GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

Response to Information Request by the National Assembly for Wales: Health, Social Care and Sports Committee

ABM University Health Board

The Health Board covers a population of approximately 500,000 people and has a budget of £1.3 billion. The Health Board is a population health organisation, responsible for both the health and wellbeing of its population and for delivering high quality health and care where it is needed. Both functions are done in partnerships with a range of other organisations.

The Health Board employs around 16,500 members of staff, 70% of whom are involved in direct patient care. From April 2019 the population of Bridgend will become the responsibility of Cwm Taf Health Board.

The Health Board has four acute hospitals providing a range of services; these are Singleton and Morriston Hospitals in Swansea, Neath Port Talbot Hospital in Port Talbot and the Princess of Wales Hospital in Bridgend. There are a number of mental health hospital sites, smaller community hospitals primary care resource centres providing important clinical services to our residents outside of the four main acute hospital settings.

The Health Board is currently structured into six Service Delivery Units, comprising of the four acute hospitals, Mental Health and Learning Disabilities services and Primary and Community Care services.

The Health Board acts as the service provider for Wales and the South West of England in respect of Burns and Plastic Surgery. In addition, Forensic Mental Health services are provided to a wider community, which extends across the whole of South Wales, while Learning Disability services are provided from Swansea to Cardiff. A range of community based services are also delivered in patients' homes, via community hospitals, health centres and clinics.

The Health Board contracts with independent practitioners in respect of primary care services, which are delivered by General Practitioners, Opticians, Pharmacists and Dentists. There are 77 General Practices across the Health Board.

During 2017/18 the number of General Medical Practices in the ABMU area reduced from 73 to 66 (having reduced from 77 in the previous 3 years, mainly due to practice mergers).

The Health Board also contracts with 125 Community Pharmacies, 95 Dental practitioners (including 7 Orthodontic and two oral surgery specialists) and engages with 52 Optometry practices who provide enhanced eye care services.

The Health Board remains responsible for directly providing general medical services to the registered patients of Cymmer Health Centre (circa 2500 patients). From 1st April 2017 the Health Board was also responsible for providing managed General Medical Services in Cwmavon for 3300 patients. To enable the Health Board to deliver high quality directly managed primary care services and to maintain the best possible service to patients, the two practices merged to become one Practice team delivering services from the two Health Board premises at Cwmavon and Cymmer.

General Medical Services within Her Majesty's Prison Swansea are also provided via ABMU. Outside normal practice hours the Health Board also has responsibility for the provision of an Out of Hours GP service.

Contents

Appendices

Section	Detail
1.	An extract of the NHS Outcomes Framework of relevance to mental health services
2.	The data source summary for the Together for Mental Health outcomes
3.	The MH and LD Annual Plan for 2018-19 being appendix 3 of the Health Board Annual Plan

1. Mental Health

1.1. A detailed breakdown of spend on mental health services for the last 3 years (including how total spend compares to the ring-fenced allocation).

The ring fencing of Mental Health Services was established in 2008. The basis of the original ring fencing was determined by the Programme Budget share of costs for Mental Health Services identified by Health Boards at that time.

The Mental Health Programme Budget includes:

- Mental Health Hospital and Community Services delivered within the Health Board, including overheads and indirect costs managed out with Mental Health Operational Budgets;
- Acute services provided for patients with diagnoses within the Mental Health Programme Budget definition;
- Services provided for Health Board residents by neighbouring Health Boards;
- Specialist services commissioned for Health Board residents by WHSSC;
- Prescribing and Primary Care Services relating to mental health diagnoses; and
- Continuing Health Care provided to patients with Mental Health diagnoses.

The Programme Budget spend for the last available 3 years is summarised below and compared to the ring-fenced sum included in the Health Board Allocation Letter. (2017-18 data will not be available until December 2018).

Figure 2: Programme Budget and Ring Fence Allocation			
	2014-15	**2015-16**	**2016-17**
	£000	**£000**	**£000**
Mental Health Programme Budget:			
Pharmacists	2,023	1,817	1,464
QOF	989	913	948
Enhance Services	517	798	900
Drug Prescribing	7,530	7,166	5,596
Other Primary	707	606	1,513
Sub Total	**11,766**	**11,300**	**10,421**
ABMU Provider	72,853	74,793	79,796
Other Providers	4,503	4,455	5,021
WHSSC	10,686	8,802	11,337
CHC (WCR1 PC Section)	19,470	21,728	24,091
Other Secondary Sectors	2,291	2,405	259
Total Programme Budget	**121,569**	**123,483**	**130,925**
	2014-15	**2015-16**	**2016-17**
	£000	**£000**	**£000**
Ring Fence	**108,278**	**108,278**	**111,013**

This comparison suggests a level of spend in excess of the ring-fenced sum. However direct comparison is not valid as the ring-fence includes significant elements not under the control of Mental Health clinicians and movements in spend against Programme Budgets will be subject to numerous variables including:

- Changes in Programme Budgeting guidance and definitions;
- Changes in costing policy impacting on fully absorbed costing returns;
- Data quality changes impacting on apportionment of costs to specialty level and assignment to Programme Budget; and
- Changes in flows of activity between Health Boards.

1.2. What mechanisms are used to track spend on mental health to patient outcomes?

Mental Health and Learning Disability Services are part of the overall NHS Outcomes Framework and outcomes are reported in the performance scorecard. Appendix 1 details those outcomes relevant to the delivery of Mental Health services, NHS Outcomes Framework – Mental Health.

In addition, **The Together for Mental Health (T4MH) Delivery Plan** includes a series of measures against outcomes as defined by Welsh Government. As follows:

Figure 3: Extract from The Together for Mental Health (T4MH) Delivery Plan

Chapter One: Better Mental Wellbeing and Preventing Mental Health Problems	1. Population wide physical and mental wellbeing is improved: people live longer, in better health and as independently as possible for as long as possible.
	2. People and communities are more resilient and better able to deal with the stresses in everyday life and at times of crisis.
	3. Child welfare and development, educational attainment and workplace productivity are improved as we address poverty.
Chapter two: A New Partnership with the Public	4. People with protected characteristics and vulnerable groups, experience equitable access and services are more responsive to the needs of a diverse Welsh population.
	5. Welsh speakers in Wales are able to access linguistically appropriate mental health treatment and care where they need to do so.
	6. People in Wales have the information and support they need to sustain and improve their mental health and self manage mental health problems.
	7. People with mental ill health experience less stigma and discrimination and feel that these problems are being tackled.

	8. People feel in more control as partners in decision making about their treatment and how it is delivered.
	9. Families and carers of all ages are involved in assessments for support in their caring roles.
	10. People of all ages and communities in Wales are effectively engaged in the planning, delivery and evaluation of their local mental health services.
Chapter Three: A Well Designed, Fully Integrated Network of Care	11. Service users experience a more integrated approach from those delivering services.
	12. People of all ages benefit from evidence based interventions delivered as early as possible and from improved access to psychological therapies.
	13. Service user experience is improved, and safety, protection and dignity are ensured and embedded in sustainable services.
	14. Providers are positively managing risk, supporting people to increase their levels of hope and aspiration and enabling them to realise their full potential through recovery and enablement approaches.
Chapter Four: One System to Improve Mental Health	15. People of all ages experience sustained improvement to their mental health and wellbeing as a result of cross-Government commitment to all sectors working together.
Chapter Five: Delivering Better Mental Health	16. Staff across the wider workforce recognize and respond to signs and symptoms of mental illness and dementia.
	17. Inspirational leadership and a well-trained, competent workforce in sufficient numbers ensure a culture which is safe, therapeutic, respectful and empowering.
	18. Evidence-based high quality services are delivered through appropriate, cost effective investment in mental health.

There is a defined source of information for the above outcomes, which are set out in Appendix 2: Data Source for T4MH outcomes.

Clinicians use tools for measuring outcomes. These are not used universally but in response to identified clinical need, examples include HAD scale, PHQ9, CORE-10, and Warwick Edinburgh Mental Well-being Scales:

- HAD Scale - The Hospital Anxiety and Depression Scale is an easy to use 14 question tool in common use to gauge a person's level of anxiety and depression as they often come hand in hand.
- PHQ9 - The Patient Health Questionnaire 9 is a simple and quick to use 9 question, primary care level tool that can be used to predict the presence and severity of depression.

- CORE 10 - Clinical Outcomes in Routine Evaluation 10 is one of a number of outcome measurement tools that can be used for screening and monitoring, session by session, in relation to psychological distress. The CORE 10 version is brief for questions cover anxiety, depression, trauma, physical problems, functioning and risk to self which can be tracked over time.
- The Warwick-Edinburgh Mental Well-being scale is a 14 question scale used in monitoring mental wellbeing in the general population and also the evaluation of projects which aim to improve mental wellbeing.

The Health Board continues to engage with Welsh Government and contributes to a national project to develop a Mental Health core dataset which, linked to the roll-out of the Welsh Community Care Information System, will improve future outcome measurement. The WCCIS is the new computer system being introduced in Wales to help health and social care professionals work together to provide care closer to people's homes.

Welsh Government has established a Mental Health and Learning Disabilities Core Data Set Project Board supported by the 1,000 lives improvement team in Public Health Wales. The aims of this national project are to improve the quality of care and treatment planning, and to improve therapeutic relationships. They have published a paper on the proposed model for outcome measurement in Wales. All health boards will capture three measures: the service user experience; whether goals identified by the service user were met; and a measure to consider improvement. A subgroup is developing a work plan that will see them engage with each health board in Wales including service users and carers. We are looking forward to this support for developing consistent approaches to services user and carer focused outcome measurement in health and social care.

Whilst there are a wide range of outcome measures for Mental Health and Learning Disability services and patients, and ongoing work to define and measure outcomes, there are currently no routine processes in place for tracking spend to these outcomes. There are however well established mechanism for tracking spend.

1.3. Health board priorities for mental health services/spend for the next three years. How outcomes will be measured?

Due to the Health Board's escalation status, Targeted Intervention, it currently has an annual plan, the ABMUHB Annual Plan 2018-19.

Priorities for Mental Health and Learning Disabilities are captured within the body of the Plan and within the supporting Service Improvement Plan. The Service Improvement Plan includes measures of success. Priorities within the body of the Plan include:

- In 2017-18, the Health Board commissioned an external clinical review of Older People's Services. This concluded that there was significant potential to improve the quality of care by rebalancing the service model from an inpatient to a community-based service. The report highlighted that Welsh peer group services have a 50:50 ratio of inpatient to community services which in ABMUHB is a 70:30 ratio. To

underpin the changing service model, the Health Board has invested approximately £1.5m in Older People's Community Mental Health services and this has a supported a programme of changing service models with 18 beds being reduced in 2017-18 on a temporary basis pending consultation. Plans are in place within the overall Service Remodeling Programme for a further reduction in 2018-19 which will be phased based on the ratio levels. Further detail on the plans for and impact of these changes is included in appendix 3.

