not used to its full capacity. There are beds in there that people from north Wales could be accessing, but unfortunately some are being sent elsewhere—sometimes to south Wales, sometimes hundreds of miles away over the border. We did receive an update from Carol Shillabeer that seemed to suggest that capacity was less of an issue than my postbag and other people's postbags are telling us. I just wonder, are you confident that Wales has sufficient inpatient bed capacity for children and young people with mental health problems in Wales?

[91] **Vaughan Gething:** Our out-of-area placements have reduced significantly. In the last year we had—well, from April to December, we only had 12 out-of-areas placements on a regular basis. So, you see that's been a significant reduction. And every bed placement is a really high—it's a really specialist need and so there's a significant cost that goes with it. We'll always want to look at whether we can do more to make sure that children and young people are seen closer to their home, but that will depend on the nature of the need and our ability to deal with it. If we're going to invest in more capacity, we need to understand whether we do have the demand need to go into it and how that's assessed. But I think we've made really significant progress. It's an area where I always say we'll, of course, review whether we think the capacity exists. But there's been really significant progress.

[92] **Darren Millar:** The big problem is that many people are wondering why a significant sum of money—many millions of pounds—was spent on a facility in Abergele, which was supposed to deal with the capacity issues in north Wales, that has never operated at full capacity. Half of it is shut at the moment. Why is that? Surely, the demand was assessed and a building was developed in order to meet the demand. Why is it not operating at full capacity, and why are we still sending people hundreds of miles away from my own constituency when they could be treated on their doorstep?

[93] **Dr Watkins:** Can I take that? It does vary. So, within north Wales, I had

figures last month that said that 11 of the 12 beds were full, and there were only three children being looked after outside the area. It will depend on the level of demand within the unit. So, sometimes, if you have a very complex child who might need, perhaps, sometimes two or three members of staff, that will reduce their ability to admit new people. I also understand that, in north Wales, they've now developed a small community eating disorder CAMHS team that is improving significantly the ability for young people with eating disorders to be managed, which has improved the capacity. So, the vision is that as few children are looked after outside Wales as is practicable. Some months, we've had just two children in north and two children in south Wales being cared for outside—out of area—plus some forensic cases, which are different. So, we have about four children with forensic needs being looked after outside Wales, but they've got very high needs. Most of the time we've actually got a low level, but, if a child comes in that's got exceptionally high needs, that position can change quite quickly.

[94] **Darren Millar:** Can I just ask one final question? It's just returning to this waiting time to assessment, or waiting time to treatment, and you're looking at the targets. The biggest complaint seems to be about access to talking therapies and the waiting times that people have to access a talking therapy if they need one. That, to me, seems a very important measure that still needs to be reported against in the future. Can you give us some confidence that you're certainly not going to scrap any kind of reporting against targets for access to talking therapies?

[95] **Vaughan Gething:** I think we're confusing children and adult services here. In terms of how children's needs are—

[96] **Darren Millar:** I'm not, with respect.

[97] **Vaughan Gething:** In terms of how children's needs are met through CAMHS, our previous answers hold, and they're accurate as to what we expect. Many of the interventions will be, effectively, talking therapies rather than an alternative intervention. So, I don't think you should have any concern, or any reasonable concern—.

[98] **Darren Millar:** The evidence that the committee has received in the past, which it has raised concerns about, is very often a medical model is the approach that is taken with children and young people when a talking therapy and a recovery model might be more appropriate. Now, if you are not reporting and there's no transparency about access to a recovery approach

versus a medical approach then it's going to be very difficult for people to be able to measure the quality. All I can say is that, from my experience, individuals who present—

[99] **Vaughan Gething:** You're asking a different question now, Darren. It's an entirely different—

[100] **Darren Millar:** If you just let me finish, with respect, the issue that presents itself in my surgery and other people's surgeries, and no doubt in your own, is very often the wait that people have—children, young people and adults—to talking therapies. Is there any confidence that you can give us that that sort of information is something that will be shared in the future in the public domain and that we won't shy away from baring all, as it were, in terms of the performance of services in that respect in particular?

[101] **Vaughan Gething:** In terms of the performance of services, I think we're upfront about providing information about where we are. From our own point of view, we need to know that. When it comes to accessing different interventions, and different interventions that are appropriate, that again has to be done on what is the need that's assessed and understood, and how is that then met. It goes back to the earlier point, that actually trying to understand and provide referral-to-treatment information I think is difficult and I'd question the value of doing it in terms of the way our resources are used. The investment we are making, we think there should not be a problem in accessing appropriate therapeutic interventions for children and young people who are going through CAMHS.

[102] **Lynne Neagle:** Thank you. Just two final quick questions from me, then, particularly in relation to neurodevelopmental services. The strategy said that, by November 2016, care pathways would be implemented across Wales. Are they up and running and being implemented consistently, and is there any update on the 26-week waiting-time target for assessment for neurodevelopmental conditions, please?

[103] **Vaughan Gething:** Yes, my understanding is that the care pathways are up and available. Again, we expect that health boards will meet the 26-week target within this year.

[104] **Lynne Neagle:** Within this calendar year.

[105] **Vaughan Gething:** Within the calendar year, yes.

[106] **Lynne Neagle:** Okay, thank you. John, on physical activity.

[107] **John Griffiths:** Thank you very much, Chair. I think there's quite a consensus that we need to be more preventative in healthcare for our children and young people, and indeed people of all ages. I just wanted to ask a little bit about some of the links with schools with developing the new curriculum under Donaldson, of course. Part of that is about an area of learning and experience that's about health and well-being. We had the Tanni Grey-Thompson report about physical literacy. I just wonder what joint working there is between health and education in Welsh Government to try and ensure that we get those good habits of physical activity instilled, hopefully, in our young people at an early age, which, hopefully, will then stick with them throughout life and they'll have better health and there'll be less demand on our health services.

[108] **The Minister for Social Services and Public Health (Rebecca Evans):** Good morning, committee. I thank you for that question, and for raising the importance of physical activity and the potential, really, that we have within the school environment for improving levels of physical activity. I've met with the Cabinet Secretary for Education, and we're really keen to work together to strengthen the way in which our two departments deal with physical activity. One example would be some early work that we're doing on the daily mile. I've seen this in practice myself in Merthyr, and it was really impressive talking to the children themselves about how much they just enjoyed the physical activity at the start of the day, but then also parents saying, 'If we didn't have the daily mile in school, I'd make my child go and do the daily mile', because they can really see the difference, both in terms of their behaviour in school and also starting to see it in terms of attainment and concentration in the class and so on. Obviously, for the same reasons, teachers are really excited about it as well. So, we're looking to see what we can do to support that much more widely across Wales—we do have some schools doing it—and preparing resources and so on. So, I'll be making a joint statement with the Cabinet Secretary for Education, specifically on the daily mile, very shortly to say a bit more about that approach.

[109] Another exciting approach, I think, has been the school holiday enrichment programme, which was recently announced. It's already been undertaken as part of a pilot programme in various school settings across Wales—rural settings, more deprived communities and so on—to look at the different issues there in terms of physical activity, but also taking the whole-

school approach to health and offering children a healthy lunch. Because, during school holidays, we know that there are many children who, unfortunately, perhaps won't have a meal and won't have a healthy meal and won't have activities. We know that, in terms of attainment—for some children who aren't read to and engaged with over the school holiday, for example, their attainment falls back over the course of that summer holiday as well. So, I think that the school holiday enrichment programme, and the £0.5 million investment we're putting into it, is really exciting. I'm looking forward to seeing the progress there as well.

[110] **John Griffiths:** On that, might that be connected with trying to find a mechanism to ensure consistency and quality in community focused schools in Wales? I know that under the twenty-first century schools programme there are requirements, but obviously a lot of the schools are existing stock, and it's frustrating, often, certainly for me—and I know for others—that schools can be closed off to the local community during holidays, weekends and evenings. It seems to me, if we are going to get a more active school population and local population, having consistent and quality community-focused schools would be a big improvement, but it seems that there must be some mechanism established to enable that to happen consistently, otherwise it's up to the individual preference of governing bodies and headteachers.

10:30

[111] **Rebecca Evans:** Yes, and that does seem to be something that is preventing some schools from opening up on the weekend and of an evening, as well, in terms of governing bodies of the schools being resistant to that, because, perhaps, they see a risk to the school and so on. So, I think there's work certainly for us to do in promoting the importance of it, but also, particularly with the huge investment that we're making in twenty-first century schools, that school estate has to be for the whole community, and we're making that very clear when we are putting that investment in as well. Because many of these new schools now have community rooms at the front of the school, which will have internet access, for example, for people in the community who don't have access to the internet at home. So, they can be a real hub of the community, and I think that's good for the children, actually, in terms of wider benefits to the school and so on. But I think that there is a leadership role for Government in terms of doing that and we can see, also, through what we require, through our investments, that the school gives back to the community as well.

[112] **John Griffiths:** If I might, Chair, I just want to ask—

[113] **Lynne Neagle:** Briefly.

[114] **John Griffiths:** Very briefly, then. In Newport, I know you're aware that we've been meeting with the health sector, the leisure centre and local authority registered social landlords and a range of sports bodies and others to try and work up steps to achieve a more active population, for health benefits and other benefits. So, I'm just interested in how the Welsh Government might support that sort of local initiative and I know there's interest in the well-being bonds, for example. I just wonder if there's anything you could say about what Welsh Government support might be available for those sorts of initiatives.

