Agenda – Health, Social Care and Sport Committee

Meeting Venue:	For further information contact:
Committee Room 3 – Senedd	**Claire Morris**
Meeting date: 11 October 2017	Committee Clerk
Members' pre-meeting: 09.15	0300 200 6355
Meeting time: 09.00	SeneddHealth@assembly.wales

Informal pre-meeting (09.15 – 09.30)

1 Introductions, apologies, substitutions and declarations of interest

2 Preparation for scrutiny of the Welsh Government draft budget 2018-19 – evidence session 3 – Abertawe Bro Morgannwg University Health Board, Aneurin Bevan University Health Board and Powys Teaching Health Board

(09.30 – 10.30) (Pages 1 – 48)

Alex Howells, Interim Chief Executive Officer, Abertawe Bro Morgannwg University Health Board

Lynne Hamilton, Director of Finance, Abertawe Bro Morgannwg University Health Board

Judith Paget, Chief Executive Officer, Aneurin Bevan University Health Board

Hywel Jones, Assistant Finance Director, Aneurin Bevan University Health Board

Carol Shillabeer, Chief Executive Officer, Powys Teaching Health Board

Eifion Williams, Director of Finance, Powys Teaching Health Board

3 Preparation for scrutiny of the Welsh Government draft budget 2018-19 - evidence session 4 - Welsh Local Government Association and Association of Directors and Social Services

(10.35 - 11.35) (Pages 49 - 60)

Jon Rae, Director of Resources, Welsh Local Government Association

Cllr Huw David, Spokesperson for Social Services and Health, Welsh Local Government Association, and Leader of Bridgend Council

Dave Street, President, Association of Directors and Social Services, and Director of Social Services in Caerphilly

4 Paper(s) to note

4.1 Letter from the Chair of the Finance Committee regarding the Finance Committee's inquiry into the cost of caring for an ageing population

(Pages 61 - 62)

4.2 Letter from the Cabinet Secretary for Health, Well-being and Sport regarding Health Education and Improvement Wales (HEIW)

(Pages 63 - 65)

4.3 Inquiry into the use of antipsychotic medication in care homes – additional information from the Royal College of Psychiatrists

(Pages 66 - 94)

4.4 Preparation for scrutiny of the Welsh Government draft budget 2018-19 - additional information from Hywel Dda University Health Board

(Pages 95 - 99)

5 Motion under Standing Order 17.42 to resolve to exclude the public from the remainder of the meeting

6 Preparation for scrutiny of the Welsh Government draft budget 2018-19 - consideration of evidence

(11.35 - 11.45)

7 Inquiry into loneliness and isolation - consideration of report

(11.45 - 12.30) (Pages 100 - 137)

Agenda Item 2

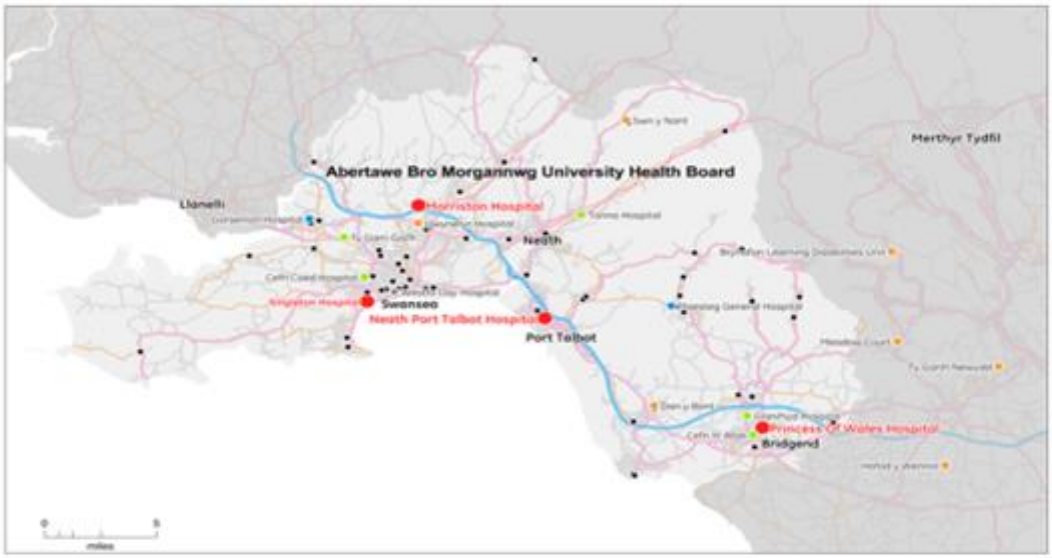
Document is Restricted

Response to Information request by the Health, Social Care and Sport Committee

INFORMATION REQUESTED BY THE HEALTH, SOCIAL CARE AND SPORT COMMITTEE

ABOUT ABMU HEALTH BOARD

Figure 1: ABMUHB Local Catchment Area and Healthcare Services



ABMU Health Board has the third largest population of the seven Health Boards in Wales, serving a population of approximately 500,000 across three local authorities: Bridgend, Neath Port Talbot and Swansea. The Board is responsible for assessing the needs of our population and delivering care to meet those needs. The Board commissions primary care services and also directly provides almost all community, secondary, mental health and learning disability services for our resident population. We also provide tertiary care for some specialist services over a wider population.