- Investment in the infrastructure to support the redesign of Learning Disabilities and Mental Health accommodation to support new ways of working.

The Service Improvement Plan includes the following specific actions on Mental Health and Learning Disabilities:

Figure 4: Specific Actions on Mental Health and Learning Disabilities from The Service Improvement Plan

Corporate Objectives	Drivers	Actions	Measures
Promoting and enabling healthier communities	Living Well	Improve access to services to support mental health wellbeing as part of the implementation plan for the Strategic Framework for Adult Mental Health and the plans for the new Health and Wellbeing Centres.	The measures are to be confirmed as part of the development of Health and Wellbeing Centres.
Delivering excellent patient outcomes experience and access	Timely access to urgent or emergency care	Development of Elderly Mental Illness, EMI, care home in-reach services to support care home staff in management of mental health needs of residents and avoid need for referral to ED or admission to acute or psychiatric inpatient care.	Reduction in admissions from EMI Care Homes on 2017-18 baseline.
	Reduction in unnecessary hospital attendance	Psychiatric liaison service to be introduced.	98% compliance with 1 hour response time from referral to assessment for psychiatric liaison services.

			Reduction in numbers of frequent mental health attendees on 2017-18 baseline.
	Reduce patient risk through reduction in avoidable delays and prolonged hospital stay	Implement measures for mental health services to general wards.	Improvement in compliance with same day admission by psychiatric liaison team on 2017-18 baseline. Reduction in numbers of patients on general wards awaiting a MH bed.

The overall strategic direction for mental health within the Health Board remains unchanged, reflecting the current all-Wales Strategy for Mental Health and Wellbeing, Together for Mental Health (T4MH), and extant policy guidance. The Health Board is fully engaged in delivering the Together for Mental Health Delivery Plan and the Mental Health Measure 2010. The Mental Health and Learning Disabilities Plan is included as Appendix 3 to the overall HB plan, see attached Appendix 3 to this response.

1.4 Do funding arrangements, including the mental health ring-fence, strike the right balance between taking a holistic approach to meeting an individual's needs, and ensuring resources for mental health are protected?

There is real merit in ring fencing mental health funding to protect resources for Mental Health. However there is a potential conflict between protection of direct Mental Health service provision and meeting the holistic mental health needs of an individual. This becomes increasingly challenging due to the complexity of patient needs which may span Mental Health and many other services.

1.5 How demand/capacity and spend on mental health services not directly provided by the health board is captured (e.g. in primary care, voluntary sector)?

The expenditure associated with care provided within primary care and by external bodies can be identified as relating to Mental Health are captured as part of the Programme Budget calculation described in 1.1.

Primary Mental Health Services are addressed through Primary Care Cluster Plans. Some examples of services to support demand include: Counselling Services provided by Third Sector, Wellbeing Counsellor attached to the Neath Hub and Active Social Prescribing to alternative sources of support.

1.6 A breakdown of spend on emotional and mental health services for children and young people (last 3 years). This should include information on all services, not only specialist CAMHS, and should be broken down by area (e.g. primary, secondary, crisis, therapeutic, voluntary sector etc.).

The majority of CAMHS services are provided by Cwm Taf University HB supplemented by some in-house provision by ABMU HB. The services provided by Cwm Taf University Health Board are managed through a Long Term Agreement, LTA, between the two health boards. Further specialist services are commissioned by WHSSC, the Welsh Health Specialised Service Committee. These are provided by Cwm Taf University Health Board and from out of area placements and services.

Figure 5: CAMHS Expenditure

Services	Provider	2015-16 £000	2016-17 £000	2017-18 £000
Core Services	Cwm Taf UHB	2,972	4,166	4,226
	ABMU HB	-	461	470
	Sub-total	**2,972**	**4,627**	**4,696**
Specialist Services	Cwm Taf UHB	794	885	1,016
	Out of Area	472	378	299
	Sub-total	**1,266**	**1,263**	**1,316**
All	**Grand Total**	**4,238**	**5,891**	**6,012**

Further analysis of the core services is provided below:

Figure 6: Further Analysis of Core CAMHS Services

Service	2015-16 £	2016-17 £	2017-18 £
Core LTA Services	2,971,873	3,244,082	3,451,252
Additional Services:			
Cwm Taf - Local Primary Mental Health Services	-	132,102	134,744
Cwm Taf - Psychological Therapies	-	181,641	185,274
Cwm Taf - Crisis Support + T4CYP	-	445,845	454,762
ABMU - Neuro Disability Development Team	-	330,256	336,861
ABMU - Early Psychosis	-	130,646	133,259
Other:			
Non-recurrent costs of high cost patient	-	162,797	-
Total	**2,971,873**	**4,627,369**	**4,696,151**

Note: T4CYP – Together for Children and Younger People

2. Primary Care/Secondary Care split

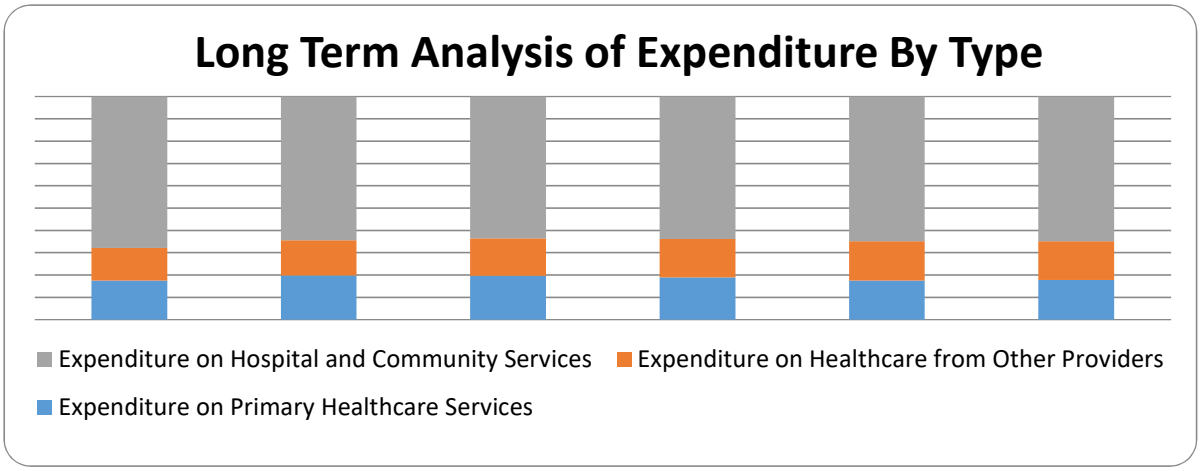
2.1. Health Board spend on Primary Care for the last three years including proportion of Health Board spending

The Health Board has seen movements in its expenditure patterns since its inception and the movements in the expenditure for the financial years 2012/13 to 2017/18 are documented below by the main expenditure headings of:

- Expenditure on Primary Healthcare Services;
- Expenditure on Healthcare from Other Providers;
- Expenditure on Hospital and Community Services;

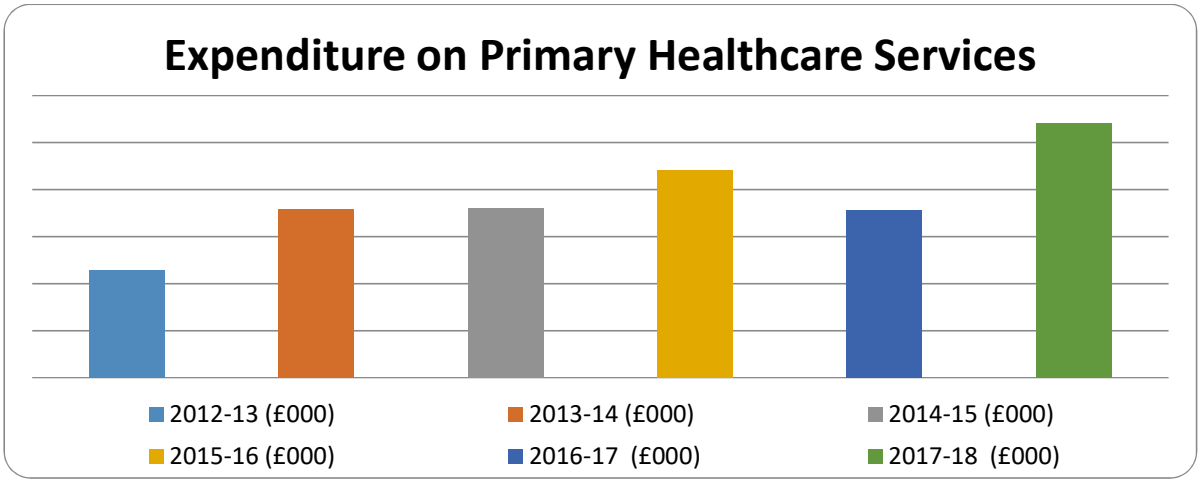
As demonstrated in the table below whilst there have been movements in each of these headings over the last 5 years, an analysis of the expenditure shows that the mix of expenditure is broadly consistent year on year.

	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000
Primary Healthcare Services	226,411	232,867	232,967	237,071	232,790	242,052
Healthcare from Other Providers	188,769	186,724	199,632	216,761	236,363	238,469
Hospital & Community Services	881,006	762,917	756,410	802,341	868,757	887,423



Expenditure on Primary Healthcare Services

Expenditure on Primary Healthcare Services comprises expenditure on the Primary Care contracts for General Medical Services, Pharmaceutical Services, General Dental Services, General Ophthalmic Services, Prescribed Drugs and Appliances and other Primary Health Care Expenditure.



After an increase from £226m to £232m in 2013/14, expenditure on Primary Health Care Services remained consistently at around £232m over the period 2013/14 to 2014/15. In 2015/16, expenditure increased to £237m as a result of increased costs of prescribed drugs and appliances with increases in the volume of items prescribed and price increases.

In 2016/17, there was a reduction in expenditure to £233m which was due to £3.501m of rates rebates (relating to 2016/17 and previous years) in respect of GP premises following successful ratings appeals. In 2017/18, expenditure increased to £242m with the main increases being in General Medical Services of £5.7m which included increases in the costs of enhanced services and the costs of GP Out of Hours Services. Both of these areas of spend reflect a movement of services away from hospitals to a Primary Care setting.