[115] **Rebecca Evans:** Well, in terms of the well-being bond, we committed in the 'Taking Wales Forward' document to a new Wales well-being bond, aimed at improving mental and physical health and to reduce sedentary lifestyles, poor nutrition and excessive alcohol consumption. I know that the Newport Live project very much operates within that space. At the moment, I'm exploring with officials different models of well-being bonds. We have one in existence, Valleys Steps, in Wales. There are models elsewhere across the UK and internationally that we're looking at as well, so we're looking at the different models, the benefits and risks of each, and teasing out what we want to achieve from it and also having discussions with some organisations that have already expressed an interest. I think that a discussion with Newport Live would be really useful in terms of how Newport Live would see a well-being bond working for them.

[116] I did meet some of the young people involved in Newport Live, as well, earlier this week at an event for opening up communities and opening up sport to children in the evening, and they were really impressive, and also talked about the importance of having something to do and somewhere to go where they can be physically active, but also not necessarily doing the same old sports—so, doing things that are interesting to them, trying different things, finding the one thing that they really love and enjoy and then can pursue as well. So, that was a really useful discussion as well.

[117] **Lynne Neagle:** Thank you. Hefin.

[118] **Hefin David:** Sport Wales has been an organisation without a board

since 23 November. How are they coping?

[119] **Rebecca Evans:** As you say, in November, I suspended the activities of Sport Wales, and the reasons I set out in the written statement and I took an urgent question following that as well. The day-to-day business of Sport Wales continues. For example, yesterday I had a good meeting with Sport Wales and others about how we can support street soccer to become more sustainable in Wales. All of the normal work that you would normally expect of Sport Wales is continuing uninterrupted, so people who are involved in Sport Wales initiatives shouldn't see any difference. I did say at the time that I was expecting the report from officials within six to eight weeks. I don't see any slippage for the governance report, and so, when I receive it, then I'll consider it and I'm going to the Assembly the next steps.

[120] **Hefin David:** You said in your statement that the chief executive

[121] 'will take up matters that would normally have been brought to the attention of the Board'.

[122] **Rebecca Evans:** The chief executive would take up with a senior Welsh Government official matters that would normally be drawn to the attention of the board.

[123] **Hefin David:** What level of scrutiny is there of that process, which would normally be scrutinised—

[124] **Rebecca Evans:** There haven't been any issues that would normally have been brought to the attention of the board over this period.

[125] **Hefin David:** Okay, thank you.

[126] **Lynne Neagle:** Thank you. Julie.

[127] **Julie Morgan:** Yes, I wanted to ask about safeguarding children in sport, because there's been recently a lot of publicity about historical stuff about playing football and what's happened to people in those scenes. So, I wondered what reassurances you could give that children are safe in these settings.

[128] **Rebecca Evans:** I was very pleased that the Social Services and Well-being (Wales) Act 2014 really strengthened the safeguarding arrangements

that we have in Wales for both children and adults. It put a duty to report on relevant partners when they have reasonable cause to suspect that a child is at risk, and I think that's really important and a huge step forward. Those partners include health, police, probation, youth offending teams and so on, and so the local authority then would have to investigate when those concerns were drawn to their attention. I think that's a big step forward, as is the establishment of the children's safeguarding board and the national safeguarding board, which would advise Ministers on any future developments, and so on. I'll be meeting with the national safeguarding board very shortly.

[129] I've also met with the FAW Trust to talk about safeguarding in football, and I sought and received from them assurances about the safeguarding processes that were in place to protect children in football particularly. I'll be meeting with the NSPCC shortly to discuss the concerns that they've raised recently as well.

[130] **Julie Morgan:** Yes, I think the NSPCC feel that more should be done.

[131] **Rebecca Evans:** I'd be more than happy to explore with the NSPCC what improvements they would like to see, obviously. I do know that Sport Wales works closely with the NSPCC's child protection in sport unit as well. There's a full-time officer from that unit working in Sport Wales's national centre, supporting their safeguarding activities as well. So, that includes advising sporting national governing bodies on safeguarding issues, action plans for communicating important safeguarding information with people partaking in sport, and also safeguarding in education and training settings as well. So, Sport Wales is very much engaged with the NSPCC, but if there are issues or improvements that people would like to discuss, obviously I would be open to those. But I am satisfied that we do have a robust system in place.

[132] **Julie Morgan:** It is difficult to be confident about an unregulated system, but, as far as you are able, you are satisfied that everything is in place that should be.

[133] **Rebecca Evans:** Yes. We also have DBS checks, of course, which is important in terms of ensuring that people coming into contact through sport in a voluntary capacity, for example, have had all the necessary checks and assurances made there.

[134] **Lynne Neagle:** Thank you. Okay, we're going to move on now to school nursing.

[135] **Darren Millar:** I just wanted to ask whether there was any update on the review that was undertaken into school nursing in Wales, and where things are at in terms of the publication of a fresh framework for school nursing.

[136] **Vaughan Gething:** Yes. I expect, before the end of March, to have met with the chief nurse and to understand exactly where those proposals are, so it's still on track and within a few months.

[137] **Darren Millar:** You say it's on track; we were expecting back in December. That was the last information you shared with us.

[138] **Vaughan Gething:** Well, I'm meeting the chief nurse within the next few weeks, and I expect to have something we can publish and get on with before the end of March.

[139] **Darren Millar:** So, is there any reason for the slippage?

[140] **Vaughan Gething:** Well, I can't tell you until I've met the chief nurse. It's actually about getting the right strategy in place.

[141] **Darren Millar:** I understand that, but is there any reason for the delay? What is the reason for the delay?

[142] **Vaughan Gething:** Well, I've said I can't tell you until I've met the chief nurse, and when I've met the chief nurse I'll know more about where we are, about the strategy and what we expect to roll out for the nursing service.

[143] **Darren Millar:** So, has her review been completed?

[144] **Vaughan Gething:** Sorry?

[145] **Darren Millar:** Has her review been completed?

[146] **Vaughan Gething:** I think I've answered your question, Darren. I'm going to meet the chief nurse and then I'll know where we are, but I'm expecting that, before the end of March, we'll be able to make progress on this.

[147] **Darren Millar:** But you seem to be very satisfied with the progress, even though there's a delay in you receiving the completion of her work, and a delay in the publication of the revised framework, which we were expecting in December.

[148] **Vaughan Gething:** As I say, I think I've answered the question. I'm very interested in getting the framework right, and I think that actually spending another couple of months on getting it right is the right thing to do, surely.

[149] **Lynne Neagle:** Maybe the committee could have a note on it when you've had the meeting with the nurse.

[150] **Vaughan Gething:** I'd be very happy to provide an update to the committee.

[151] **Darren Millar:** I'm sure you will.

[152] **Lynne Neagle:** Can we just move on, then, to child health inequalities? The chief medical officer's report was very strong on the need for the NHS to do more to tackle health inequalities amongst children. Can I just ask what steps you are taking and also what steps the CMO is taking to actually drive that change forward within the NHS?

[153] **Vaughan Gething:** Frank, do you want to start about where we are and the response to the report?

[154] **Dr Atherton:** Yes, certainly. Thank you very much for asking that question. Obviously, the CMO's report from last year was very focused on inequalities generally, and child inequalities as a major part of that, and we really used the report to put down a challenge to the NHS, because we've known that inequalities and tackling inequalities require a broad societal response, but we did flag that there is much more that the health system itself can do to address health inequalities. And the kind of things that we were recommending were that health boards and health services pay much more attention to the question of who is accessing the services and who is unable to access the services, often for reasons rooted in socioeconomic deprivation. And so, in terms of what we're doing and your question, Chair, we've been having numerous discussions with the NHS. We've talked with the NHS boards, with all chief executives, and I've spoken personally with all medical directors. I've made an offer to go around health boards and meet

with those, and I've met some of the local health boards on that. And I also meet regularly with professional groups and different specialties. The Cabinet Secretary and I met with the British Association of Physicians of Indian Origin very recently, and we raised the issue with them. So, across a broad range of fora. And what I'm finding very constructive and very helpful is that we are getting a lot of positive feedback and appreciation that this is a major challenge and that it's not just about health services providing good-quality support to the whole population but that we need to provide good-quality support to people in more deprived circumstances. So, a general awareness that this is an issue that the health service needs to address.

[155] **Lynne Neagle:** Okay, thank you. Julie.

[156] **Julie Morgan:** Yes, I wanted to ask about breastfeeding and whether you could tell us what progress has been made in increasing the rates of breastfeeding and what help is out there.

[157] **Rebecca Evans:** Well, breastfeeding rates have increased since 2005, but it is only up by 5 per cent. So, we're at 60 per cent now, so it's nowhere near, I think it's fair to say, where we'd like to be. However, things are moving in the right direction, albeit very slowly. One of the things that does concern me—again, this is a health inequalities point—is the difference in terms of the most affluent mothers as compared to the least in terms of the uptake of breastfeeding, which is why I think it's really important that it is a crucial part of the Healthy Child Wales programme, so that those discussions that health visitors and other professionals have with mothers, with expectant mothers, do raise the issue of breastfeeding and how important it is for so many reasons, not least why it's included in our 10 Steps to a Healthy Weight programme that we also have for expectant mothers as well, to talk about the importance of breastfeeding in helping their child maintain a healthy weight through childhood and on into adulthood as well.