The Health Board also serves a wider catchment given the regional and specialist role of a number of its services.

The financial turnover of the organisation is approximately £1.3bn and we employ around 16,000 staff.

MENTAL HEALTH EXPENDITURE

The Health Board's operating structure includes a Mental Health and Learning Disability Unit which is responsible for the delivery of primary mental health, older people's mental health services, adult mental health services, specialist mental health services, and a range of learning disability services to our own population as well as Cwm Taf Health Board and Cardiff and Vale Health Board. Child and Adolescent Mental Health Services are delivered by Cwm Taff Health board via the CAMHS network.

The total spend on Mental Health Services is captured in the UHBs Programme Budgeting returns.

The latest set available is for the financial year 2015/16 where the UHB spent £123.5m on Mental Health Services against an allocation of £98.6m.

The Delivery Unit budget and expenditure for the last financial year and 2017/18 year to date are provided below:

Please note that the Mental Health element of the 17/18 budget is 74% (£68.5m) and 50% of the Continuing Health Care budget (£10.45m) whereas Mental Health CHC spend to date is 41% of the total (£4.47m).

	2016/17		**2017/18**		
	Budget £'m	**Actual £'m**	**Annual budget £'m**	**Month 5 budget £'m**	**Month 5 Actual £'m**
Mental Health and Learning Disability Division (excl. CHC)	84.8	86.9	92.6	38.5	35.6
Continuing Health Care	16.4	25.1	20.9	8.8	10.9
Total	**101.2**	**112.0**	**113.5**	**47.3**	**46.5**

The allocation for 17/18 is £105.8m. However, from 1st April 2017 a budget rebasing exercise was undertaken across the Health Board which led to the MHLD Delivery Unit receiving an additional £8.5m to reflect actual expenditure.

In addition, the Health Board received additional funding of £3.5m in 2017/18 to support delivery. However, Continuing Health Care (CHC) continues to be a significant pressure. Despite these pressures, the overall budget for the Delivery Unit remains within budget.

Spending on Mental Health Strategy and Delivery Plan

The 'Together for Mental Health' Delivery Plan and 3 year strategy 2016 - 2019 is being progressed through local Mental Health plans. The local delivery plan has been supported by new Welsh Government Investment into Mental Health Services - set out below:

Service Investment Mental Health	2015/16 Funding £'000	2016/17 Funding £'000	2017/18 Funding £000
Psychological Therapies	257	321	321
Psychiatric Liaison Services	342	684	684
Occupational Therapies	83	83	83
Perinatal Services	118	236	236
Local Primary Mental Health Support Services		125	249
General Hospital Based Flexible Resource Teams for Psychiatric Liaison Services		136	384
Inpatient Psychological Therapies		86	192
Gatekeeping / Case Monitoring (Forensic)		97	228
Early Intervention Psychosis		26	26
Memory Clinics (Non Recurrent Funding)		56	

'Together for Mental Health' recognises that people have medical, psychological and social needs and we are increasingly aware of the complex patterns of co-morbidities. Our strategy also recognises that our services need to deliver integrated holistic care focussing on recovery and emphasises active rehabilitation.

Key priorities for mental health within the 2017/18 Health Board Annual Plan include:

- Complete Strategic Frameworks for Mental Health and Dementia.
- Implement Mental Health Delivery Plan.
- Older People's Service Model and scope the enhancement of community services.
- Local referral dementia pathway.
- Mental Health Triage for primary and secondary care services.
- Early Intervention in Psychosis (EIP) service model and pathway.
- Psychiatric Liaison services in acute hospital settings - operations and resources.
- Scope and deliver third sector provided "sanctuary" services as part of alternatives to hospital crisis provision.
- Review use of specialist residential service and, acute assessment and treatment unit resources.
- Integrated Autistic Spectrum Disorder service.