2.2. Health Board prioritisation of capital funding for Primary Care

The Health Board has invested £1.372m in Primary Care sites since 2015. This can be broken down into these individual schemes below:

	Capital Spend £'000		
Scheme	**15/16**	**16/17**	**17/18**
Bron Y Gan , Maesteg	390	42	
Briton Ferry HC	26		
Cwmbwrla Clinic	17		
Pontardulais	33		
Brynhyfryd		20	3
Glanrhyd North Hub		440	12
Cwmafan		8	
Ystalyfera			64
Dyfed Road			317
Total	**466**	**510**	**396**

A number of other schemes have also been undertaken as Joint ventures through Primary Care revenue eg Mayhill, Vale of Neath and Porthcawl.

In addition to the above, Welsh Government has approved four large capital schemes, which are scheduled to complete before the December 2020. These four schemes are:

- Murton Clinic refurbishment £400k;
- Penclawdd Clinic refurbishment £800k;
- Bridgend Well Being Centre New Build £5m;
- Swansea Well Being Centre New Build £10m.

3. Preventative spend / integration

3.1. Can the health board demonstrate a greater focus on prevention and early intervention in its allocation of resources;

The Health Board – through its medium term plans, and supported by the allocation of resources to various service units and pathways – has always aimed to shift the focus from treatment to prevention, or at least earlier intervention.

These efforts range from measures that can be defined as primary prevention – those that seek to prevent ill health – to those that seek to intervene as early as possible when illness or risk factors are identified in order to halt or slow the progress of conditions. Examples from the last few years include:

<u>Primary prevention</u>

- Significant work to increase vaccinations and inoculations, especially for vulnerable residents. This is especially true of efforts to increase influenza vaccination, where we have undertaken a number of initiatives targeting care home residents, vulnerable adults etc. This has included general practice, community pharmacy and district nursing teams, as well as efforts to improve our own staff uptake;
- Improvement plans to increase rates of childhood vaccination and immunisation, including 2 and 5 year old boosters;
- Increasing rates of commissioning from community pharmacies in areas such as smoking cessation and flu vaccinations;
- Improved commissioning of third sector services, such as “Healthy Home” initiatives, befriending schemes, social prescribing, older people’s café, career support mechanisms etc.;
- A major scheme to pilot cardio vascular risk assessment and health checks in relatively deprived areas, to identify residents with cardio risk before it manifests in ill health;
- Work across four cluster areas to identify residents with pre-diabetic conditions with an aim to improve rates of exercise, promote healthy diet and prevent onset of diabetes. In addition, across a number of other cluster areas, a number of pilot

schemes have been introduced to promote activity, reduce obesity and increase general "healthy living" activities;

- Promotion of screening initiatives including brief GP intervention, especially in low take-up screening streams such as bowel cancer;
- Progress has been made in introducing health and wellbeing initiatives for young people to deflect from risky activity, improve levels of counselling support and promote healthy lifestyles. In addition, the introduction of primary care early years workers aims to embed healthy lifestyles, reduction of harms etc. at very early ages;
- In dental services, the introduction of the contract reforms promoted by Welsh Government has seen a step change away from "see and treat" as the model for contract remuneration, instead moving to a "see and prevent" approach. This is beginning to change attitudes of both the dental profession and patients away from treatment being the main goal of a dental appointment, and instead the creation of prevention plans and quality of care being the goal of general dental practice. This is beginning to show better levels of accessibility to dental services, especially for those for whom there have been difficulties in the past.

<u>Early intervention</u>

- Commissioning diabetes and care home enhanced services from general practice, to shift the emphasis from treatment to planning and preventive care;
- Efforts to reduce levels of inappropriate or unnecessary antibiotic prescribing, through professional education, public awareness, use of new techniques such as point of care testing for C-reactive proteins etc.;
- Adoption of an anticipatory care model of community care, which seeks to identify the future likely care and treatment needs of vulnerable and frail residents. This was successfully adopted and is gradually becoming embedded in everyday practice;
- Implementation of revised approaches to people with mild to moderate mental illness such as depression and anxiety. The aim is to "de-medicalise" care for people who instead derive more benefit from social prescribing, counselling or other treatment to reduce the likelihood of progression of mental illness. This incorporates the trialing of local area coordinators who have access to a range of services to reduce social isolation, non-medical referrals etc.;

Through its work with Public Service Board partners, the Health Board is also engaged in a number of multi-agency initiatives and programmes that have a 'health in all policies' approach, seeking to influence the risk and protective factors that have a bearing on health and wellbeing. Examples include work on housing and the wellbeing at work agendas.

3.2 What evidence can the health board provide about progress made towards more integrated health and social care services?

The Health Board works in partnership across a range of Child and Adult Primary and Community Services as identified below:

Integrated Flying Start service

Flying Start is the Welsh Government's flagship Early Years Programme for families with children who are under 4 years of age. The programme aims to make a decisive difference to the life chances of eligible children in identified Flying Start areas.

There are 18 Flying Start childcare settings based in schools across Swansea with the Health Visitors and Community Nursery Nurses co – located. These settings are grouped into 5 teams with midwives, speech and language therapists, early language workers and family facilitators allocated to a team.

The 4 Flying Start Entitlements

Health Visiting & Midwifery deliver

- An enhanced Child Health Programme for the child's first 4 years
- Smaller number of children on their caseloads
- Conduct group activities e.g. baby massage
- Midwives work with first time mothers who are under 25 years and their partners
- Midwives provide 1-1 and group support

Early Language Development

- Pathway to support language, communication and social skills
- Provided by Speech & Language Therapists and Early Years workers
- Conduct group activities e.g. Baby language and play, parent toddler, language and play for 2-3 year olds

Family Partnership

- Support families through their parenting journey and the challenges they face as a parent/carer
- Specific work with Dads

Quality Childcare for 2-3 year olds

- 5x 2.5 hours free childcare a week for 42 weeks
- Delivered through medium of Welsh and English
- Well qualified staff in settings of the highest standard
- Additional support for children with emerging or diagnosed disability

Health Visiting delivers the health Child Wales Programme, working with partners across public and third sector.

The (Healthy Child Wales Programme) HCWP will be a universal health Programme for all families with 0 – 7 year old children. The HCWP sets out what planned contacts children and their families can expect from their health boards from maternity service handover to the first years of schooling. These universal contacts cover three areas of intervention:

- Screening;
- Immunisation; and

- Monitoring and supporting child development.

ABMU is a partner organisation with Bridgend County Borough Council, South Wales Police, Police Commissioners Office and Probation Service in the development and delivery of a Multi Agency Safeguarding Hub (MASH). This concluded that the MASH approach leads to:

- Streamlined decision making through enhanced intelligence;
- Risk is collectively addressed;
- Opportunity for early intervention and prevention of repeat referrals;
- Demand being created but repeat referrals can be effectively reduced.

Safeguarding and promoting the welfare of vulnerable groups is everyone's responsibility and the evidence nationally and locally indicates that information sharing is vital to achieving this. Despite professionals' best efforts, information sharing is always a theme within any review process where improvements have to be made. The MASH provides the opportunity for agencies to do this better through co-locating professionals (either physically or through virtual means) to improve the quality of information on which decisions are based and making the sharing of this information quicker and easier.

The MASH brings key professionals together to facilitate early, better quality information sharing, analysis and decision-making, to safeguard vulnerable children, young people and adults more effectively. In addition, the development of the MASH in Bridgend coincided with the implementation of the Social Services and Well Being (Wales) Act 2014 (the Act).
Official Launch date is 16th October 2018.

In relation to Integrated Adult Community Services

One of the main, and quantifiable, pressures on current services arises from the growth in the number of people who are frail. People who are frail are also typically, though not exclusively, old and many will therefore have dementia. Identifying the potential impact on services, and resource use, from this group of people, and then focussing our efforts on meeting these needs differently through an enhanced intermediate, integrated health and social care model is therefore vital.

Working together Abertawe BroMorgannwg Univesity Health board, (ABMU HB) the City and County of Swansea (CCoS), Neath Port Talbot County Borough Council (NPT CBC) and Bridgend County Borough Council (BCBC) have developed integrated community services to tackle these pressures.

In September 2013, the four Western Bay partners approved the joint commitment for Community Services, *Delivering Improved Community Services,* through their respective Cabinets/Health Board.

Following the development of the Business Case, further work was undertaken to develop a model that continues to underpin Community Services delivery across Western Bay. The model '*What Matters to Me – Supporting our older population; The new way of working for health and social care across the Western bay region'* was developed in 2015.

Statutory requirement

There is a strong intent to improve health and wellbeing in Wales as outlined in *The Parliamentary Review of Health and Social Care in Wales - A Revolution from Within: Transforming Health and Care in Wales (Jan 2018);* which supports sustainable development through the Social Services and Wellbeing (Wales) Act 2014 and the Wellbeing of Future Generations (Wales) Act 2015.

In terms of complying with the Social Services and Wellbeing (Wales) Act 2014, integrating services to deliver the intermediate tier of services to the frail and elderly has enabled a range of services to delay, or prevent, the need for dependence on long term formal statutory service support.

- Services are available to provide the right support at the right time;
- More information and advice is available;
- Assessment is simpler and proportionate – via a central access point – one point of contact;
- Carers have an equal right to be assessed for support.