[158] **Julie Morgan:** And this 60 per cent rate—is that 60 per cent leaving hospital or is it 60 per cent at—? Because I know it drops, doesn't it, fairly drastically.

[159] **Rebecca Evans:** It does.

[160] **Julie Morgan:** And I wondered if you had those figures as well.

[161] **Rebecca Evans:** It's 60 per cent at birth, and then the drop off is

seen—so, it's 45 per cent at 10 days and 36 per cent, then, at six to eight weeks. So, there is a drop-off when people go home.

[162] **Julie Morgan:** And what are the World Health Organization's recommendations for how long breastfeeding—. Six months, is it? Six months, I think.

[163] **Rebecca Evans:** Six to eight?

[164] **Dr Atherton:** Yes, the WHO recommends exclusive breastfeeding up to six months. So, we still have an awfully long way to go in Wales, that's for sure.

[165] **Julie Morgan:** So, what would our figure be for six months?

[166] **Dr Atherton:** I don't have that, but we could try to dig that out if the committee would like that.

[167] **Julie Morgan:** It'd be useful, because if it's 36 per cent, did you say, at six weeks—?

[168] **Rebecca Evans:** That's right, yes.

[169] **Julie Morgan:** It's probably half or more at six months. So, what more can we do than we are doing to try to boost these figures?

[170] **Rebecca Evans:** I think the Healthy Child Wales programme will be really important in helping us address this. I launched it back in September, and health boards have been required to implement it in full by two years' time. We are having quarterly reports from health boards in terms of the progress that they've made, and we'll also be having a stakeholder group as well to monitor that implementation and feed back to Ministers so that we can continue to challenge health boards on the delivery of it.

10:45

[171] I think there are other things that we can do as well. I know that Public Health Wales, which does have the responsibility for improving rates of breastfeeding and promoting breastfeeding across Wales, are doing some good work. For example, in north Wales, the public health team there has introduced a new website, which includes social media and so on. So, it's

about contacting parents or expectant mothers in ways that are easy for them, but also with language that is interesting to them, which is appropriate for them and so on. I think there's also an age issue here as well. It tends to be mothers over 30 who do breastfeed. So, there's certainly work to do with younger mothers as well.

[172] **Julie Morgan:** What about the general acceptance and the culture of accepting breastfeeding? Do you feel that that is improving?

[173] **Rebecca Evans:** You would hope so, but, then again, it does seem to be a fairly slow improvement. I think that it's fair to say that we have seen an improvement there, but every now and again you do hear a story that makes you think that perhaps we aren't as far forward as we could be. So, again, this is a role for Public Health Wales in terms of raising awareness of the importance and trying to create a culture of acceptance. I think that's something for all of us.

[174] **Julie Morgan:** Okay. Finally, would you agree that, as this is one of the first experiences that a child has, this is one of the most important areas where we need to go all out to improve the situation?

[175] **Rebecca Evans:** I absolutely agree that it's important, which is why it's there in the 10 steps and is also there in our Healthy Child Wales programme, because it is so important for a child's lifelong well-being and health.

[176] **Lynne Neagle:** Thank you. Can we move on to neonatal? Is there any update on the general situation in relation to staffing and meeting the neonatal standards across Wales?

[177] **Vaughan Gething:** Yes. We continue to make some progress on staffing, but we're still not where we want to be on the number of staff that we have within the workforce. The number of paediatric doctors has increased 22 per cent in the last 10 years. We're seeing more nurses, and more nurses going into training, but there's no complacency that we're at a point where we can say that everything's been resolved. Again, it's an area of the workforce where there are UK-wide pressures and shortages. There is a general shortage in nursing across most of the western world. We're all trying to recruit people into this profession, and neonatal nursing is no different in the sense of there being a real pressure. But what I think we're doing to try and make it more attractive, to recruit people into the service, is

that we're investing in updated models of care. That's why I announced some fairly significant investments in terms of the £18 million for the sub-regional neonatal intensive care centre in north Wales and the £31 million that I've recently announced for Prince Charles Hospital and the Heath hospital. We've also put money into the Royal Gwent Hospital to make sure that the model that we're trying to create is properly resourced to give us the best prospect of actually attracting people into the service.

[178] We'll know more with the regular updates that we do get from both the network and external organisations too. So, I expect I'll come back to you again in the next year and I'll be able to point to further progress that's been made, because we have made some real progress on nurse recruitment, but there's still more to do and I know that there are more questions that I can expect to be asked.

[179] **Lynne Neagle:** Okay, thank you. Julie, did you have a question on this?

[180] **Julie Morgan:** Yes. First of all, I'm very pleased that £25 million is going into the Heath, which is brilliant. I think there was a report looking at neonatal units, and I think the Heath reported—I can't quite remember, but it was at risk—

[181] **Lynne Neagle:** It was on the risk register.

[182] **Julie Morgan:** It was on the risk register. Have you any explanation for that?

[183] **Vaughan Gething:** Part of the challenge is understanding the risks that they're still carrying. It's partly about the structure of the service that they have and it's also about their ability to recruit and retain staff in the unit. I'll happily provide you with a note on where they are on the risk register and perhaps in the context of the whole system as well. Would that be helpful, Chair?

[184] **Lynne Neagle:** Yes, lovely. Thank you. Moving on then to young carers, Angela.

[185] **Angela Burns:** Minister, we obviously don't know enough about our young carers—we don't know where they are. I think that some 782 were known to social services last year and, yet, the Carers Trust says that there are some 11,000 young carers in Wales. I appreciate that not every young carer will require support, but I think that one could make the overview

statement that most young carers will require some element of handholding, even if it's simply joining a peer support group. Can you just give us an update on what progress has been made to identify young carers throughout Wales?

[186] **Rebecca Evans:** Under the Social Services and Well-being (Wales) Act 2014, carers, for the first time, including young carers, have the same right as the person they care for in terms of an assessment of their need. I think that this particular approach will help us identify more carers, but there does have to be that offer to young carers from professionals, as to, 'Do you need an assessment of your need?' Part of it, having met with the carers alliance recently, is about how that question is asked. So, when you ask somebody if they require an assessment of their need, it's a very different question to, 'Have you got all the help that you need? Is there something that someone can do to help you?' So, we're having a look at those kinds of questions in particular.

[187] We are working to strengthen the promotion of our carers assessments through local authorities, but also through the good work that the third sector is doing, Barnardo's would be one example, in terms of encouraging young carers to identify as such and to have an assessment of their needs as well. We do collect the data on an annual basis, so we do know those carers who you've identified—those 782 who are receiving support through social services. There will be other carers out there who we need to make a concerted effort to identify.

[188] When I met with the carers alliance, I did undertake to write to all of our local authorities about how they are promoting the carers assessment to carers, and to let us know if there are barriers, actually, because we need, right at the start of the implementation of the social services and well-being Act, to know if there are barriers to uptake amongst carers, with a particular interest in young carers as well.

[189] When we come to evaluating the Act in the three-phase evaluation, I'm really keen, especially in this first stage, which is more informal—so, it's listening to experiences and stories—to ensure that we have the voice of young carers in that work, and carers and service users as well. So, rather than just collecting data, which tells us a lot, actually it's the voice of carers that we want to hear in terms of their experience as to whether the Act, they feel, is delivering for them as well.

[190] I met with the young carers network very recently. The Welsh Government funds Children in Wales to support the young carers network, and they arranged for me to discuss, first of all, their experience of the Act. I think their experience was positive, and they were pleased that they now feel recognised under the Act—that they are young carers and that their work is valued and that there is support available for them. I think that they felt that was important. But there was also a lot in that meeting that was really challenging in terms of how we improve things for carers, such as within the education setting, for example. I know that the Cabinet Secretary for Education is meeting with young carers later this month, I think, in order to explore those issues in more depth as well.

[191] **Angela Burns:** That, very neatly, actually, Minister, brings me on to the follow-up question that I was going to ask you, about a letter from you to local authorities, and I wonder if it will just end up within the social services stream. I was going to ask you what discussions you've had with education in terms of identifying young carers—I appreciate that you can put the proposition in more youth-friendly terms than 'assessment'; that's not a warm word for a young teenager or even a younger person—in order to identify these young carers, for somebody then to have that conversation with them about what help they may require, one of the key ways has got to be through the schooling system, because most teachers will mostly know, in their class, who needs that help. So, have you got any plans to actually try to run some kind of school-wide campaign to garner that information so that then individual approaches can be made?

[192] **Rebecca Evans:** Well, we do have a carers toolkit at the moment for health and social services professionals, and we're looking to enhance and develop that—it was 2013 when that was developed. But, actually, we realise the benefit that it does have for professionals, so we're now working with the Carers Trust to make a specific toolkit for the education setting as well. Albert might want to say a bit more about that.

[193] **Mr Heaney:** Thank you very much, Minister. Thank you for the question—a really important issue. In terms of carers, what we want to see is more carers being supported. That support can be through social services and through the assessment route, but it also can be within the educational setting. So, Carers Trust developed a very good carers toolkit that helps in terms of raising awareness, but that's currently being refreshed. It's being looked at in terms of specifically driving into the heart of how we can work better in education, and, importantly for this committee, there's current work

taking place to actually build young carers issues directly into the curriculum so that they are picked up much earlier and supported much earlier within the education setting.