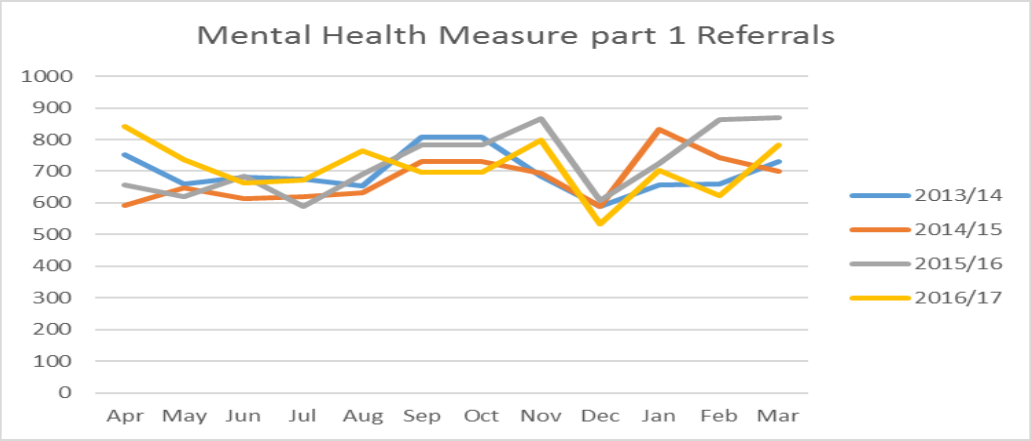
Key priorities will be taken forward using the total resources available for Mental Health services including the allocation uplift provided in 2017/18.

Resources for Primary and Secondary Care Funding

The UHBs Programme Budgeting returns are inclusive of expenditure within Primary Care and Secondary Care settings, these include services provided under the GMS contract, investment by GP clusters, including dementia link workers, and care within acute hospitals. Within Mental Health Services, the 2017/18 budget includes £2.233m for Local Primary Mental Health Support Services (LPMHSS) and £77.827m within secondary care, such as hospital and community services.

Impact of the Mental Health Measure on Expenditure

ABMU currently employ practitioners at a rate of 1.4 per 20k based on the original guidelines. Since the establishment of the service the population has increased and a number of staff have stayed in post beyond midpoint which has created a cost pressure which has had to be supported by redirection of other mental health provision. The following table outlines Part 1 Mental Health Measure referrals:



With the introduction of the Measure, patients previously known to Services now have a statutory right to self-referral directly into secondary care services for reassessment (Part 3). The volume of patients who have referred themselves in this way is relatively small and has had limited financial impact.

In addition, it has become clear that although there is some evidence that demand on secondary care has reduced in terms of follow up appointments the availability of dedicated mental health teams in primary care has in fact highlighted a significant, previously unmet, need and Community Mental Health Teams continue to experience high caseloads.

Prison Estate Funding

ABMU Health Board has a budget of £0.734m in 2017/18 for Mental Health prison estate services. ABMU is facing on going pressures on its secondary care mental health in-reach team serving HMP Parc. This service was originally commissioned based on a prison population of 800. Since the service was commissioned planned developments within the Prison involving the prison service and Welsh Government, have resulted in the prisoner population rising to 2000, (a rise of 150%) whilst level of in-reach resource has remained static. This issue has been raised at the HMP Parc Partnership Board meetings and escalated to Welsh Government. The Health Board estimates a pressure of approximately £400k.

Operation of the Ring-Fence

The Health Board Allocation is derived from the Mental Health Programme Budget and consequently includes not only Direct Hospital and Community Mental Health service costs, but also:

- Overheads and Indirect Costs
- Services commissioned by WHSSC attributed on an apportionment basis
- Prescribing
- Continuing Healthcare

- The cost of patients treated in acute settings with diagnoses such as dementia or substance misuse
- GMS, Local Authority and voluntary funding

The ring-fenced allocation provides a snapshot of the Programme Cost which is subject to significant fluctuation. For example, prescribing price fluctuations, small changes in Patient activity in high cost/low volume specialist services, for instance Continuing Healthcare. The allocation does not therefore provide an appropriate measure of direct investment in Mental Health Services. This could be better understood by considering Delivery Unit budgets and expenditure.

In terms of the delegated budget allocated to Mental Health Services as part of the ring fence this has been protected since its inception. The Delivery Unit is not required to deliver a specific CIP to support the cost pressures identified in acute and other services, however it is required to manage its own internal cost pressures within its ring fenced resource.

Notable Demand Trends with Mental Health Services

Within Adult Services the volume of admissions has remained largely consistent over the five years since 2012/13 however, the length of stay has improved significantly. This has allowed increasing numbers of individuals to be cared for within the available capacity. This reduction in length of stay has been accompanied by a rise in outpatient activity indicating a move away from inpatient care to care in a less restrictive environment.