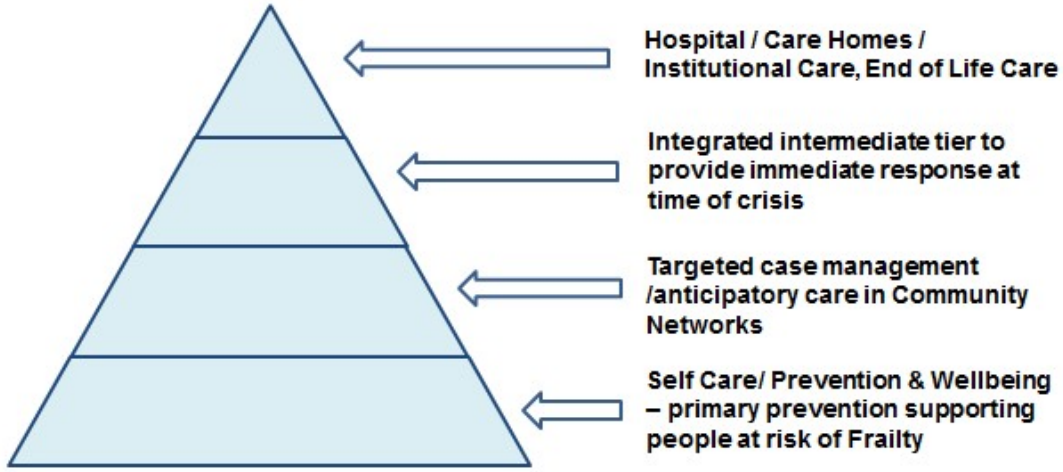
Intermediate Care Business case vs Progress to date/delivery

The integration of health and social care is making a significant contribution to the wider health and social care community as a result of the joint commitment delivering improved community services enabling:

- Support for people to remain independent and keep well;
- More people to be cared for at home, with shorter stays in hospital if they are unwell;
- A change in the pathway away from institutional care to community care;
- Less people being asked to consider long term residential or nursing home care, particularly in a crisis;
- More people living with the support of technology and appropriate support services;
- Services that are more joined up around the needs of the individual with less duplication and hand-offs between health and social care agencies;
- More treatment being provided at home, as an alternative to hospital admission;
- Services available on a 7 day basis;
- Earlier diagnosis of dementia and quicker access to specialist support for those who need it.

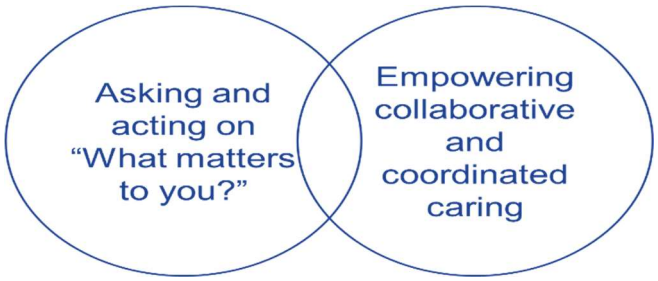
This means that we are now delivering:

1. Services that support people to remain confident independent and safe in their own homes for as long as possible and in accordance with their dignity and choice.
2. Services that are coordinated to reduce the number of unplanned admissions into hospital and long term care and support timely discharge when a hospital admission is appropriate.



In time this work will result in realignment of capacity, and a shift of resources, into community services to enable more people to receive the right assessment and service in the setting most able to meet their needs.

Two overlapping principles are central to helping us deliver our vision:
Asking and acting on "What matters to you?"



Each part of the pathway is supported by a multi-disciplinary – cross sector team from Health and Social care with the most appropriate professional supporting individuals/families as required.

Common Access Point
Access via one contact number, on the basis of that conversation, either they are offered a rapid response, advice and information or signposting, including third sector, where appropriate. Where applicable, a proportionate assessment will be undertaken to access the most suitable response or intervention.

Rapid Response
The rapid response service is available through a rapid clinical response (doctor, nurse and/or therapist). The response will be within 4 hours between 8am and 8pm. The main intention of rapid response is avoiding admission where appropriate or expediting discharge.

Access for people with Dementia
A rapid response access pathway for a person with dementia that needs support from a mental health professional during a crisis.

Step-up/Step-down Assessment
A package of care lasting up to 6 weeks, commonly in an individual's usual residential setting, which provides care and support to maximise independence. This would normally be offered where support is needed to avoid hospital admission, or when someone needs intensive support upon discharge from hospital.

Reablement
Reablement focuses on helping people to regain skills that they may have lost, due to hospital admission or illness. A package of care lasting up to 6 weeks which may include both health and social care interventions to address the client's individual needs.

Third Sector Brokerage
A third sector representative who operates as part of a Common Access Point to provide alternative solutions where statutory support is not needed.

With regional support and ICF funding, the Intermediate Care Services developed the Optimal Model:

Business case 2014 recommended delivering	**Delivery mechanism via the Optimal Model 2018**
Support for people to remain independent and keep well	**Local delivery and links to prevention;** **WB need to engage further to share what is being achieved;** **Acute Clinical Team;** **Reablement;** **Step up/step down;** **Third Sector Broker**
More people cared for at home, with shorter stays in hospital if they are unwell;	**Acute Clinical Teams (ACT);** **Reablement;** **Step up /step down;** **Domiciliary care market stability (part of wider community services)**
A change in the pathway away from institutional care to community care;	**Reducing residential care home placements due to more support being delivered at home;** **Reablement;** **Domiciliary care**
Less people being asked to consider long term residential or nursing home care, particularly in a crisis;	**ACT;** **Reablement;** **Step up/step down**

More people living with the support of technology and appropriate support services	**Local delivery**
Services that are more joined up around the needs of the individual with less duplication and hand-offs between health and social care agencies;	**Integrated Health and Social Care Teams that are also co-located; Will be enabled and enhanced by WCCIS development**
More treatment being provided at home, as an alternative to hospital admission;	**ACT; Reablement**
Services available on a 7 day basis	**ACT across all Local Authorities**
Earlier diagnosis of dementia and quicker access to specialist support for those who need it.	**Mental Health leads in each Common Access Point; Dementia Support Workers**

3.3 How will outcomes be measured, given that the benefits of preventative activity may only be seen in the longer term.

Reporting outcomes over a long period can be challenging. Below are a range of reporting outcomes used for some of the services identified.

Childhood and Healthy Child Wales Programme

Dental Health, number of dental caries
Immunisations rates
Domestic Violence rates
Flying start Service Activity Data

Public Health

Mortality figures
Morbidity figures
Public Health Outcomes Framework indicators

Optimal Adult Service Reporting and Outcomes

The key features of the optimal model are tracked from baseline for each area and key performance measures are reported to the performance sub group on a monthly basis and back to the Community service board quarterly.

- Emergency Unscheduled Hospital Admissions 65+ and 75 + Month by Month comparison between 2014—2017.

- Hospital Admissions Rates (>75) Per 1000 Population between April 14—April 17.
- Emergency Unscheduled Hospital Admissions (>75) Patients between April 14—April 17.
- Total Bed Days Consumed (Age 75+) originally admitted as an unscheduled care medical admission April 2014—April 2017.
- Emergency Unscheduled Hospital Admissions 65+ and 75 Month by Month comparison between 2014—2017.
- Total Number of People Support In a Care Home Aged 65+ between 2015—2017.
- Total Number of New Care Home Admissions Month by Month Comparison between 2014—2017.
- Care Home Admissions aged 65> between April 2014 and April 2017.
- Total Number of Funded Continuing Healthcare (CHC) new starters April 2015 - *Month* 2017.
- Total Number of people supported By CHC April 2015 — *Month* 2017
- Total Number of Funded Nursing Care (FNC) new starters April 2015 — *Month* 2017
- Total Number of people supported by FNS April 2015 – *Month* 2017
- Total Number of New Domiciliary Care Starts aged 65+, Quarter by Quarter comparison 2014—2017
- Average Domiciliary Care Hours per Client Per Month between April 2014—April 2017
- Total Number of Domiciliary Care hours provided between April 2014 and April 2017
- Rapid Response (ACT):

Analysis from the Service Evaluation suggested that the Western Bay programme is performing effectively in a number of areas; Cordis Bright (2017), further suggests investment in intermediate care services should be continued in areas showing the greatest impact.

4. Admitted patient care

4.1. The total spend for admitted patient care is derived from Patient Level Costing Returns (PLICs).

The 2017/18 Costing Returns in Wales will not be available until November 2018, following the implementation of a new All Wales Costing System. An estimate based on activity and total expenditure has therefore been included.

The figures below reflect the cost of Inpatient and Day case admissions in acute specialties (excluding Mental Health):

Admitted Care Spend £m	Elective	Emergency	Total APC
2015/16	154	220	374

2016/17	165	234	399
2017/18 est.	167	244	411

Future levels of demand and expenditure will be subject to numerous variables including:

- Demographic and social change.
- Inflation and other cost pressures.
- Technological advances.
- The impact of prevention and admission avoidance schemes.

These impact of these variables are unpredictable, taking into account the impact of ***demographic change only*** the following levels have been projected over the next three years:

Admitted Care Spend £m	Elective	Emergency	Total APC
2018/19 Demand Impact	169	246	415
2019/20 Demand Impact	171	249	420
2020/21 Demand Impact	172	251	424

5. Workforce

5.1. Progress in addressing workforce pressures identified by the health board ahead of last year's budget:

At the end of last year the Health Board reviewed its workforce recovery and sustainability programme and refocused the work to concentrate on three main areas that would address the main workforce pressures; these are Improving rostering, employee health and wellbeing and reduction of variable pay.

Improving rostering

The Health Board is implementing several measures to ensure the effective use of our resources. To support the role out of e rostering in nursing, standardised shift patterns have been introduced to reduce the variance in working arrangements and increase efficiency in providing our services.

There has been investment to migrate all nursing staff to one integrated rostering and bank system which supports efficient rostering and allows increased management scrutiny of

variable pay. This will enable us to improve our rostering practice and manage our staffing resource more effectively.

We will be implementing a reporting template based on key performance to support consistent reporting. The roll out of the rostering system is on schedule and has been well received by nursing staff.

The Health Board is also extending the use of the bank system to other professionals including Medical staff to ensure a consistent framework for the effective management of temporary staff.

Health and Wellbeing

The Health Board recognises the importance of supporting our staff to maintain their Health and Wellbeing and has focused it work in this area in enabling managers to support staff through providing training opportunities for managers in 'Mental Health in the Workplace for managers' and training in the HSE work related stress risk assessment for managers.

A key component of our work has been to improve access to health and wellbeing services and we have implemented a single point of access and established an Occupational Health early intervention wellness service. We are also working on improving our occupational health processes and making use of technology to gain efficiencies, such as using text reminders for appointments, using speech recognition software to type reports and implementing the Cohort referral module.

Plans are in place to review our service model of delivery and we are developing AHP and nurse practioner roles to support improved service delivery so staff and managers have improved access and response from our occupational health service.

Variable Pay

There are numbers of drivers affecting variable pay, and we have focused on some key areas to work on. Sickness absence remains high and we have focused on supporting managers to manage effectively. We have undertaken a best practice case study and will be rolling out the findings of this in the coming months. We have developed return to work pathways for common conditions to support managers in managing staff with these conditions and we are reviewing are phased return to work guidance to support managers and staff to manage staffs return to work following sickness absence more appropriately, giving greatly flexibility regarding the length the return to work and duties undertaken.