[194] **Rebecca Evans:** I will say as well that we are currently refreshing our carers strategy with a specifically strong focus on young carers, having recognised, actually, that this is an area where we can and must do more. But also, I know that lots of young carers are really keen on a national ID card, which will allow them to discreetly show in school that they might need some extra leniency.

[195] **Angela Burns:** So am I—it's in my manifesto.

[196] **Rebecca Evans:** Okay. [*Laughter.*] We are all on the same page. I just want to reassure the committee that work is going on to develop that.

[197] **Lynne Neagle:** Thank you. Final questions, then, on the autism strategy—Hefin.

[198] **Hefin David:** As part of the refreshed autism strategy, you said that you would establish an autism spectrum disorder advisory group before 1 April. Can you update us on progress with that?

[199] **Rebecca Evans:** I am currently looking at membership of that group and making approaches in order to set up that group. We have had some interesting discussions so far, but, when I do have the membership, I will be able to make a statement or write to Members, whichever is more appropriate.

[200] **Hefin David:** How will you use the group and other means to assess the success of the refreshed strategy?

[201] **Rebecca Evans:** Well, it's really important that we have the right monitoring and evaluation in place, and the group is going to be particularly important in terms of doing that, which is why I am really keen that we have the voice of people with autism on that group. The representative groups are really important, obviously, and we engage well and consistently with them. But actually, the voice of people with autism is important, as is recognising the huge spectrum that autism represents as well. So, I want to hear from people across the spectrum.

[202] **Hefin David:** When the group is established, by what means will you inform the Assembly that it has been?

[203] **Rebecca Evans:** I intend to provide an update on autism more widely in due course, but perhaps a letter or a written statement might be the most appropriate way to demonstrate the membership of the group.

[204] **Lynne Neagle:** Thank you. Angela.

[205] **Angela Burns:** No, actually, Hefin's covered that. Thank you.

[206] **Lynne Neagle:** Okay. A final question, then, from Darren.

[207] **Darren Millar:** I just have a question in respect of the public health Bill, Minister. You know that one of the big asks from children and young people in my own constituency is to impose a tobacco smoking ban around bus stops, in particular, as places where young people often congregate when they are catching buses to school and back home, et cetera. Is that something that you are hoping to be able to address through the public health Bill? I know it's not on the face of the Bill, but are the tools in the Bill tools that you intend to use to introduce a ban on smoking around bus stops?

[208] **Rebecca Evans:** Thank you for that. As you recall, when the Bill was first introduced in the previous Assembly, there were no specific places on the face of the Bill, so it was through scrutiny in committee and so on where schools, playgrounds and hospitals were added to the face of the Bill. The Bill does give Ministers the power in future to add other settings to the Bill—or the Act, as I hope it will be. That would have to be done through wide consultation and then through the affirmative process in the Assembly. One thing has surprised me as the Bill has been developed and my work with it has become more in-depth, and that is how difficult it actually is to include smoke-free settings. We are actually talking about limiting a legal activity in a public place, which is actually more complex in terms of legal terms and human rights issues than you would expect. The priority, really, will be looking at what the next steps will be for future roll-out to other settings. I know that the Health, Social Care and Sport Committee is keen on childcare settings, and I think that probably is a logical next step after school grounds, for example.

[209] One of the reasons as well that the schools, hospitals and playgrounds

were chosen was because voluntary bans had been in place for some time. In some places they had worked, but actually, in others there were real enforcement issues. So, these particular areas had really strong public support for action as well. I know that there are lots of areas in which people are interested in terms of banning smoking—everything from outdoor cafes to bus stops and beaches and so on. Obviously, they will be considered in due course. But, in terms of next steps, I think childcare settings are the ones that are of particular interest, bearing in mind all of the consultation and legal work that we would have to do.

[210] **Darren Millar:** Thanks.

[211] **Lynne Neagle:** Okay. Well, that's us come to the end of our time. So, can I thank the Cabinet Secretary and the Minister for attending, and also the officials? Thank you for your time this morning and for answering our questions. As usual, you will be sent a transcript of the meeting to check for accuracy. Thank you again for coming. The committee will now break until 11.05 a.m.

[212] **Vaughan Gething:** You're very welcome. It's always a pleasure, Chair.

*Gohiriwyd y cyfarfod rhwng 11:00 ac 11:09.
The meeting adjourned between 11:00 and 11:09.*

**Y Bil Anghenion Dysgu Ychwanegol a'r Tribiwnlys Addysg (Cymru):
Sesiwn Dystiolaeth 2
Additional Learning Needs and Education Tribunal (Wales) Bill:
Evidence Session 2**

[213] **Lynne Neagle:** Can I welcome everybody back for item 3, which is a session with the third sector additional needs alliance, on the additional learning needs Bill? Thank you very much for attending this morning. We're all very much looking forward to hearing what you've got to say. Can I just remind Members that this is meant to be a scene-setting session, rather than a scrutiny session? Would our witnesses mind just introducing themselves for the record please? Shall we start with you, Zoe?

[214] **Ms Richards:** Hi. I'm Zoe Richards, children and young people's policy officer at Learning Disability Wales.

[215] **Ms Thomas:** I'm Debbie Thomas, policy and campaigns officer, NDCS Cymru, which is the National Deaf Children's Society.

[216] **Ms Inger:** I'm Denise Inger, and I'm chief executive of SNAP Cymru.

[217] **Mr Ruscoe:** Tim Ruscoe, public affairs officer for Barnardo's Cymru.

[218] **Ms Contestabile:** Angie Contestabile, policy and campaigns officer with Sense Cymru.

[219] **Lynne Neagle:** Okay. Lovely. Well, thank you all for coming. We'll go straight into questions, then. If I can just start by asking you how much you feel any concerns you had about the draft Bill have been addressed in this new Bill that's been published by the Welsh Government. I don't know who would like to start. Maybe Denise.

[220] **Ms Thomas:** I'm happy to start. I think there have clearly been some changes made in light of concerns that we've raised. Some of them are positive steps forward, but I'll be really honest in saying that most of our concerns, and by and large most of our very big concerns, have not been addressed and are still worrying us. So, as an example, there are positive steps forward in terms of the Welsh language, although we'd like it to go a bit further. There's some movement on the mainstream education stance but it still needs a little bit of work. But there are really big areas that haven't been addressed, really, at all, such as early years, further education and transition. Our big concerns in those areas still remain.

[221] **Lynne Neagle:** Does anybody have anything to add to that?

[222] **Ms Inger:** We're very much aware that a lot of the detail will be in the code. We know that we are waiting for that. Indeed, there are some very positive things that have come out, I think, of the Bill as well—in particular, I would say, the alignment of the social care Bill, particularly for looked-after children. We'd like to see, perhaps, some of that list from the White Paper, which was a while back. We know that we can't extend it to all, but perhaps, for adopted children as well as looked-after children, that could be strengthened within the Bill as well.

[223] **Lynne Neagle:** Okay. Thank you. Could I just ask you, then, as you're all obviously representing slightly different interests and you're here on behalf of your organisations as well, maybe just to say what your main

concern is about the Bill as it stands? Zoe.

[224] **Ms Richards:** For us, it's around the non-inclusion of apprenticeships and work-based learning opportunities. The Bill is described as 'ambitious'. We feel, from Learning Disability Wales, that if it's to be ambitious for the learner, it has to extend to apprenticeships with work-based learning. There's difficulty around who you put the duty with, but there are providers of apprenticeships that the duty could sit with, with the young person taking their budget with them through education. Once they enter apprenticeships, there's access to employment available for them, so they can pull down other funds. They can use the personal independence payment et cetera. So, there are a number of things that are open to them and would make their better-off calculation stand if they were able to access apprenticeships through the scheme. Something that we don't have that we don't recognise in Wales is supported internships. In England, for the group of learners there, they use supported internships instead of apprenticeships for some of the learners—not particularly well, because supported internships are not paid, therefore putting this group of learners at a disadvantage to those without an additional learning need. But supported internships in Wales would work. We already have some pilots going on—Project SEARCH in Wales through the Engage to Change project—but that is our big issue with the Bill: that it doesn't include those learners. To provide young Welsh citizens who are contributing, we have to see apprenticeships included in work-based learning.

[225] **Lynne Neagle:** Thank you. Debbie.

[226] **Ms Thomas:** Yes, I'd echo your concerns. I know that a lot of young people with additional learning needs do tend to go for more vocational options post 16, so it is a real issue and—I'm not going to lie—a real gripe when we see that it is there for learners in England and it's not here for learners in Wales. So, that's definitely a problem for us as well. But in terms of our massive concerns—our deal-breaker concerns—I'd split them into four main areas. I think health is a really big concern. Although it looks as though there has been amendment to try and address health, it doesn't address those problems. In some areas, I think it's weaker than the current system. So, as an example, the new version of the Bill says that, once health provision goes into an individual development plan, local authorities will lose responsibility for it. However, that's not backed up by the tribunal having any jurisdiction over health. So, in current legislation, if speech and language therapy is in a statement, it's legally enforceable. Under this legislation, we

lose that, and speech and language therapy is already a difficult area. There are other concerns on health that I'll probably touch on later.