Within Older Peoples Services, National Benchmarking has shown ABMU Health Board to be an outlier in terms of bed numbers and admission rates. Investment in Community Services is enabling the Health Board to realign capacity moving care out of hospital into the home. This is reflected in a reducing trend in hospital admissions across Older People's Services. The Outpatient referrals remains static overall, however, there is a reducing trend in the number of follow up appointments. This reflects the impact of The Measure, which has moved more activity into primary care.

Community data within Mental Health Services is currently limited. (ABMU's adoption of the Welsh Community Care Information System (WCCIS) will resolve this in future). However the caseload data available for the years since 2013/14, indicates a static position within Adult CMHT's, whilst activity in Older Peoples CMHT's has declined slightly. Both Older and Adult Services consistently achieve the target for Part 2 of the Mental Health Measure for 90% of patients who are in receipt of secondary mental health services to have a valid Care and Treatment plan (CTP). Referral activity within LPMHSS (Part 1 of the Mental Health Measure) demonstrates relatively consistent demand within MH Primary Care services.

FINANCIAL PERFORMANCE

Historical Financial Context

The Health Board has two key statutory duties to achieve:

- To submit an Integrated Medium Term Plan (IMTP) to secure compliance with breakeven over 3 years

- To achieve financial breakeven over a rolling three year period (the first of which commenced on 1st April 2014 and ended on 31st March 2017).

IMTP

The Health Board had an approved IMTP for 2014/15-2016/17 and 2015/16-2017/18, however the 2016/17-2018/19 plan submitted to Welsh Government was not approved and the Health Board and therefore operated under an Annual Operating Plan for 2016/17 and is currently operating on a similar basis in 2017/18.

2016/2017 Financial Position

The Health Board delivered financial breakeven in 2014/15 and 2015/16 and had done so since its formal creation in 2009 i.e. the Board achieved a breakeven position in six of the last seven years. Although financial balance was achieved in both 2014/15 and 2015/16 it should be noted that this was achieved by the use of non-recurrent funding and non- recurrent savings. In the financial year 2016/17 the Health Board reported a £39.317m overspend, against a forecast deficit of £20.1m. The Health Board year-end outturn position was therefore £19.217m above the financial plan of the IMTP.

2017/2018 Financial Position

The Health Board submitted a financial plan for 2017/18 which contained a projected end of year deficit of £36 million.

Movement of Opening Financial Plan to forecast outturn

The Health Board has submitted an Annual Operating Plan for consideration. The Interim Resource Plan within this currently shows a deficit of £36m as set out in the table below:-

Costs	**£m**	**Savings/Funding**	**£m**
2016/17 Underlying Carry Forward Deficit	53.0	Savings	(25.0)
<u>2017/18 New Costs</u>		<u>Additional Funding</u>	
Cost Growth		WG General Allocation Uplift	(16.1)
Service Growth	19.2	WG Treatment Fund	(2.8)
	9.7	WG Mental Health/ICF	(2.0)
Total	**81.9**	**Total**	**(45.9)**
DEFICIT			**36.0**

At the end of August 2017 (P5) the Health Board was reporting a year to date deficit of £17,007 million which was £2m deterioration on the planned year to date position. However, at this stage the Health Board has maintained its year-end forecast of £36 million. The adverse position is primarily due to the non-achievement of the full-targeted cash releasing cost improvements together with medical and nursing variable pay pressures and a number of non-pay pressures including medical consumables.

Key Pressure Areas and Plans to make improvements;

Underlying Causes of the Deficit

The underlying causes fall broadly into two categories those relating to cost drivers and spending decisions and those relating to governance and accountability.

a. Cost Drivers and Spending Decisions

The cost drivers include:

- Long term care
- Staffing costs
- Clinical supplies
- Efficiency and productivity performance such as length of stay.

During the last three years the Health Board has also invested in key priority areas to deliver improvements in quality and access, including:

- Critical Care capacity
- Unscheduled Care services
- Surgical capacity
- Cleaning and Nutrition standards
- RTT delivery
- CNO Nurse Staffing requirements
- Community Services
- Sustaining Services e.g. Rotas
- Trusted to Care.

The Health Board has undertaken a review of the financial position from 2014/15 which marked the start of the IMTP regime to track key movements and issues. The Health Board financial deficit has built up over a number of years. Cost drivers and investment in key priority areas were not mitigated by the required level of savings, resulting in an increasing level of carry forward deficit year on year.