We have undertaken the diagnostic element of the Monitor Agency Diagnostic Tool and will be rolling out the recommendations of this this year. We have migrated migrate all nursing staff to one integrated rostering and bank system which supports efficient rostering and allows increased management scrutiny of variable pay and we are developing a proposal to have a central bank for all staff which will support greater efficiencies and ensure effective controls and management scrutiny are in place.

We have also undertaken extensive work to support nurse recruitment and we continue to engage nurses from outside the UK to help mitigate the UK shortage of registered nurses. To date we have in our employ:

- EU Nurses employed at Band 5 = 70
- Philippine nurses arrived in 17/18 and employed at Band 5 = 30
- Eight HCSW's with overseas registration have recently commenced a programme developed with Swansea University to become registered nurses in the UK.

We also hold regionally organised nurse recruitment days, these are heavily advertised across social media platforms via our communications team.

Eleven of our Health Care Support Workers (HCSW's) have been recruited to a part time degree in nursing. Seven commenced in September 2017 on a four-year programme, the remainder commenced in January 2018 on a two year nine month programme. We have also secured further external funding to offer similar places to Thirteen HCSW's in 18/19 and recruitment to these places is underway. A further thirteen of our HCSW's are currently undertaking a two-year master's programme.

We are also undertaking work to understand what our workforce of the future needs to be to deliver our services, this will include workforce redesign and the development of the unregistered workforce.

We have secured additional resource to enable to progress all elements of this work.

5.2. Actions to ensure a sustainable workforce following the UKs withdrawal from the EU - What assessment has been made of future funding needs post-Brexit?

The challenges that we face are not related solely to Brexit but to the wider UK immigration policies and regulations that are yet to be determined.

The Health Board has recruited both nursing and medical staff from the EU for some years. However, the popularity of this approach has negatively affected the numbers of EU staff available and the Health Board has therefore gone further afield to non-EU countries such as India and the Philippines to recruit Nurses and Doctors.

The Health Board has undertaken a number of actions to ensure a sustainable workforce following the UK's withdrawal from the EU, which includes:

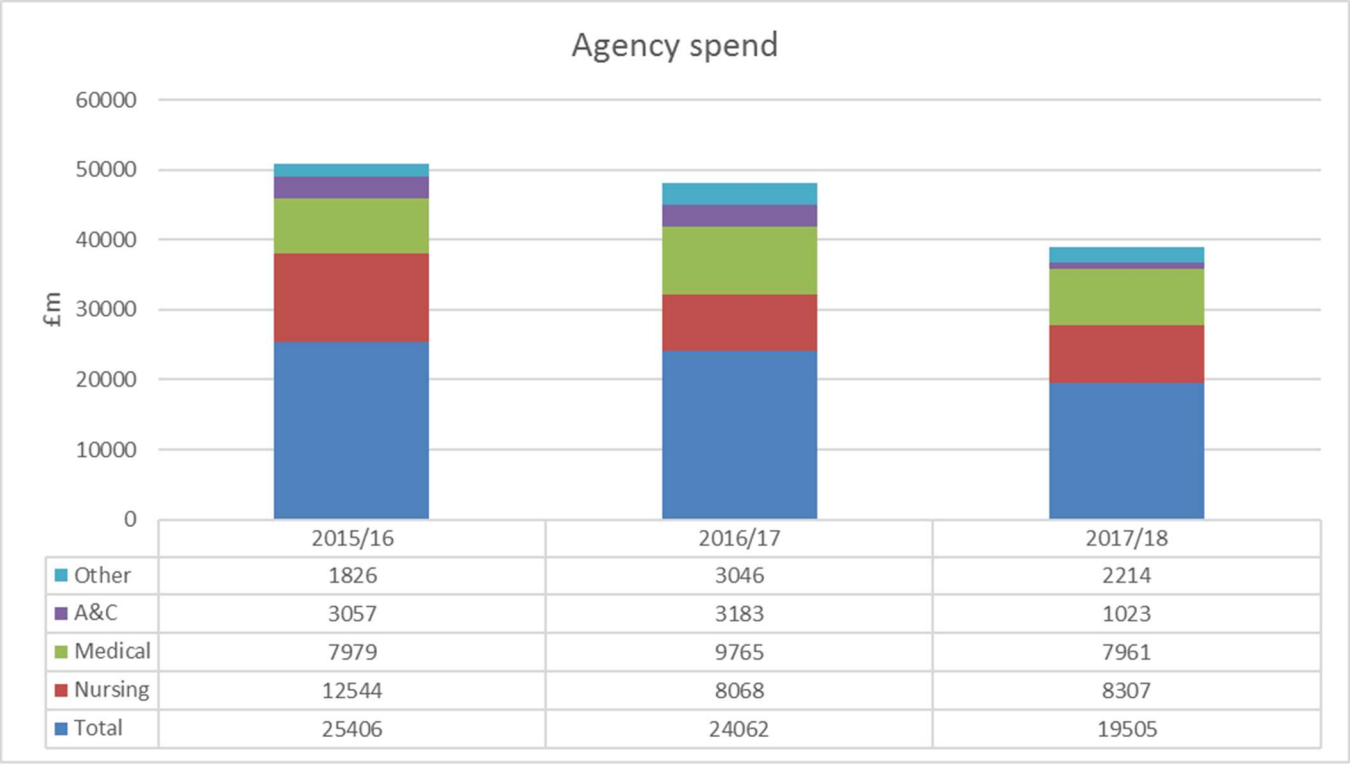
- Recruiting from non-EU counties as stated above;
- Increasing its education commissioning figures for certain professional groups;
- Supporting flexible training routes to nurse registration including; supporting Health Care support Workers (HCSWs) to undertake part time nursing degrees, supporting HCSW with overseas nurse registration to become registered nurses in the UK;

- Redesigning our workforce to utilise new and extended roles for example Physician Associates;
- Developing our non-registered workforce to address deficits within our registrant workforce by allowing them to work at the top of their license;
- Looking at innovative ways to recruit and retain our workforce.

The Health Board is currently assessing the impact of Brexit on the current EU workforce. However, as the UK government has not yet provided clarity on EU citizen's rights after the transition period of December 2020, it is difficult to assess any additional workforce costs.

5.3. Evidence about progress made in reducing and controlling spend on agency staff.

The Health Board considers reducing and controlling spend on agency staff as one of its key aims. Over the last three years there has been a reduction in agency expenditure as shown in the graph below:



	2015/16	2016/17	2017/18
Other	1826	3046	2214
A&C	3057	3183	1023
Medical	7979	9765	7961
Nursing	12544	8068	8307
Total	25406	24062	19505

The total agency spend reduced by £4.5m in 2017/18 when compared to 2016/17, the most significant reductions in agency spend were in Admin & Clerical, Medical & Dental and Additional Clinical Services staff groups.

In 2017, Welsh Government introduced changes to locum arrangements to ensure continuity of service provision and fairness in payments amongst Health Board in Wales.

The Health Board spends approximately £8m per annum (approximately 650 duties per month) on medical locum agency shifts and as a result of national changes has introduced manual reporting mechanisms to ensure compliance and reporting against the standards. Reporting processes are cumbersome and are not accurately capturing the true demand of locum duties.

Consequently, the Health Board has extended the Nurse bank functionality to manage locum shifts. The purchase and implementation of Locum on Duty will allow increased visibility of locum shifts, a robust and auditable process that is consistent and more control of shifts that are deemed to exceed the Medical capped rate that has been agreed nationally. This has the potential to provide the Health Board with up to 5% savings on internal medical locum spend then this will give the Health Board a return of £30,000 per month (£360,000 per annum).

During the last 15 months, the Health Board has been implementing an Electronic Job Planning system that records and manages Job Plans for consultants. It is recognised that job plans are becoming more flexible often with a different timetable for each week. We have also seen an increase in compressed working. Consequently, these issues increase the complexity of calculating job plans and ensuring service provision. The Health Board has invested in resources to work with Delivery Units to maximise the functionality of the system in scrutinising job plans to ensure that they are correct, in line with service demands and appropriately paid.

In 2017, the Health Board implemented a nurse bank system that allowed service managers and bank staff the ability to self-mange vacant shifts. Since implementation, the Health Board has begun the process of moving all nursing staff over to one rostering system which is integrated with the Nurse Bank module. This allows higher level of scrutiny in relation to substantive and temporary staff to ensure appropriate use of resources.

The Health Board has a high number of medical vacancies, these vacancies contribute to the expenditure on agency staff. Plans are being developed to recruit more medical staff. These include:-

Participating in the All Wales British Association of Physicians of Indian Origin Campaign in November 2018. So far the Health Board have identified thirty nine posts to recruit to. The specialties included in the initiative are T&O, Surgery, Medicine, Emergency Medicine, Mental Health, Paediatrics, Ophthalmology and Anaesthetics. For this round, BAPIO are informing candidates to sit either the IELTS or OET language tests as soon as they apply and it is hoped this will help to reduce the time from recruitment to commencing employment. Consideration is being given to undertaking a second BAPIO Campaign each year either in conjunction with All Wales or stand alone as a Health Board.

It was reported that some of the thirty nine posts are at a junior clinical fellow level and the Royal College will only sponsor senior clinical fellows at ST4 and above. It has been decided the doctors will be assessed at interview on their level of experience and those at the junior level will be asked if they wish to take up the offer of employment under a Tier 2 visa following

the changes to visa restrictions by the Home Office. We are developing innovative rotations between different specialities, which will support recruitment of doctors.

Further work this year will including developing a recruitment strategy to support recruitment too hard to fill posts, work is also been undertaken to review the skill mix required in hard fill specialties such as radiology and to support the review of junior doctors rotas. It is anticipated that this work will support the reduction of agency and locum expenditure.