11:15

[227] Early years is crucial. The early years, particularly for deaf children and young people, is a crucial time when they're developing their language. If you don't get the early years right, they start school and they don't have the language skills so they're already on the back foot. This Bill barely mentions early years. It's not delivering on its promise for 0–25. Post-16; there's still nowhere near enough detail on how this will work for post-16. There's not enough information about the collaboration between local authorities and FEIs. So, FEIs are given responsibility for mainstream IDPs, local authorities for specialist placements. What about those young people who are borderline—potentially going to go for a specialist placement, potentially going to be in mainstream placement? Where do they go to have those assessments? How does that IDP process work for them? That's not been ironed out. The other huge one is advocacy and involvement of families. 'Advocacy services' as mentioned in this Bill only refers to advocacy services for children. It doesn't refer to advocacy services for parents, and that's a crucial failing. We don't want this legislation to work for the most informed parents, but not work for the more vulnerable parents who aren't, perhaps, informed or well educated in this regard. In the same sense, throughout the Bill, it's mentioned that local authorities and governing bodies must notify parents and families of decisions, but it's not mentioned that they must involve them in discussions in coming to those decisions, aside from the initial assessment—things like ceasing to maintain an IDP. In here, the letter of the law is just saying, 'Notify them that there's a problem'.

[228] **Lynne Neagle:** Okay, thank you. Denise.

[229] **Ms Inger:** Just to add to it, really. Our main concern is around the information, advice and early explanation, so that will enable all families and young people to fully explore their rights and choices. So, whereas we welcome that disagreement resolution should be facilitated by the independent provider, we're not sure that it's strong enough to ensure that the legislation could enshrine the rights for a service to be independent, and would then support the right for support throughout the whole of the process—not wait until there is a disagreement, or wait until there is a concern. We would like to have seen the legislation be a lot stronger than that, so that providers would be more proactive in ensuring that all parents—

not just those that can shout loudest—will have access to support to fully engage with the process, and, indeed, to be proactive in ensuring that children’s voices are heard from the outset.

[230] **Lynne Neagle:** Thank you. Tim.

[231] **Mr Ruscoe:** It’s really difficult to decide, as an organisation, which is the main concern. All of the concerns that you’ve heard are our concerns too, so perhaps I’ll just illustrate something that, for us, is missing. There has been some improvement from the previous Bill to this Bill in the use of language. It’s far more prescriptive, it’s stronger in its musts—there are a lot more ‘musts’ that could fit in—and it also has quite a good attempt at a rights language within some of the sections. It’s not good enough, but it makes a really good stab. In terms of rights, we consider that there is no reason at all why due regard to the UNCRC and the United Nations convention on the rights of disabled people is not on the face of the Bill. For us, it’s not a question; it just seems sensible to do that. If you do that, things will actually simplify. The Minister, in his evidence, was talking about simple processes, making things simple, and that the parent and the children were actually fully involved and engaged in simple processes, yet the educational tribunal element of missing health is likely to confuse, rather than simplify. Because people are going to have to go down two routes. The provision of treatment and service in an IDP forms a critical element of the IDP, so why isn’t one tribunal looking at the whole IDP, including all of the providers, no matter where they’re from? That’s a simple solution for the family and for the children: one process, one result.

[232] **Lynne Neagle:** Thank you. Angie.

[233] **Ms Contestable:** Our concerns are mostly around the early years, so there’s a lack of detail, we feel, about how the system will work in this context. We think that the age group might struggle then to access appropriate support. For children with multisensory impairments, early years support and learning development all begin at birth and that’s why we feel that teachers should be holding mandatory qualifications for every child who has MSI where they’re providing support. In the English Bill, it’s noted that this is an entitlement. We feel that this needs to be going into the code of practice as well as listing it as an entitlement with IDPs as well. Multisensory impairments is a very low incidence condition, so we can’t reasonably expect a nursery, school or further education institution to have knowledge or capacity or be able to appropriately assess and meet the learning needs of

children or young people with multisensory impairments. So, we think that a local authority should always be responsible for preparing and maintaining the IDP of children and young people with MSI, given that specialist involvement will always be provided by the local authorities and inclusion teams.

[234] **Lynne Neagle:** Thank you. Llyr.

[235] **Llyr Gruffydd:** We've heard references to the duty in terms of health. Clearly, it has been improved, but you're suggesting it hasn't been improved that quickly. Would you like to expand?

[236] **Ms Thomas:** I've actually got five—this sounds awful—gripes with health in this Bill. So, the first one is the one they've already mentioned, and then the second one is the duty for health authorities to refer cases on to a local authority when they think a child would benefit from additional learning needs. It only applies to the early years, and I don't understand why, because if a health professional sees someone of any age up to 25 who would benefit from an additional learning need, surely they should be referring that on to a local authority.

[237] The other one is that the Bill, when it talks about local authorities referring cases on to an NHS body, seems to not mention early years—preschool years. I'm a bit nervous of that, because health support in the early years is important as well.

[238] On the designated education clinical lead officer—I always want to say DCMO; it's changed its name—we said, on a previous draft of the Bill, that this role was important, but that there's potential danger with it, because the DECLO is one person in a health board. What I don't want to see happening is front-line staff ending up having to take a back seat or having to delay decisions because they've got to run everything by this one person who might be very busy, might be off, or might be here, there or everywhere. So, we asked for this role to be clarified more, and I felt nervous in reading the explanatory memorandum, because they've changed the title, and the explanatory memorandum seems to suggest that that has defined the role, but that's not what we meant. What we mean is that we want the actual role to be outlined more so that people can see it's a high-level role that doesn't prevent front-line staff from going to assessments and putting their views across there.

[239] Then, finally, my fifth health gripe is that the clause on health complying with a request for information is potentially a bit flimsy. It does give them, potentially, quite an easy get-out clause if they feel that they're quite busy and they don't wish to comply.

[240] **Llyr Gruffydd:** Right, well there are five there for us to chew on. The DECLO one, of course, we touched upon with the Cabinet Secretary in the session just before this one. I don't know if you heard that at all, but he seemed to see it as that top-level, strategic—and not necessarily getting involved, if I understood him correctly, in individual cases. Do you feel that the resources are there for health boards to be able to play the meaningful role that they need to play? We're moving from a situation where we have 30,000-odd statements to 100-odd IDPs, potentially. Are there any concerns around resourcing, at all, that you'd reiterate?

[241] **Ms Thomas:** My biggest concern is around training and awareness raising. I think that's the key.

[242] **Llyr Gruffydd:** Amongst the teaching profession.

[243] **Ms Thomas:** Amongst the teaching profession, but also amongst health. They are expected, particularly in terms of early years—I've got a young child myself, and if she had additional learning needs, she would really be picked up from the health visitor, I would have thought, because, at nought to three, you're not necessarily going to go into nursery placements, so where else is it going to be picked up? But if those health visitors aren't trained and made aware of this legislation, and the fact that it's out there, then nothing's going to happen. So, for me, in terms of the biggest barrier in their involvement, it's training and awareness raising rather than resources.

[244] **Ms Inger:** I'm just picking up, then, on some of the therapies and the issues that we've had over the past couple of decades, really. I can't see that changing. For instance, if you had a disagreement resolution now, where the issue was around health provision, the disagreement resolution meeting will fail if there isn't anyone there to make a judgment on the health provision. Do you see? So, we're still in the same position here now, and if I could look at it from the way of practice, if a family were to come for a service from SNAP Cymru, we would have to look at how it is written now—has the school made sufficient enquiries to get a health assessment for this child? If they have, okay, there's no recourse through education, so this family would have to go then through the health provision disagreement resolution. So, it could

be that the families—how can this be better for families? I can't see it being better for families in that sense. So, I think what we need is clarity, really, of how the school or other agency would get an assessment in the first instance from health, and then what recourse there would be if provision wasn't provided even if it was agreed. So, there's no clarity here.

[245] **Llyr Gruffydd:** But that would come in the code, would it not, and not on the face of the Bill, potentially? Or would you like to see it reflected somewhat stronger on the face of the Bill?

[246] **Ms Inger:** I'm just throwing out what it would be. I don't see anything that actually tells me that it can.

[247] **Ms Thomas:** I think the specific clause that removes the responsibility from the local authorities once health provision has been written into the IDP should be removed from the Bill. I think that gets to the nub of that issue for me.

[248] **Lynne Neagle:** Tim.

[249] **Mr Ruscoe:** You are right to highlight capacity. In our day-to-day lives, across all of the lives of the children and young people and families that we work with, health capacity is always an issue. And you're right to highlight that 104,000 IDPs are likely to create an additional capacity demand. That should exercise this committee in the scrutiny of this Bill. I have no solutions other than to say, 'This is the world that we're living in every single day'. Adding additional work into a workload is not going to help the capacities that are already not found.

[250] **Lynne Neagle:** Okay. I've got Hefin and then Darren on this. Okay, Darren.

[251] **Darren Millar:** I just want to ask about this redress issue and the lack of accountability to the education tribunal for the health service. At the moment, of course, if people have a problem with the health service, they can go through the NHS complaints procedure. There are no prescribed timescales in the same way as there might be in terms of decisions from the educational tribunal, and it's not independent—it's actually the NHS itself that determines whether your complaint is valid or not. If you're still not happy, you've got to go to the public service ombudsman. So, I assume that what you're saying is that that's far too complex a system; let's get it all

under this one roof, with the educational tribunal and the NHS and the local authorities, the governing bodies of schools, the FEIs, all being accountable directly to that in terms of the support that's got to be provided.