Our examination of the detail has shown us that the costs in some key spend areas have grown significantly over the last three years:

- Long Term Care £16m
- Clinical Supplies £30m
- Staff Costs £72m

b. Governance and Accountability

The underlying causes of the Health Board's deficit have informed work to improve the Board's governance and accountability framework. This has led to:

- More focus on adopting a value-based Healthcare approach to system and service transformation;
- A more rigorous approach to planning and delivery against agreed in-year savings plans and reducing reliance on non-recurrent opportunities;
- The establishment of an Investment and Benefits Group and the promotion of Business Case good practice in investment decision making to ensure benefits are realised;
- More rigorous identification, tracking, measuring, reporting and accounting for financial and non-financial benefits;
- Implementation of more robust controls on expenditure in key areas, especially workforce.

Actions have been taken and further plans are in place to address financial governance and accountability issues.

Action on Reducing the Deficit

The Health Board has taken significant action over the last 10 months to address its financial position. However, whilst it recognises that progress has been made in the last few months of the current financial year, the pace of delivery throughout the rest of the year needs to improve to provide assurance about the achievement of the year-end position of a deficit of £36m. In recognition of this, we have and continue to strengthen our Recovery and Sustainability Programme. We have Executive-led work streams focussing on opportunities to improve efficiency and value drawing on the work of the National Efficiency and Value Board:

- **Workforce** – focussed on sickness absence reduction; improved rostering; reduced recruitment time; incentivising bank take up; job controls/grading drift.

- **Medical Workforce** – focussed on job planning to improve productivity; amending junior doctor rotas to reduce spend/make sustainable; reducing agency spend.

- **Patient Flow** – focussed on reducing bed days used, reductions in length of stay, reducing internal hospital transfer delays; increasing discharges before 11.00am and 4pm.

- **Outpatients** – targeting reduced follow ups; reduced 'Did Not Attends' (DNAs); reducing the need for patients to attend outpatients through development of alternative models – linked to targets identified in benchmarking reports.

- **Theatres**- aims to achieve optimal use of existing theatres across all sites; reduce cancellations, increased throughput – linked to targets identified in benchmarking reports.

- **Capacity Redesign** –encompasses all service changes leading to transfer of capacity between hospital and community settings.

- **Medicines Management** – this is developed work programme targeting nationally agreed programme as well as local hot spots in ABMU.

- **Procurement** – Via establishing of a Non-Pay control panel explicitly targeting and stopping discretionary non-clinical spend, and variation in clinical consumables where it is safe to do so. Also reviewing procurement delegations and accountability.

- **Back Office and Estates** – to focus on the rationalisation /disposal of underutilised properties; minimise financial risk of vacant floor of HQ; identification and delivery of Corporate CIP.

- **Unwarranted Clinical Variation** - this work stream has provided Units with a tool to analyse and review their services.

Views on the perception that there remain opportunities for the NHS to make further efficiency savings

We recognise there are still opportunities to make further efficiencies. However, we recognise that a focus on cost management will not totally address the underlying deficit and during 2017/18 the Health Board is increasing developing a value driven approach to inform how to best to allocate resources to get the best outcomes for patients.

We need to continue to strive to get more output for the same input, e.g. by active benchmarking against top quartile performers from across the whole of the UK as well as building upon the work of the National Efficiency and Value Board.

To improve Allocative Efficiency we are looking to improve outcomes for our patients through pathway change and more strategic solutions rather than simply fine tuning existing treatment regimes. This will include switching to community-based services and a heavy focus on an upstream health promotion and maintaining a good health agenda. These actions should not only ease the pressure on secondary care but greatly benefit the patients and their carers by preventing unnecessary admissions. The Health Board is actively participating in measuring outcomes using the ICHOM framework.

Projected spend on technology and infrastructure to support quality and efficiency

The adoption of technology to support quality and efficiency across ABMU is a high priority and underpinned by our Digital Strategy 'Destination Digital'. We refreshed our Informatics Strategic Outline Programme and submitted to Welsh Government in July 2016. The programme described the need to invest £20m across 7 themes / enablers:

- Digital Patient Record
- Patient Flow
- Mobilising the Workforce
- Patient Empowerment
- Streamlining Business Processes and Communication
- Digital Infrastructure & Cyber Security
- Business Intelligence

In 2017/18 we have committed £3.5m discretionary capital to our Informatics plans and await confirmation of our allocation from the Welsh Government Digital Strategy capital fund.

NHS Finances (Wales) Act 2014

The Health Board acknowledges the useful contribution made by the Wales Audit Office in its report in the implementation of the Act and fully concurs with the responses made by the Welsh Government to this report.

Aligned to the Act, ABMU welcomes the research based approach which the Welsh Government is increasingly adopting in financial policy development, such as the Institute of Fiscal Studies report into the Welsh budgetary trade-offs; the Health Foundation's' report on the Financial sustainability of the NHS in Wales or the Nuffield Trust's 'Decade of Austerity in Wales' report. Such evidence is focussing on the longer-term resource requirements of the NHS and will service to ensure that Wales is well placed to adopt best practice in resource allocation.