Appendix 1

NHS Outcomes Framework Performance Measures

Outcome	No	Performance Measure	Target	Information Source	Reporting Frequency	Policy Area
Health care and support are delivered at or as close to my home as possible	31	Delayed transfer of care delivery per 10,000 LHB population – mental health (all ages)	12 month reduction trend	DToC Database	Monthly	Social Services & Integration
To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need	70	The percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral	80%	Mental Health (Wales) Measure 2010 Data Collection – Part 1 Proforma (Welsh Government)	Monthly	Mental Health, Vulnerable Groups & Offenders
To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need	71	The percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS	80%	Mental Health (Wales) Measure 2010 Data Collection – Part 1 Proforma (Welsh Government)	Monthly	Mental Health, Vulnerable Groups & Offenders
My individual circumstances are considered	76	Rate of calls to the mental health line CALL (Community Advice and Listening Line) by Welsh residents per 100,000 of the population	4 quarter improvement trend	CALL Database (BCUHB)	Quarterly	Mental Health, Vulnerable Groups & Offenders
My individual circumstances are considered	77	Rate of calls to the Welsh dementia helpline by Welsh residents per 100,000 of the population	4 quarter improvement trend	CALL Database (BCUHB)	Quarterly	Mental Health, Vulnerable Groups & Offenders
My individual circumstances are considered	78	Rate of calls to the DAN 24/7 helpline by Welsh residents per 100,000 of the population	4 quarter improvement trend	CALL Database (BCUHB)	Quarterly	Mental Health, Vulnerable Groups & Offenders
My individual circumstances are considered	79	The percentage of health board residents in receipt of secondary mental health services (all ages) who have a	90%	Mental Health (Wales) Measure 2010 Data Collection –	Monthly	Mental Health, Vulnerable Groups & Offenders

Outcome	No	Performance Measure	Target	Information Source	Reporting Frequency	Policy Area	
		valid care and treatment plan (CTP)		Part 2 Proforma (Welsh Government)			
My individual circumstances are considered	80	All health board residents who have been assessed under part 3 of the mental health measure to be sent a copy of their outcome assessment report up to and including 10 working days after the assessment has taken place	100%	Mental Health (Wales) Measure 2010 Data Collection – Part 3 Proforma (Welsh Government)	Monthly	Mental Health, Vulnerable Groups & Offenders	
My individual circumstances are considered	81	The percentage of hospitals within a health board which have arrangements in place to ensure advocacy is available for all qualifying patients	100%	Mental Health (Wales) Measure 2010 Data Collection – Part 4 Proforma (Welsh Government)	Bi annually	Mental Health, Vulnerable Groups & Offenders	
I work with the NHS to improve the use of resources	83	The percentage of patients who did not attend a new outpatient appointment	12 month reduction trend	Outpatient Minimum Dataset	Monthly	Delivery & Performance	
I work with the NHS to improve the use of resources	84	The percentage of patients who did not attend a follow-up outpatient appointment	12 month reduction trend	Outpatient Minimum Dataset	Monthly	Delivery & Performance	
Quality trained staff who are fully engaged in delivering excellent care and support to me and my family	91	Percentage of staff undertaking performance appraisal	85%	Electronic Staff Record (ESR) and Medical Appraisal and Revalidation system (MARS)	Monthly	Workforce & Organisation Development	
Quality trained staff who are fully engaged in delivering excellent care and support to me and my family	92	Percentage of those who are undertaking performance appraisal who agree it helps them feel valued and improves how they do the job	Bi annual improvement	Staff Survey Pulse Survey	Bi annually	Workforce & Organisation Development	New

NHS Outcomes framework – Performance measures

Outcome	No	Performance Measure	Target	Information Source	Reporting Frequency	Policy Area
Quality trained staff who are fully engaged in delivering excellent care and support to me and my family	93	Percentage of staff who are engaged	Bi annual improvement	Staff Survey Pulse Survey	Bi annually	Workforce & Organisation Development
Quality trained staff who are fully engaged in delivering excellent care and support to me and my family	94	Percentage of staff completing statutory and mandatory training	85%	Electronic Staff Record (ESR)	Quarterly	Workforce & Organisation Development
Quality trained staff who are fully engaged in delivering excellent care and support to me and my family	95	Percentage of sickness absence rate of staff	1% annual reduction	Electronic Staff Record (ESR)	Monthly	Workforce & Organisation Development
Quality trained staff who are fully engaged in delivering excellent care and support to me and my family	96	Percentage of staff who would be happy with the standards of care provided by their organisation if a friend or relative needed treatment	Bi annual improvement	Staff Survey Pulse Survey	Bi annually	Workforce & Organisation Development
I am safe and protected from harm through high quality care, treatment and support	15	The rate of laboratory confirmed *S.aureus* bacteraemias (MRSA and MSSA) cases per 100,000 population	12 month reduction trend (target of 28 per 100,000 population will begin from Oct-16)	Public Health Wales	Monthly	Nursing
I am safe and protected from harm through high quality care, treatment and support	16	The rate of laboratory confirmed *c.difficile* cases per 100,000 population	12 month reduction trend (target of 20 per 100,000 population will begin from Oct-16)	Public Health Wales	Monthly	Nursing

Others that refer to mental health and vulnerable groups but which lie outside the delivery unit....

My voice is heard and listened to	46	Percentage of the population in Wales who are registered with dementia with their GP practice	Annual improvement	GP Practice Quality & Outcomes (QOF) Disease Register & Office for National Statistics	Annually	Mental Health, Vulnerable Groups & Offenders
I am treated with dignity and respect and treat others the same	48	Percentage of GP practice teams that have completed mental health Direct Enhanced Services (DES) in dementia care or other directed training	Annual improvement	Mental Health Direct Enhanced Service Data Monitoring Return (Welsh Government)	Annually	Mental Health, Vulnerable Groups & Offenders
Inequalities that may prevent me from leading a healthy life are reduced	72	Qualitative report detailing progress against the 5 standards that enable the health and wellbeing of homeless and vulnerable groups to be identified and targeted	N/A	Improving the Health & Wellbeing of Homeless & Specific Vulnerable Groups Monitoring Return (Welsh Government)	Bi annually	Mental Health, Vulnerable Groups & Offenders

Appendix 2

TOGETHER FOR MENTAL HEALTH DELIVERY PLAN 2016-2019 QUANTITATIVE DATA SUMMARY

TOGETHER FOR MENTAL HEALTH DELIVERY PLAN 2016-2019

QUANTITATIVE DATA SUMMARY

MENTAL HEALTH MEASURE DATA	T4MH ACTIONS	SOURCE / BASELINE POSITION
PART I - Monthly referral rates - Referral to assessment wait times - Assessment to treatment times	1.1 i) 4.3 i) iii) 9.4 i)	**MONTHLY** data submitted by HB and monitored on an ongoing basis Publicly available at: http://gov.wales/statistics-and-research/mental-health-wales-measure-2010/?lang=en * Strategy lead to provide summary of findings in annual report
PART II Service Users with a Care & Treatment Plan	(Part of CTP audit process)	As Above / Delivery Unit & PHW working with health boards and teams around Care & Treatment Planning audits
PART III Number of Part III re-assessments	None	As Above
NATIONAL SURVEY DATA	**T4MH ACTIONS**	**SOURCE / BASELINE POSITION**
Mean mental wellbeing score (WEMWBS)	1.1 i) 1.3 i) 4.1 iii) 4.3 i)	**ANNUAL** data available from National Survey for Wales (WEMWBS used from 2016) Publicly available at: http://gov.wales/statistics-and-research/national-survey/?skip=1&lang=en * Strategy lead to provide summary of findings in annual report

% people reporting loneliness	2.1 i) iii)	As Above
% people reporting feeling involved in decisions about their care and support	6.3 ii)	As Above
% people rating care as good	8.4 ii)	As Above
Decreased gap in mental well-being score between most / least deprived areas in Wales	9.3 i)	As Above
No. people speaking Welsh to staff	3.2 i)	As Above
WELSH GOVERNMENT INTERNAL DATA	**T4MH ACTIONS**	**SOURCE / BASELINE POSITION**
% working population engaged in Healthy Working Wales (HWW)	1.3 i)	As of Feb 2017, 460,000 people are engaged in HWW (33% of the working population) since 2011
- No. orgs	4.2 i)	As of Feb 2017, there were 3,000 organizations signed up to TTCW

signed up to Time To Change Wales - No. TTCW champions		
26 week neuro-development al target for children and young people	8.1 ii)	WG is working with NWIS to embed this target in CCIS / IT infrastructure
26 week access to psychological therapies target	8.3 i)	WG is working with NWIS as above
Early Intervention in Psychosis access time targets	8.4 i) ii)	In discussion / not currently collected at baseline
Wait times for SCAMHS 48h urgent / 28days routine	7.1 i)	Collected monthly and monitored by WG
Healthy Working Wales data	9.2 i) ii) iii)	**In and Out of Work service data Feb 2017:** In Work Service supported 254 people Out of Work Service supported 710 people 21 employers and 29 health care professionals engaged (in work)
Housing and mental health	9.1	HAVGAPS monitoring around housing actions continues (WG)
Ring fence reports / additional funding	11.4 i) ii)	All health boards report having spent above the minimum ring-fenced amount on mental health in the past financial year. New funding is monitored regularly to ensure staff are appointed in designated work streams (inpatient psychological therapies, hospital based flexible resource teams, memory clinics, local primary mental health support services, early intervention in psychosis). This will be reported annually.

reports		
Mental Health outcomes for CYP with additional learning needs	6.2 ii)	Named WG lead to report on data (education)
% schools achieving Welsh Network of Healthy School Schemes National Quality Award	6.1 v)	Named WG lead to report on data (education)
CALL / 111 usage data (increasing)	1.1 ii)	Annual report requested from named WG lead Janet Roberts - Helplines Manager BCU Tel: 01978 366206 Email: janet.roberts2@wales.nhs.uk Mbl: 07 881 857 826 CALL, DAN, Dementia Helpline, Terrorist attack line
100% staff demonstrate formal substance misuse training	8.11 i)	Monitored by WG / some issues with ESR
DEMENTIA	**T4MH ACTIONS**	**SOURCE / BASELINE POSITION**
Increase in dementia friends / communities	10.1	Source: Alzheimer's Society Cymru * To be included in annual report
75% staff to have undertaken dementia training	10.1 4.1 ii)	**NHS Outcomes Framework** More detail about measures collected available at: http://gov.wales/topics/health/socialcare/well-being/?lang=en