[252] **Ms Inger:** That would be best for children and families. It may not be best for local authorities or health authorities, but that would be best for children and families.

[253] **Darren Millar:** Okay. And in terms of the point that you made, Debbie, about the duty to refer on to a local authority if an additional learning need is identified with a child in the early years, have you had any explanation or rationale provided from Welsh Government or officials of why that might not be extended to above the age of three?

11:30

[254] **Ms Thomas:** To be completely honest with you, no, because—. I only work two days a week, so, in terms of reading the Bill and digesting the Bill for today, I haven't had the time to go through my—. I've gone through with my colleagues and created a list of concerns, but I haven't yet been able to go back to the key officials with our list of concerns, although of course I will be; it's just early days.

[255] **Darren Millar:** I assume the majority of additional learning needs would present themselves or be identifiable by the age of three, but others could have a later onset, at some point, or someone might become disabled through an accident or an illness.

[256] **Ms Thomas:** Certainly. With deafness, meningitis can be quite a big cause of deafness as well, so that obviously could happen at later stages. So, yes, you're absolutely right.

[257] **Darren Millar:** Okay, thanks.

[258] **Lynne Neagle:** Okay, thank you. Some organisations have been pressing committee members to include a duty to meet the medical needs of children in schools as part of this Bill, but I know there's also a train of thought that that might weaken the emphasis on additional learning needs. Are you comfortable with the possibility that that might be included in the Bill?

[259] **Ms Inger:** Most of the formal medical needs are, perhaps, met in other ways, but when it comes to children's access into education, I think it could be strengthened by including it in the Bill.

[260] **Ms Thomas:** We have individual healthcare plans, which the guidance has just been reviewed for and there's a lot of good stuff in that guidance, but, of course, isn't statutory and an IDP is statutory. So, I think there's some merit in it, but, in order to really form a position on it, I'd need to know more about the proposals, really. But I would say it seems a bit strange that the IHP has been developed and the IDP has been developed and there doesn't appear to be much thought about how the two marry together.

[261] **Lynne Neagle:** Okay, thank you.

[262] **Mr Ruscoe:** Education, being an individual experience and an individual pathway, is often affected at times through other things, other than what might be considered an additional learning need under the Bill, yet it still has the same effect and has to be considered, because, if we don't, we're actually diminishing that individual's right to an education, to drive towards their potential. So, we would consider that it should be strengthened within the Bill. When the White Paper hit the table, years ago, it had all sorts of additional categories and issues listed in it, which was very exciting, and we weren't really surprised it had to be reduced back down again for pragmatic reasons. But the effects of young caring, the effects of other, what are now being referred to as 'adverse childhood experiences' on the opportunity to learn, if we're going to consider it in one place, we have to consider it elsewhere, otherwise we have to consider who we are actually going to discriminate against.

[263] **Lynne Neagle:** Okay, thank you. John.

[264] **John Griffiths:** Yes, I wanted to ask you questions about dispute resolution and openness and transparency, and fairness in the system. In terms of independent advocacy and the provisions regarding that, and the provision of information, are you reasonably content with what's proposed, or do you have considerable concerns?

[265] **Ms Inger:** We've got some considerable concerns that it's not clear, really. There's no surety that the provision of services will be independent. Parents are concerned that local authorities may look at it as independent between authorities, for instance, rather than independent within the third

sector, in that sense. So, we'd like to have seen that strengthened within the Bill—the information and advice, as well as the disagreement resolution itself.

[266] **John Griffiths:** I see.

[267] **Ms Thomas:** I agree. I think it's very weak. It's one of the areas that I was most disappointed in, actually. I think, to get the system to stand up, you really need the advocacy to be right, and one of the big things that the TSANA's been calling for for a long time is national statutory guidelines for advocacy services to make sure that they're transparent, consistent and operating to a minimum standard, and there's no clause within this Bill to permit the Welsh Government to create the statutory guidelines. But, aside from that, throughout the Bill, there's mention of notifying parents of decisions to cease an IDP and to review an IDP, but no mention, at the same time, of having to inform them of their right to appeal and their right to access advocacy. That's a massive oversight, to my mind. As families go through this process, at every single key stage, they need to be told directly where they can access this advocacy support, because the very people who need advocacy support are not the people who are going to be finding out where they can go to access advocacy.

[268] Aside from that, there's another issue that I really wanted to make sure that I brought up, because there's a big emphasis in the Bill on consent. Where a young person doesn't consent to have an IDP, the local authority governing body absolves itself of all responsibility. I completely understand that and I wouldn't want to force something on someone, but there is obviously a danger in that and we need to make sure that young people are fully informed of what an IDP is before they decline it and of what they're missing out on if they do decline it. I'm particularly concerned about that with the young deaf population, because I have met quite a few young people with hearing impairment who are—and they shouldn't be—almost embarrassed by the fact that they do have a hearing impairment and don't want to be labelled by that. I'm concerned that those people could be vulnerable to not having an IDP, just because they don't want to make a fuss. I wanted to make sure that I brought that up.

[269] **Ms Thomas:** I'd just say that, overwhelmingly, parents and young people do feel on the back foot, if you like, and stressed and anxious when dealing with schools and other agencies. That's how they feel. That's their perception, and I think that we do need to deal with that and to have schools

and all other agencies really being proactive in ensuring that children and young people and their families have access to that independent information and advice and support from the outset because that really is levelling the playing field and giving fair access to all families.

[270] **Lynne Neagle:** Tim.

[271] **Mr Ruscoe:** In the committee's questions to the Minister last week, you asked about the independence of advocacy, and the official was clear that information, advice and assistance wasn't necessarily independent, but that subsequent support would be considered independent. From long experience, we know that the earlier an advocate is available, people whose lives might be in periods of chaos and turmoil are better able to understand the system. So, we would suggest that, actually, independent advocacy services earlier in the information and advice stage is critical if you want to level the playing field in terms of understanding that information.

[272] I think Debbie was right in terms of the fact that there is no parent provision of advocacy in here, and if we're going to go through to a tribunal, for example, the child and the parent should be represented differently and independently of each other to ensure that each of those voices are heard and identified as separate. They might say the same things, but then you'll guarantee that the voices are properly heard.

[273] We have another concern about advocacy, in that, in the Bill, under section 62(1)(a):

[274] 'A local authority must—

[275] '(a) make arrangements for the provision of independent advocacy services',

[276] but, under (b) and (c), the authority must,

[277] 'refer any child or young person for whom it is responsible...to an independent advocacy service'.

[278] That implies that, under subsection (a), it might be free, and that, under subsections (b) and (c), there might be a charge. So, if we're talking about families going into dispute before an educational tribunal, they're not families who we want to put an additional charge on to get proper

representation.

[279] **Lynne Neagle:** Okay, thank you. Can I just ask about the new proposed system of IDPs, which replaces the other system, which was a three-tier system? Have you got any concerns that that might lead to a reduction in support for some of the neediest learners?

[280] **Ms Thomas:** I think Angie touched on it right at the start when she said about one of her biggest concerns, and that's about low-incidence needs needing to go up to local authorities. My experience in meeting front-line teachers is that quite often, they say to me, 'Oh, I've never had a deaf learner', and I go, 'Really? What, you've never had anyone who uses a radio wave or hearing aids or cochlear implants?', and they say, 'Oh yes, we've had some of those, but never a deaf learner'. It's not their fault, but they don't know that those children are deaf and, although they have assisted-listening devices, they can't hear in the same way that you or I can and they still need adaptations.

[281] Now, there's a lot of emphasis being put on schools and governing bodies to make decisions around whether or not children have IDPs in the first instance, and those types of needs are really vulnerable to being missed off the radar simply because front-line teachers, with the best will in the world, just don't have the awareness there. So, from a NDCS point of view, but also from a TSANA point of view, what we've been calling for is for specific disability awareness training for teachers. I've been disappointed in seeing the other ongoing developments in relation to initial teacher training. At the moment, it doesn't really address our concerns in that regard, and I was hoping for more marry up.

[282] The other big thing that we've been calling for, from a TSANA perspective, is for provision pathways to sit alongside the Bill to highlight disability-specific assessments that could be needed for different disabilities to help schools understand when things need to be passed up to local authorities and which professionals they need to call on for IDP assessments. I'm really happy to report that the key officials that we've been working with are keen to take forward disability-specific provision pathways, which is a great step forward.

[283] However, what we would have really liked is to see the provision pathways embedded into the face of the Bill to really give them that strength and clout, because I don't want them to become really good documents that

sit on a shelf, because the emphasis is always going to be on what people have to do. So, yes, I think low-incidence needs are very vulnerable in the system unless the appropriate checks and balances are put in place. The appropriate checks and balances are provision pathways—but making sure they're on a statutory footing—and teacher training.

[284] **Lynne Neagle:** Thank you.

[285] **Ms Richards:** I think, for a lot of young people that we represent, having an identified need may happen very early on—having an identified diagnosis may happen between the ages of five and 10. So, those children with autism, those children with speech and language issues and those children with a learning disability may not be diagnosed until seven or eight years of age. So, having access to an IDP when the need is identified, before the diagnosis, is really important in that circumstance.

[286] **Lynne Neagle:** Thank you. Did you want to say something?

[287] **Ms Inger:** Just to say, overall, the IDP is very welcome but, again, we need to ensure that we have the specialism that we need to run alongside that as well.

[288] **Lynne Neagle:** Okay. Tim.