Consequently, it is important that there is stability and consistent in the overall NHS budget alongside a recognition of the growing pressures facing the system.

The Board welcomes the fact that over the last budget cycle, the funding allocation to the NHS has broadly followed the recommendations in the Nuffield Trust and the Health Foundation reports.

It is important to recognise that healthy lives are determined, not just by spending directly on health, but through communities which are prosperous, secure, active, well-educated and well-connected. The broader policy framework from Welsh Government has become increasingly consistent. Linking the NHS Finances (Wales) Act with the Wellbeing of Future Generations Act, for instance, has increased the focus on long term planning and collaboration with public sector partners. Likewise, prudent healthcare and the development of the value agenda helps to provide a longer term solution to address the issues facing the NHS.

Views of Effectiveness of the 3 year Plans

The Health Board had its three year plans approved for the first two years of their implementation – 2013/14 and 2014/16, since then annual plans have been prepared and implemented. Three year plans provided a good basis for longer term change and improvement, and provided a more strategic focus for organisations in the development of their plans. In reality, plans were primarily focussed on the first year of implementation and this was reflected in the need to achieve financial balance and deliver performance targets on an annual basis.

The Health Board was placed in Targeted Intervention in late 2016 and has not submitted a three-year plan. As a result of this, the Health Board has been operating under Annual Operating Plan arrangements. Coupled with the significant underlying deficit the Health Board has not been in a position to consider the flexibilities that the Act provides. However, the underlying principle of developing three year plans provides a clear framework to support longer term planning which is to be encouraged.

THE PACE OF CHANGE

Views on how effective current funding mechanisms are in driving transformational change

Current funding mechanisms support to a large degree transformational change within Health Board organisational boundaries – given the constraints set out above of the requirement to deliver financial balance on an annual basis. The shortage of NHS Wales Capital funding in the foreseeable future will, however, be a constraint within this, and further advice and support on securing alternative sources of funding would be welcomed.

Further work is required to consider how funding mechanisms should operate more effectively on a regional basis, and the recent White Paper which sets out requirements to plan on a population basis rather than an organisational one may support this. Agreements to enable this – eg for paediatric and neonatal services in the South Central Acute Care Alliance too significant time and agreement between Chief Executives before they were implemented.

These arrangements will require significant further effort as services increasingly become planned and delivered on a regional basis.

Relatively small amounts of monies which are made available for specific services (eg through the national Delivery Groups) can make it more difficult to support local transformational change. This has also been some of the experience with some of the primary care investment to cluster networks, which has delivered on very local priorities but has consequently not been targeted at opportunities to make system wide changes in pathways and models of care.

The extent to which a preventative approach to funding service is currently possible

This can be challenge given the time taken to deliver return on investment – and the three year planning timeframe may be too short for some changes. Through its commissioning work the Health Board made a start in these areas, and undertook preventative work on eg bowel screening, PBMA work on MSK services and atrial fibrillation and breast feeding. All of these activities are resource intensive in terms of data gathering, clinical engagement and agreeing new models of care, however, it is vital to continue this to secure improvements in health and well being and reduce demand on core health services. The Health Board is continuing to progress this through Value-based healthcare, however progress will be determined by capacity to develop new models through re-investment "upstream" of resources, given the current financial position of the organisation.

Action the NHS Bodies would like to see from the Welsh Government to address these issues

In recent years the Welsh NHS has managed to deliver an overall reasonable, but still challenging financial settlement. There are competing demands on this however, as some resources have been used to provide structural support to financially struggling organisations and to take forward Welsh Government priorities and policy developments. In addition, a significant proportion of the NHS allocation is ring-fenced. Relaxing ring fencing arrangements and providing a greater level of discretionary growth would provide greater flexibility in the delivery of sustainable services.

WORKFORCE PRESSURES

Details of particular pressures and staff shortages and plans to address this

Medical Workforce

Reflecting national shortages in a number of key disciplines ABMU has experienced difficulties in recruiting sufficient numbers of medical trainees to fulfil work rotas on all health board sites. The same issues affect the Health Board's ability to attract non-medical training grades. Some Consultant posts are difficult to recruit to in some areas such as Radiology, Oncology, Pathology, Respiratory, Gastroenterology and Psychiatry.

International Recruitment and Medical Training Initiatives

Following three overseas recruitment initiatives with Health Care Locums Limited, Medacs Agencies, and the Royal College the following number of doctors have now started employment within the Health Board. The remaining doctors are due to start between now and October subject to passing the International English Language Testing System language tests. Of the number of doctors who have started in post five have resigned.