('Good Work')		Reported by health boards and performance managed with vice chairs. Strategy lead to include in annual report
Number of people on GP dementia registers (50% diagnosis by 2016, increasing annually)	10.1	**NHS Outcomes Framework** (T4MH annual report)
All DGH to have psychiatric liaison service in place.	10.1 8.2 i)	**Health Boards (T4MH)** Baseline Feb 2017: Most health boards confirm a service is in place, though several are struggling to recruit for posts and resources appear to be stretched across the board. In some health boards not all DGH have operational service. For monitoring / discussion with clinical leads. Additional funding provided for this work stream which is being closely monitored re. getting staff in post
All those diagnosed referred to a HCSW	10.1	**Health Boards (T4MH)** Baseline Feb 2017: All health boards confirm that dementia health care support workers have been appointed and are in post.
1 dementia HCSW per 2 GP clusters	10.1	**Health Boards (T4MH)** To be calculated for annual report based on numbers recruited / no. GP clusters (additional funding monitoring). HB to confirm in November update
OTHER SOURCES OF ONLINE DATA	**T4MH ACTIONS**	**SOURCE / BASELINE POSITION**
Suicide rate reducing	1.2 i) T2M2	Office of National Statistics website: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/previousReleases Talk to Me 2 guidance to be issued 13/07/2017. Development of regional suicide prevention plans in progress / to be monitored via National T2M2 Advisory Group / annual reports by 3 regional forums and T4MH biannual reports. Health boards report variable progress at baseline, with some awaiting national guidance. Strategy lead to follow up with regional chairs and Dr. Ann John who is leading on the strategy implementation.
Admissions for self harm	1.2 i) T2M2	Patient Episode Database for Wales (PEDW): http://www.infoandstats.wales.nhs.uk/page.cfm?orgid=869&pid=40977

		* Strategy Lead to include in annual report / see T2M2 annual report once available
Increased mental wellbeing in Children & Young People	6.3 ii) 6.1 i)	Understanding Society: https://www.understandingsociety.ac.uk/about
Decreased % children in need with mental health issues	5.2 i) 6.3 iv)	From census: https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Social-Services/Childrens-Services/Children-in-Need/mentalhealthstatusofchildreninneed-by-localauthority-measure **Annual Trend:** 2014 - 7.97% 2015 - 8.21% 2016 - 7.48%
All patients prescribed anti-psychotics to have health check	8.2 ii)	Quality Outcomes Framework (QOF): http://gov.wales/statistics-and-research/general-medical-services-contract/?lang=en
WHSCC DATA	**T4MH ACTIONS**	**SOURCE / BASELINE POSITION**
Children and young people out of area placements / length of stay	7.1	WHSCC collect this information and provide reports as requested
Out of area placements for eating disorders	8.7 iii)	WHSCC collects data and provides reports to WG
OTHER DATA FROM HEALTH BOARDS	**T4MH ACTIONS**	**SOURCE / BASELINE POSITION**

Service users accessing social prescription	1.1 iii)	Health boards all reference offering social prescription in various ways in their baseline returns, but no figures have been provided. This may be difficult to track – 'signposting' is one of the interventions recorded in monthly Part I returns (Mental Health Measure), but may not be captured where this was not the primary intervention. For discussion with clinical leads / input from WAMH on this? Exercise / Book prescription rates may be available. Might be better to focus on examples of good practice / innovations?
Individuals offered follow up contact within 5 days of discharge from inpatient care	1.2 i)	This is difficult to record with current data systems / variation in recording of contacts. Most HB would be required to do a manual review of clinical records to find the information and patients are discharged to various different teams / home following admission. Follow up could come from any source (GP, PMHSS, secondary care, specialist care etc) so there is no one location to find the details. This is an item for further discussion.
Service User and Carer satisfaction survey outcomes / CTP audits	1.1 i) 3.1 ii) 4.1 iii) 4.2 ii) 4.3 i) 9.1 iii) 9.3 i) 9.4 i) 11.3 ii)	All health boards report using some form of satisfaction survey – implementation varies greatly as does follow up actions from feedback. For further discussion about how to maximize benefit from this process Number of CTP where housing needs addressed relates to actions 9.1, 9.3, 9.4 (part of DU work / audits)
Reduced frequent attenders to ED departments	8.2 iv)	All health boards report having a committee /service in place to address this issue. Information varied on baseline return
10% of mothers in contact with perinatal services	5.1 iv)	This was not requested at baseline due to the new inception of perinatal services across Wales. Health boards are in regular dialogue with Welsh Government around the implementation of perinatal services and regular discussions with key officials is taking place as data collection systems are established.
OTHER DATA	**T4MH ACTIONS**	**SOURCE / BASELINE POSITION**
Number of setting implementing PHW framework	6.1 iv)	Named PHW lead tracking information

for CYP resilience / wellbeing		
Youth Offending Team data re. access times / interface with SCAMHS	7.1 vi)	Data collected by Youth Justice Board
Veteran's Wales data on wait times, referrals	8.8 i)	Veteran's service (Cardiff & Vale) collects Wales data and health boards report in to committee
100% First night reception for prisoners / reduced use of s.135/136 / never event reports CYP in custody	8.9 i) ii) 4.5 i) 7.1 ii)	Crisis Care Concordat information is reported to WG via health boards and prisons
Duty to Review Compliance	11.5 i)	Recent workshop held with Mental Health Measure Advisory group – overlap with T4MH actions discussed and mechanisms for monitoring other actions reviewed. Further work to ensure collection of information planned with legislation manager / group. To discuss role of Communities of Practice in supporting this.
Other strategies referenced in Delivery Plan		SUBSTANCE MISUSE PLANS (8.11) T2M2 / NAG (1.2) DUTY TO REVIEW (11.5) VIOLENCE AGAINST WOMEN (9.5) DEMENTIA STRATEGY MORE THAN JUST WORDS FRAMEWORK HEALTHY CHILD WALES PROGRAMME (5.2 ii) Healthy and Sustainable HIGHER EDUCATION FRAMEWORK 6.1 T4CYP FRAMEWORK FOR IMPROVEMENT SCAMHS NPTMC ACTION PLAN (DEVELOPING)- update at next NPB EATING DISORDERS FRAMEWORK (8.7) SECURE SERVICES ACTION PLAN (8.10)

		HEALTHY WORKING WALES (9.2) SSWB / WBFG ACT MATRICS CYMRU

Appendix 3

MENTAL HEALTH AND LEARNING DISABILITIES PLAN 2018/19

Appendix 3. MENTAL HEALTH AND LEARNING DISABILITIES PLAN 2018/19

3.1 Strategic Approach

Adult Mental Health

The overall strategic direction for mental health within the Health Board remains unchanged, reflecting the current all-Wales Strategy for Mental Health and Wellbeing, Together for Mental Health (T4MH), and extant policy guidance. The Health Board is fully engaged in delivering the Together for Mental Health Delivery Plan and the Mental Health Measure 2010.

As planned in our Annual Plan 2017/18, during the year the Health Board has engaged with stakeholders and involved service users and carers in an extensive engagement exercise to develop a Strategic Framework for Adult Mental Health to inform our future service direction. This process was co-designed and co-produced with elected service user and carer representatives from our T4MH Local Partnership Board and included in-person feedback from more than 105 individuals and 170 other people or organisations through an online survey and group discussions. The process has been managed through our Commissioning Board for Mental Health and Learning Disabilities which includes wide range of stakeholders from within the Health Board, Local Authority and partner organisations. A number of wide-ranging themes were identified through the engagement exercise and the top priorities identified by service users and carers through the process are shown in the diagram.

The principles of the future optimum service model are:

• Focus on positivity – people's abilities not disabilities
• To be based on a psychosocial model focusing on the holistic needs of individuals;
• More emphasis on wellbeing at work;
• Early intervention, education and prevention underpinning all services;
• Ensuring that service users, their carers and families are central to all we do and central to resolving their issues as well as being meaningfully involved in, and influencing how and where services are developed, and their evaluation;
• Services deliver advice, support and care that maintains and promotes self-determination and independence;
• Providing a straightforward way for people to access the range of services they need, which suits them rather than us as organisations;,

- Timely access to services which are needs-led, including in rural areas, and primary care; and,
- Holistic care delivered through partnership working between health, social care and third sector services including user-led services.

There is agreement across all agencies that the views shared through the engagement process will influence the Strategic Framework and our joint priorities and there is an agreed commitment to change. A Working Group between the three Local Authorities and the Health Board has been formed to develop an optimum service model and this will also include the findings of the Alder Advice's Report, commissioned by the Western Bay Partnership into Unmet Need in Mental Health.

The emerging Strategic Framework was agreed by the Health Board in November and consultation on the final draft Framework will begin in March 2018. We will set out an agreed optimum model in the final draft Framework against which existing services will be compared and this will be agreed through the local T4MH Partnership Board. The final Strategic Framework will be approved by the Health Board and Regional Partnership Board in May 2018, with an implementation plan and transformation programme in place. The emerging priorities and principles form the basis for our plans for 2018/19 and the implementation of the Framework has been included in the Western Bay Area Plan 2018-23 as a key priority with a requirement for programme management to

ensure implementation. All partners, including service users and carers are clear that the level of change we would like to effect is undoubtedly challenging, but it is imperative that, to repay the people who have invested their time in telling us what they think will make a difference, we jointly agree and deliver on some early changes over the next 12 months. The joint priorities that are emerging for early action include:

- A single point of access for all services and ages;
- Direct provision of a crisis sanctuary service offering an out-of-hours listening and safe space service. This would be contracted from the third sector as an additional service to what we have, and will respond directly to an issue people have told us is a gap;
- Information, which is readily available for service users and carers and other professionals, in accessible formats on the range of services available to help and support them; and,
- A range of third sector peer / activity groups and support networks through a Clubhouse approach, based on a non-clinical co-production approach giving its members a place to go, meaningful work, meaningful relationships and a place to return.

Any additional ring-fenced monies allocated by Welsh Government for Mental Health will be treated on the same basis as last year. It is proposed that these available funds could helpfully be used to strengthen the low-level support, particularly in the evenings and weekends, which is currently only patchily available, across the ABMUHB area. This would allow us to start developing an earlier intervention / more preventative approach to mental health services which is an underpinning principle of the Strategic Framework.

Older People's Mental Health

The all-Wales Dementia Strategy has now been published and there is an understanding that there will be funding for the accompanying action plan for its implementation. Mental health services are already engaged in the development of the Older Person's Charter, in dementia awareness and dementia care training. We are aware that the local actions to implement the Dementia Strategy are likely to focus on education and awareness raising in all sectors, availability of information, timely response to memory assessment, care home in-reach, and increasing the availability of psychosocial and psychological interventions. The overall response to the Dementia Strategy will be overseen by our multiagency Dementia Group for the Western Bay area to ensure that improvements in care and experience for people with dementia covers all sectors and is not just seen as the role for mental health services.