[289] **Mr Ruscoe:** As an organisation, an alliance, we would welcome statutory templates, aiding the transition, the movement between local authorities—that there is a consistency, that there is a core content to the IDP that then is transferable.

[290] **Lynne Neagle:** Okay, thank you.

[291] **Ms Contestabile:** Just to pick up a bit more on Tim's point, IDPs really need to be linked in with other services, particularly social services for young people who are post 16. We feel there needs to be a legal requirement outlined so that young people's learning and development doesn't stop when they leave education in the traditional sense.

[292] **Lynne Neagle:** Okay, thank you. Llyr.

[293] **Llyr Gruffydd:** We touched maybe earlier on on where local authorities take responsibility for IDPs as opposed to governing bodies in schools or

further education institutions. I'm picking up clearly that you're not happy that there's sufficient clarity around at what point that sort of switch is made. So, how do you address that, then?

11:45

[294] **Ms Thomas:** For me, I think provision pathways are really important in terms of making sure that there's consistency for disabilities where there's a lack of awareness when they move up. So, for me, provision pathways are a big part of the answer. But the other problem in terms of the switch of responsibility that I touched on earlier is the fact that local authorities are responsible for specialist FE placements, and FEIs are responsible for mainstream placement IDPs. But that doesn't help us in terms of where does the young person go if they are looking at going for a specialist placement but they're refused, or they're looking at going for a mainstream placement but they're refused. Are they batted back and forth? How does that system work for them? In terms of my suggestion, the most easy solution would be for those to sit with the local authority, because that local authority probably would have been doing their IDP previously, so it's like more of a natural follow-on. I hope that answers the question.

[295] **Lynne Neagle:** Any other comments? No, okay. Did you want to ask—?

[296] **Llyr Gruffydd:** Yes. I'm struggling, really, with how—. It is difficult, isn't it, to draw that line clinically somewhere as to whether you fall into one category or the other. Surely that happens to an extent under the existing system. So, I'm just grappling a little bit with—. You mentioned the provision pathways, which is one way of potentially addressing it, but, then again, it will be different for every individual, won't it?

[297] **Ms Thomas:** Provision pathways would give you—. I mean, deafness: I reckon that deafness—. I know, when I first started, I didn't know very much about deafness, and I remember thinking, 'I wonder how you can have a full-time job where you are just looking at deafness.' But there are so many different needs within deafness; it is so diverse. The idea behind a provision pathway is to give the key indicators—these are the types of assessments that you might need to look at. From there, you know which set of specialist professionals do the assessments, and then it signposts on from there. So, from there, you can make the decision on can it then go back to the governing body, because, actually, all they need is a little bit of advice from a teacher for the deaf, and they're away to go, or can it stay with the local

authority because, actually, they need teacher for the deaf input on a regular basis. That's an example.

[298] **Ms Inger:** The IDP process itself will strengthen those transition arrangements if we can just have clarity of the thresholds, if you like, within that. But things are not going to be clear, really, until they are actually put into practice. There are so many what-ifs, if you know what I mean. It's about whether or not we'll have enough specialists on the ground, and whether or not we can get that health specialist in and get onto that provision pathway. So, our concerns are longer term, if you like. We're trying to put something into place, whereas, in reality, we have to begin where we are now. It's about whether or not we can do anything, really, that strengthens that transition, and those explorations, really, of what is possible and how far we need to go with the local authority, FE, or, indeed, HE, so that this young person, this unique individual, will get as much support as is possible.

[299] **Lynne Neagle:** Tim.

[300] **Mr Ruscoe:** The system is broken, and it hasn't worked for some people for a long time. Some of the reasons that it doesn't work are capacity to comply with the system. So, people are fighting to get statements, yet there isn't necessarily the capacity of the professionals required to deliver a statement in a timely fashion. So, that has to change. Going back to the original White Paper, the suggestion was that IDPs would be delivered on a multi-agency assessment basis—the multi-agency process of assessment—which we all welcomed. We thought, 'Wonderful. Everybody in the same place, working together, same hymn sheet—get it done.' And it was a multi-agency delivery plan against it. Now, things have changed, and it has moved on. Actually, there has now been this separation into sectoral responsibilities, which has diminished our excitement somewhat, whilst maintaining positivity about the individual nature of a development plan. In some ways, we think that if we could go back to a statutory requirement of a multi-agency assessment process, that will again simplify the issue for parents and families from the start.

[301] **Ms Thomas:** To follow on from that, and to hit on the point that you raised earlier, too, TSANA believes very strongly in the need for a statutory template for an IDP, for portability, for transparency, for legal accountability, for a whole host of reasons, and also for clarity for parents—that they know where they are and what is expected as well. I just wanted to highlight

research by NatSIP, which is the National Sensory Impairment Partnership. They did research into the English education, health and care plan, which really highlights that it's very problematic not to have a statutory national template.

[302] **Lynne Neagle:** Angela, on this.

[303] **Angela Burns:** I appreciate the national statutory template, and I think that's a good way forward, but I just wanted to go back to the comment that Tim made about having a statutory multi-disciplinary assessment of every child. I have to say that in the third Assembly I had thought when we looked at the previous ALN Bill that I had heard evidence that said that, actually, people were very lukewarm about that because they were worried that it would stop the progression pathways, and therefore that there might be a child, for example, who might have one need, say for speech and language therapy, and, until the whole multi-disciplinary lot could be convened, which people appreciated might take a lot of time and planning, then that child wouldn't be able to go forward on a single strand and that perhaps, rather than making that mandatory, they had to come back to the additional learning needs clinical officer, who would actually say, 'Right, we can start kicking off this child and that child on this, this and this kind of pathway'. Could you just comment on that? Because I just thought I heard—funnily enough, I'm sure it was in a TSANA round table session that I picked this up from before.

[304] **Mr Ruscoe:** If things are on the face of the Bill, it mandates that something will happen, and it can also mandate when it must happen. It can put the timely nature into the requirement. The things that you're talking about in terms of things that don't happen—. People's experiences differ because of the nature of the commitment of individuals from individual services, from different priorities within different boards, or different areas, or different local authorities. There are all those variables; we need take variables out of this process. We need to ensure that children, young people and families are properly assessed, that they know what they're going to get, and they know that they're going to get it in a timely fashion. Because that's what's missing now.

[305] **Angela Burns:** My concern with that though—and I totally agree with that, but, actually, my concern is about the reality on the ground, because if you were to say that you couldn't move forward with anything until you'd had your multi-disciplinary statutory assessment, if you take the area that I

represent, then some children will be forced to wait for four or five years because of the lack of community paediatric services that might be involved, for example, in a statutory assessment. Whereas if you put the onus back, surely, on an ALNCO, then they might be able to say, 'Well, actually, in the meantime little so-and-so could actually start having this, or I can push him into speech and language, or I can push him over here', to start some kind of intervention, 'because I know that, ultimately, we may think that he has A or B or C, and would need this kind of stuff anyway'. And I'm just so worried that, if we make it statutory, we're going to stop—because of the arguments we've all heard earlier about the fact that we don't have enough professionals in play.

[306] **Ms Thomas:** I understand where you're coming from. I agree with you; I don't want support to be held back because of waiting for another thing to take place. There is a clause in the Bill about joining IDPs up with other plans, and there's no mention there, which I would want to see, of a clause saying 'if it doesn't cause significant time delays'. I think you're right; that is a problem. From my point of view, the Bill doesn't go far enough in terms of multi-agency collaboration and encouraging it, but obviously we wouldn't want multi-agency collaboration to mean that everything gets delayed and you've got to—because it's likely to be children who are the most needy, with very complex needs, who would be those children who would be waiting time and time again. I think Tim's right, we want firm time limits in the code to help address that, but, yes, the legislation needs to be sensible.

[307] **Mr Ruscoe:** I think Angela is actually highlighting our concerns about workforce capacity in a lot of areas of the Bill. But I think, from our side of the table, it's incumbent on us to ensure that we strive for the best that the Bill can be, not the best that the Bill can deliver.

[308] **Ms Thomas:** And I think as well—I remember having a conversation quite a while back when the pilots that brought forward the ALN reforms were on, and I was having a conversation there with a local authority officer, and she was saying that potentially an IDP could state, 'Okay, we think this child might need speech and language therapy, but we haven't been able to get an assessment from a speech and language therapist, so we will put in as our action in the IDP that we will get an assessment from a speech and language therapist, and we'll still go ahead and approve the IDP so we can put the rest of the provision in place', which absolutely makes sense. I can completely understand why you'd do that, and I agree with it, but I think there need to be safeguards in place to make that that clause in the IDP that

says, 'Yes, we need to go and get a speech and language therapy assessment' is then followed up, and not left hanging, because then you're in danger of having an IDP that is a part IDP, and other crucial parts of the IDP aren't going to be legally enforceable and aren't going to be in place. So, I think that's something that the code really needs to grapple with, and it comes back again to looking at the responsibilities on how often they've not been strong enough.

[309] **Lynne Neagle:** Okay. Angela on the 0–25 system.

[310] **Angela Burns:** Yes, I just wanted to pick up on your comment, Zoe, because it's one of the areas where I've felt a weakness in the ALN Bill. Could you just give us an overview, though, of how you would like to see it operate, because, of course, once we're taking young people out of FE and putting them into either a work-based learning environment or into employment, then we're crawling into other areas that aren't necessarily under direct state control to play a part in that?