Specialty	Unit	No. Started	Nos. To start March – June 2017
Medicine	Morriston	13	9
Medicine	Singleton	0	1
Surgical Specialties	POW	3	0
Surgical Specialties	Morriston	3	0
Anaesthetics	POW	1	1
Anaesthetics	Morriston	0	1

British Association of Physicians of Indian Origin Recruitment (BAPIO)

The following specialties participated in the All Wales BAPIO Recruitment scheme. The doctors have anticipated start dates of March to June depending on the International English Language Testing System language tests.

The remaining doctors are due to start between now and October depending on the International English Language Testing System language tests.

Specialty	Unit	No. Started	Nos. To start March – June 2017
Anaesthetics	POW	0	2
Anaesthetics	Morriston	0	1
Medicine	NPT	0	1
Paediatrics	Morriston	0	2
Neonates	Singleton	0	3
Surgical Specialties	Morriston	0	2
Surgical Specialties	POW	0	7

BAPIO Recruitment Initiative 2017

A second BAPIO recruitment initiative will take place from 16th September 2017 – 23rd September 2017. ABMU Health Board has confirmed they wish to participate along with 5 other Health Boards. The initiative will include Emergency Medicine, Medicine, Mental Health, Paediatrics, Neonates, General Surgery and Trauma & Orthopaedics.

BAPIO have been requested to obtain applications for both MTI at lower and higher level where the Royal College approve both levels. If the Royal College only approves posts at a higher level then applications will be processed for equivalent Core Training posts and Health Boards will apply for Tier 2 Visas, the doctor will not be on the MTI scheme but employed as an equivalent trainee. Each Health Board will be a lead for a designated specialty to deal with the administration of applications, shortlisting, interview schedule etc.

The health board constantly monitors our recruitment position in terms of medical staff with reports to Executive Team and Board via Medical Director and Medical Workforce Board. The health board seeks to work closely with the Deanery to ensure training posts are filled. Specialty based local workforce boards are in place to monitor and control specific issues.

The health board has run recruitment campaigns including overseas for additional non-training posts to fill gaps.

Part of our strategy is to reduce turnover and we monitor leavers' data to identify local hotspots and agree local plans to address areas with higher than average turnover. We have introduced a revised exit interview process built on the health board's values system.

There is significant evidence to suggest that an engaged workforce will be more productive and effective an outcome of which would be lower levels of turnover, therefore one of the outcomes from the effective implementation of our strategy will be lower levels of leavers, particularly within the first 12 months of service.

Nursing Workforce

The national shortage of qualified nurses continues to be a challenge, particularly in acute care areas. In response the heal board has been mitigating the risk through a number of approaches identified below. The health board has also undertaken a baseline review against the potential reporting requirement within the Nurse Staffing Act Wales guidance 2016. A health board task and finish steering group has been established to manage implementation of the act. The initial baseline review identifies significant challenges and deficits in terms of agreed budgets and vacancies to meet the act requirements. Considerations and plans are in place to address these requirements through ward re-modelling, reducing average length of stay revalidation of acuity and operational management, and redefining ward profiles and definitions.

Nurse Recruitment

The Health Board is currently recruiting nurses within the UK, Europe and overseas and, also investing in a variety of options which includes;

- Enabling successful existing Health Care Support Workers (HCSW) to become Registered Nurses by supporting a new part time degree in nursing programme at Swansea University, which commences September 2017. This programme allows HCSW's to train as a registered nurse whilst still maintaining their role as a HCSW.

- Supporting a new 2-year full time Master's programme for existing HCSW's with an existing degree.
- Implementation of a new development programme to enable HCSW's with overseas registration to become registered nurses in the UK.
- Development of a specific Health Board Nurse Recruitment Campaign
- Fully engaged with the Wales Train WorkLive campaign since its launch in May 2017.
- Supporting a new all-Wales approach to student recruitment which is called the Student Streamlining Project.
- Return to Practice programmes are delivered annually by both Swansea and South Wales University.
- A joint Health Board and Higher Education Institute Task & Finish group will lead on The NMC Programme of change for Education.

Nurse Retention

The following actions are being taken to improve retention

- Implementation of an improvement initiative to analyse the themes and trends in exit interviews
- Review of clinical supervision strategy/plan with a periocular focus on nurses qualifying in the first year of practice.
- Improving access to post registration development and PDR' in line with revalidation requirements
- Development of a nursing and midwifery strategy listening from ground floor practitioners at all stages of their career.
- Monitoring wellbeing at work in line with prevention and sickness and absence trends.

Impact of Brexit

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

The Health Board has looked to the EU in recruiting both medical grades and nurse for some years, however the popularity of this approach within the NHS UK wide has negatively affected the numbers of staff available. The Board has looked abroad both to the Indian subcontinent to recruit Doctors and the Philippines to recruit Nurses and continues to look further abroad to fill gaps which cannot be filled with UK staff due to shortages in trained nurses.