During 2017/18 the Health Board commissioned an external Clinical Review of our Older People's Mental Health services and started a transformational programme of change to improve the quality and outcomes of services and to provide care 'Closer to Home'. The Clinical Review confirmed that the service model in the Health Board is too weighted towards inpatient rather than community models of care with approximately a 70% to 30% ratio of services. The report recommends remodelling towards a balance of 50:50 to support

patients and their families in the community and reduce the reliance on long term healthcare. In addition, benchmarking by the NHS Wales Delivery Unit also identified that despite judging the overall care on the wards to be of a good standard with some examples of excellence they were *''not assured that the current service model consisting of 13 wards is sustainable in relation to the staffing establishment required'.*

In 2017/18 we invested £1.6m (FYE) in Older People's community services to drive a move to a service model focused more on community rather than inpatient services. These monies have been invested in nursing, physiotherapy, occupational therapy and psychology staff to enhance our early intervention, diagnosis and treatment provision in the community in line with best practice. The process undertaken to agree the investment framework was carried out to ensure the development of a consistent community model across the three localities that addressed identified service gaps in each Local Authority area.

The overall aim is to implement a service model that would reduce the reliance on in-patient services, with more emphasis on early, community based intervention and keeping people in their own homes for as long as it is safe to do so. This reduces the risk to patient safety as it has been identified by the External Review that our current distribution of wards across multiple sites is not sustainable.

We have started to re-model services based on the investment in community services outlined above, changing our clinical models and training and development of staff. There have been reductions in length of stay which have supported the temporary closure of a suite at Tonna hospital (18 beds) in the summer of 2017. Since then the occupancy of older people's mental health wards has continued to reduce as changes to operational and clinical practice became normalised. Consequently this offers opportunities for efficiencies through further reconfiguration of the inpatient model, supported by the development of community services, during 2018/19.

Children and Adolescent Mental Health Services (CAMHS)

The provision of specialist Child and Adolescent Mental Health Services (CAMHS) has caused concerns historically because of long waiting times and the lack of support for professionals to support Children and Young People's emotional health and wellbeing. As a result, since April 2016 a new approach to tackling these issues has been taken with the Assistant Director of Strategy and Partnerships leading a new commissioning approach to these services. Both in conjunction with Cardiff & Vale and Cwm Taf University Health Board commissioners, in partnership with existing Cwm Taf CAMHS and with the relevant Delivery Units within ABMU Health Board to deliver operational responsibilities where required as services are increasingly being directly provided by ABMUHB rather than all through Cwm Taf's services.

There have been discussions through the Western Bay partnership about the importance of CAMHS being seen as a multiagency problem, which will only be resolved by a multiagency response. As a result Western Bay, for the first time, has agreed that CAMHS is a joint priority for the Regional Partnership Board consisting of ABMU Health Board and the three Local Authorities plus third sector partners. Plans are being developed to provide support for the emotional health and wellbeing of children and young people, including the joint agency development of tier 1 and 2 interventions to avoid referral into specialist CAMHS where this is not appropriate.
ABMUHB has a Delivery Plan for Services to Support the Emotional Health & Wellbeing of Children and Young People for 2017-19 with the following high-level priorities:

- Improved accessibility to local CAMHS services
- Development of a sustainable and fit for purpose workforce
- Development of NDD Service
- Securing appropriate accommodation for specialist CAMHS in Bridgend, Neath Port Talbot and Swansea areas

Cwm Taf UHB are committed to a set of principles for CAMHS and they are included within the Health Board's IMTP as follows:

1. Implementing CAPA which is a partnership approach with parents where professionals work together with families to determine what changes they are looking for and enabling them to make informed decisions about treatment options.
2. Improving links with other agencies as described above.
3. Prioritising urgent cases both through Crisis teams and robust management of waiting lists.
4. Making the best use of skills and resources by improving working relationships with primary health and with third sector colleagues who now join secondary care colleagues in intake meetings and take on those cases for whom they offer the most appropriate intervention.
5. Aim to ensure that only what is needed to be done is done by adhering to best evidence based practice through monitoring compliance with NICE guidelines and working towards reducing levels of prescribing where appropriate.
6. Introducing the regular use of ROUTINE Outcome Measure's (ROM'S) to ensure clinical practice is effective and that service users can feed back about their experience of the service.

Learning Disabilities
National commissioning guidance for learning disabilities was published in 2017and has provided the first new national strategic guidance for a considerable time. The Health Board provides Learning Disability services for three Health Board areas and it has been agreed corporately, through a joint commissioning group including Cwm Taf, Cardiff and Vale and ABMU Health Boards, that a joint Strategic Framework is developed for the modernisation of services.

At the same time the Health Board has, as part of the Recovery and Sustainability Programme, identified a range of service changes which could be implemented to deliver quality improvement, care 'Closer to Home' and better use of resources including financial savings. These include the reconfiguration of inpatient facilities to improve the quality of care for our resident populations by repatriating some of the most challenging Autistic Spectrum Disorder and complex needs patients from out of area placements, and providing care 'Closer to Home' for new patients in the future.

In order to progress these initiatives the agreement of the three commissioning Health Boards is required and a joint process has been established to take this forward, with plans to be implemented in 2018/19 as part of a longer 5 year plan.

3.2 Our Plans for 2018/19

This section describes our objectives and plans for delivery of mental health and learning disabilities in 2018/19. Specific actions relating to Unscheduled Care and Planned Care are included in the relevant Service Improvement Plans.

Priority Area	Objectives	Measures
Implementation of a Strategic Framework based on Optimum Model of services for Adult Mental Health.	Delivery of Optimum Model implementation plan in conjunction with partners. Joint priorities to be agreed for early delivery in the first 12 months. Development of business case for Acute Assessment facilities and decommissioning of Cefn Coed Hospital. Increasing access to Psychological Therapies across all ages. Simplified routes to services	Improvement in performance for access targets. Reduction in waiting times for psychological therapies. Service user satisfaction.

	Increased availability of advice information and support that helps avoid requirement for secondary care services.	
Redesign of Learning Disability Services	Develop a Strategic Framework for Learning Disability that is shared by the 3 Health Boards commissioning NHS learning disability services. Enhance skills and function of community learning disability teams to support people at times of crisis to increase likelihood of remaining in existing accommodation rather than escalating to higher levels of care. Establish a clear function for existing NHS Specialist Residential Units. Identify and establish appropriate provision of acute assessment beds based on population and need analysis. Support market development with partners to increase availability of enhanced supported accommodation to facilitate patient flow.	Reduction in numbers of out of area placements. Reduction in CHC spend.
Implementation of the Actions for Health Boards included in the Dementia Action Plan for Wales (issued Feb 2018 and currently awaiting further guidance from Welsh	More people are diagnosed earlier, enabling them to plan for the future and access early support and care if needed.	Dementia diagnosis rates recorded as part of QOF.

Government on the governance arrangements in relation to the implementation and monitoring of the plan)	Those diagnosed with dementia and their carers and families are able to receive person-centred care and support which is flexible. Each local authority area will review of actions for areas of work specific to them by Q1 for inclusion in revised Locality Plans. (The delivery plan will be revised and amended accordingly).	
Further development of Older People's Mental Health Services.	Improving patient outcomes by reducing the deconditioning effect of a hospital stay. Rebalancing the ratio of inpatient to community service resources. Shifting the Health Board's populations standardised benchmarked inpatient provision towards the UK mean thereby reaching a greater percentage of the population. Consistency in the availability of appropriately skilled staff. Future proofing the services for the increasing demands associated with changing demography	Quality of life, Functional abilities measures, patient & carer satisfaction measures. Resource ratio & UK Benchmark information Use of Bank and Agency Unmet demand & occupancy levels

Development of Regional Secure Service for Women	Improve the experience and effectiveness of secure services through gender appropriate care. To inform all Wales decision making by undertaking scoping exercises to: identify demand and capacity; explore potential clinical models; and understand service users and carer perspectives of a possible service.	Developmental stage. Desired outcome will be to get to a position where WHSSC are able to make a decision about development.
Increased capacity for gender specific locked rehabilitation provided by ABMU Health Board.	Reduce the need for locked rehabilitation placements contracted with the private sector. Provide services closer to their home area for a specific cohort of individuals with complex needs that cannot be met in a community or open rehabilitation environment due to risk issues.	Patient related Outcome Measure through use of the Recovery star. Reduction in CHC costs.
CAMHS	Potential transfer of primary care level child and adolescent mental health services from Cwm Taf to ABMU Health Board. Redesign service pathway to improve compliance with access target for LPMHSS for children, reducing waiting times for assessment	Patient related Outcome measure through application of WG prescribed questionnaire. Waiting time for primary mental health assessment <28 days. Waiting time to commence intervention following assessment.
Quality and Safety	Quality Improvement programme to use QI methodology across adult acute wards to:- • Reduce variation in risk assessment, formulation and management	TBA

	• Strengthen carer involvement in care and engagement in services • Improve record keeping • Increase use of evidence based pathways • Improve person/family centred approaches to care Development and implementation of a regional suicide Prevention action plan with partners in line with Talk To Me 2.	
Development of service to fit with the all Wales integrated Autistic Spectrum Disorder service.	Develop and implement multi-disciplinary services, assessments, proportionate to risk that are person centred. Launch of the Integrated Autism Service for the Western Bay region by November 2018	Measurement of progress against the National Standards in the IAS Model. Following launch time from referral to assessment.
Mental Health Measure	Continue to comply with the Mental Health Measure indicators taking into account the inclusion of CAMHS and Learning Disabilities data	NHS Outcomes Measures - Mental Health Measure
Workforce	Reduce sickness absence rates across the Delivery Unit Implement and reinforce ABMUHB values based culture. Undertake development work with service managers within new management structure.	Attendance levels. Reduction in vacancies. Improvement in staff satisfaction.

Revenue	Deliver financial target within ring-fenced allocation for Mental Health and Learning Disabilities.	Break even position for the Delivery Unit.
Unscheduled Care	Contribute to achieving the Health Board's targets for unscheduled care through the delivery of Psychiatric Liaison services. Achievement of 1 hour target from referral to assessment by Liaison Service in ED. Achievement of same day assessment by Liaison Service following urgent referral from acute hospital Wards. Psychiatric liaison to work with emergency department colleagues and partners to better address mental health / substance misuse needs of frequent attenders. Further development of Psychiatric care home in reach services to support care home staff in management of mental health needs of residents and avoid need for referral to ED or admission to acute or psychiatric inpatient care. Development of pathways for adults and older people requiring transfer from acute hospitals to a mental health bed to ensure that transfers take place in a timely manner and patients are cared for in the most appropriate environment.	1 hour response time performance. Reduction in numbers of frequent attenders. Length of stay of people with mental health diagnosis in acute settings (data set to be defined). Inter hospital transfers.

Planned Care	Reduction in waiting times for high intensity psychological therapies.	Performance against 26 week access target