[311] **Ms Richards:** I think that it's about putting the onus on providers of apprenticeships. It wouldn't be able to work, for example, if a provider just had two young people wanting to access the apprenticeship system. There would have to be a provider that could gear up their system to support young people with additional learning needs, through job coaching mechanisms and those mechanisms that are used widely for young people, so that they'd be able to access—. One of the issues that we have with apprenticeships at the moment is that often you need five GCSEs to access an apprenticeship. Some young people with additional learning needs don't sit—. So, the framework around apprenticeships would have to change to be able to accommodate them.

[312] Work-based learning—only 0.07 per cent of the work-based learning group have learning disabilities, or additional learning needs, at the moment. Often, work-based learning opportunities are operated by further education establishments, so if young people are able to access work-based learning through FE, but they're not able to have their IDP and have their support needs met through another mechanism, it would be discriminatory, I imagine. So, yes, it's about having the providers charged with—. There'll be a fund available, so it's about the providers providing the IDP, or the FEs drawing up the IDP.

[313] **Angela Burns:** You beat a drum very close to my heart—can I just ask

you: have you had any discussions, as Disability Wales, with, for example, Qualifications Wales, in terms of reviewing the standard that everybody must have five GCSEs at C or above, no matter what their ability?

[314] **Ms Richards:** We approached the Minister, Alun Davies, just before Christmas, before the Bill was released, about those things—about removing the need for five GCSEs for apprenticeships et cetera—and it was something that was very close to his agenda, and he was going to look at taking that forward.

[315] **Lynne Neagle:** Michelle, is it on this?

[316] **Michelle Brown:** Yes, it's generally about the IDPs.

[317] **Lynne Neagle:** I want to stay with the 0–25s for a second. Hefin.

12:00

[318] **Hefin David:** Regarding the answer that you gave to Angela Burns—on the statutory duty that you mentioned, you also said that some providers wouldn't have capacity. So, is it possible that some providers would then be caught up in this, not being able to provide what they need to provide but having a statutory duty to do so?

[319] **Ms Richards:** It's possible, yes, and it's difficult, then, where it sits around the equality duties of a provider. There would need to be a commissioning process where you commission a provider, or a certain set of providers, to provide apprenticeship opportunities for these young people.

[320] **Ms Thomas:** For me, it's chicken and egg—if they know that they've got that responsibility out there, then they will try and meet it, and if they haven't got that responsibility, then they're not necessarily going to try and meet it. But my experience, anecdotally, is that employers do want to employ equally across all disabilities and needs, but they don't have an understanding of what they need to do. So, from my experience with deafness, I know of an employer that really wanted to employ a deaf young person for his carpentry skills—he was brilliant—but they had absolutely no idea how they were going to communicate with him because he was a British Sign Language user, and no-one at the firm could use BSL. And it was just a matter of educating them about the Access to Work fund and other things available to them, communication tips, and then they offered him the place,

and it was just a matter of them not having that basic awareness. So, if a clause like this was in place, what I'm trying to say is that they would seek out awareness. It's kind of chicken and egg, as I see it.

[321] **Lynne Neagle:** Okay, thank you. Michelle.

[322] **Michelle Brown:** Thank you, Chair. I just wondered what your perception is in the Bill—do you think there's enough input for parents, carers and learners into the formulation of the IDP?

[323] **Ms Thomas:** I think there are problems in terms of input from parents and children in the reviewing of an IDP and the ceasing of an IDP, because the Bill is quite clear in saying that they are just notified of decisions, which is totally wrong.

[324] I think in former discussions around person-centred practice, the emphasis has been on involving parents in assessments, and children in assessments, which I really welcome. But I think it needs to be backed up with training, so that teachers know how to do person-centred planning properly, and appropriate advocacy services, so that children can be represented appropriately.

[325] The other thing that I wanted to draw on in relation to your point was capacity—mental capacity—because there have been quite a lot of amendments in this iteration of the Bill around mental capacity. My concern with it is that the definition of when someone doesn't have the mental capacity to be involved in the assessment of an IDP is, 'If they do not understand the information presented to them.' Now, to my mind, there needs to be a clause in there to say, 'If they do not understand the information presented to them, having had that information presented in clear, plain language and in an accessible, child-friendly way that meets any communication needs'—because, otherwise, that could potentially wipe out a whole load of children in their call for an IDP and not having the capacity to be involved in the assessment. So, I think that needs to be addressed in order to meet your point of making sure that they are properly included.

[326] **Ms Inger:** If I could just add to that, to date, the families are saying to us that they're encouraged—many families have been encouraged with the IDP person-centred process and are able to engage—but there are many, many more that need early preparation to become engaged, and they find the whole process quite overwhelming. It is about recognising that those

families require the information and the explanation very early on. Schools, and many schools are doing a wonderful job—. I think the whole idea of person-centred planning is really taking off in our schools in Wales, particularly for children and young people, and schools are doing really, really well in including young people, you know, from the classroom base prior to the actual meetings and that, and that's really good practice. But, again, when it comes to the families, the parents are overwhelmed with the process, and they do require the preparation, the information, and they need to have an explanation, and they need to be able to understand everything before that meeting, because they will nod in the meeting—they will nod and sign—and then come to SNAP Cymru after, saying, 'I don't know what happened.' We have to get to grips with this. Families do require that early information, advice and explanation for as long as it takes. And some parents will need hand-holding. It will get better for those, because that's what we will try to do, but it's about being clear. The process itself is not going to work without proper engagement.

[327] **Ms Thomas:** I would say, across the board, there needs to be information available in plain language to all parents about these systems and structures. I think that's been a problem with the existing process, which has meant that parents felt excluded from it, and that the language in the documents given to them just seems—. They can't access it, and then they can't engage and be involved in it in the way they need to and want to. So, I think a lot of it is about making sure that access requirements are met and communication needs are met, when you're informing parents as part of this process. But across the board, information to parents needs to be in plain language.

[328] **Lynne Neagle:** Okay, thank you. The last questions from Darren then.

[329] **Darren Millar:** I just wanted to ask about the portability of IDPs. You've mentioned the need for a national template in order to aid portability, but, of course, people move across borders from one country to another as well, don't they? So, that will introduce additional complexities in terms of ensuring that there's adequate support in place for someone who moves, particularly during the school year, where there isn't time to review the support, necessarily, in a timely fashion with sufficient lead-in time. How do you see—? I mean, I can't see that sort of circumstance being catered for at all on the face of the Bill. How do you think the Bill could be amended to perhaps address that?

[330] **Ms Thomas:** I think this is an issue that we raised on the last iteration of the draft Bill, and I am pleased to see that there have been improvements made; they have started to outline in the Bill what would happen with cross-border issues. But the big concern for me in terms of—. I was to look at those clauses in more detail, really, before commenting on whether or not they do the job, but I'm pleased to see that at least they're in there now. In terms of portability more generally, across the border but also within Wales, I think we need a national Welsh statutory template for an IDP. It's relevant cross-border as well, because then they know what to expect if they're getting someone from Wales. It just makes sense, and I'm really gutted that it hasn't made it into this new iteration of the Bill. A relatively small nation having 22 different versions or regional versions of an IDP is just confusing for parents, but completely makes it unportable as well.

[331] **Ms Inger:** Certainly, we would ask again for a national template for looked-after children, for Traveller children, for the most vulnerable children. We believe that the national template is required and where we will have times where we have cross-country coming across, we'd like to really tighten up those timescales—of when that should be reviewed and how we can get it back, then, onto a Welsh national template as quickly as possible.

[332] **Darren Millar:** So, the prescribed timescales are the key there?

[333] **Ms Inger:** Very much so, yes.

[334] **Darren Millar:** Okay, thanks.

[335] **Lynne Neagle:** Okay. Well, we've run out of time. Can I thank you all for coming and for answering our questions, and just to say that the committee is very much looking forward to continuing the dialogue with you, going forward, as we look at the Bill? So, thank you for coming. You will be sent a transcript to check for accuracy in due course. Thank you very much.

12:09

Papur i'w Nodi Paper to Note

[336] **Lynne Neagle:** We'll move on, then, to item 4, which is a paper to note: the letter from NUS Wales to the Cabinet Secretary for Economy and Infrastructure regarding the mytravelpass scheme. I was going to suggest, if

the committee is happy, that we may want to write to the Cabinet Secretary to raise this issue. There doesn't seem to be a lot of information on the numbers of young people participating in the public domain, and I'm not clear what evaluation had been undertaken before the decision was taken to stop funding it. So, is that okay with everybody? Okay. Great. Thank you.

12:10

**Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd
o'r Cyfarfod**

**Motion under Standing Order 17.42 to Resolve to Exclude the Public
from the Meeting**

Cynnig:

Motion:

*bod y pwyllgor yn penderfynu that the committee resolves to
gwahardd y cyhoedd o'r cyfarfod yn exclude the public from the meeting
unol â Rheol Sefydlog 17.42(vi).*

*in accordance with Standing Order
17.42(vi).*

Cynigiwyd y cynnig.

Motion moved.

[337] **Lynne Neagle:** Item 5, then, is a motion under Standing Order 17.42 to resolve to exclude the public for the remainder of the meeting. Are Members content? Thank you.

Derbyniwyd y cynnig.

Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 12:10.

The public part of the meeting ended at 12:10.