We are monitoring any potential impact on existing employees from the EU, particularly as to how any decisions regarding their right to remain in employment in the UK is affected. Any reduction in our ability to retain and recruit from the EU whist the shortage of nurses and medical staff exists is naturally unwelcome.

Primary Care

There are also significant pressures facing primary care, with difficulties in recruiting GPs, leading to sustainability challenges for the current pattern of GMS provision. The Health Board has established a Primary Care Support Team to advise, support and assist practices who run into difficulties by reviewing models of service and opportunities to improve multidisciplinary working.

Aneurin Bevan University Health Board

Response to Health & Social Care Committee Inquiry into the NHS Draft Budget

Mental Health

1. Allocated Spend on Mental Health Services (excludes Learning Disability services)

The allocated spend on mental health services for 2017/18 is as follows:

Mental Health Ring Fenced Allocation	£m
Hospital and Community Health Services	88.2
Primary Care prescribing	9.1
GMS (QOF and ES)	1.1
Substance Misuse	2.4
Total	**100.8**

The allocation has been delegated across three management divisions within the Health Board to deliver the following services:

1. Mental Health Division

   Secondary care acute inpatient care, community services and continuing health care (CHC) services.

2. Family and Therapies Division

   Provides CAMHS services, Out of county CHC placements and paediatric psychology services.

3. Primary and Community Care Division

   Primary mental health services and prescribing in primary care.

2. Spending on Mental Health Strategy and Plan

The Health Board received £3.8m in 2017/18 as part of the national £20m funding, allocated by Welsh Government, for mental health services across NHS Wales. Some of the key areas of service development include:

- Improving support for adults who present in crisis

  Investment in increased staff levels in acute in-patient wards and the remodelling of Crisis Resolution Home Treatment teams, providing an

extended service. Following consultation with users, carers and partners increased provision for crisis services has been prioritised.

- Expansion of Psychiatric Intensive Care Unit (PICU)

  An increase in local services (4 to 9 inpatient beds) should improve the pathway for patients and reduce the need to commission out of county CHC placements. This should be in place from January 2018.

- Development of sustainable care support packages

  Investment in more innovative 'In One Place' schemes, for those patients with complex needs, to access better support arrangements.

- Implementation of WCCIS

  The implementation of the new system should improve management information and improve the quality of patient care.

Other services which have been developed and embedded into mainstream mental health services include:

- RAID (Rapid Assessment Interface Discharge) team established and assessing dementia patients in main acute hospitals at an early stage,
- Psychological therapy resources used to extend services and reduce waiting times for patients,
- Perinatal services team fully established, and
- Early intervention teams enhanced through use of CAMHS funding.

New services for children and adolescents with mental health problems have improved access in the following areas:

- Neurodevelopmental service,
- Crisis response,
- Eating disorder services,
- Emergency liaison, and
- Dialectal Behaviours Therapy.

3. Resources for Primary and Secondary Mental Health Services

The following table provides a summary of the main areas of mental health spend across the Health Board:

Resources	£m
Mental Health Division:	
Older Adult services	13.9
Adult services	17.0
Primary Care Measure	3.4
Forensic	3.0
Substance Misuse services (provided by the Health Board)	1.8
Specialist Services	1.6
Local Authority and third sector agreements	1.3
Continuing Health Care (CHC) – excluding LD/EMI	12.2
Mental Health Management/Support services	5.3
	59.5
Continuing Health Care (CHC) – Elderly Mental Illness	**17.1**
Family and Therapies Division:	
CAMHS	4.3
Continuing Health Care (CHC) – CAMHS	0.3
Paediatric psychology	1.0
	5.6
Primary Care Division:	
Prescribing	8.8
GMS QOF/ES	1.1
Local Authority and third sector provided services	1.5
Other primary care mental health provision (e.g. pharmacist, improved access)	2.5
	13.9
Other Mental Health Services:	
Services provided by other NHS bodies	4.7
WHSSC – specialist commissioned services	11.9
Other secondary care provided services	4.2
	20.8
Total	**116.9**

4. The Impact of the Mental Health Measure on Spending

The Mental Health Measure was implemented during 2012/13 financial year. Through a combination of additional funding and re-allocation of existing resources, the Health Board reconfigured its mental health services – including CAMHS – to provide a more comprehensive primary care mental health service.

The service has teams based in the five local authority areas and works closely with GP practices, taking referrals from practices and assessing and providing mental health care at an early stage.

The service has been extended over the last two years, through the use of Primary Care and CAMHS funding.

Tier 1 targets for assessing and treating patients have been consistently met for the last few months.

5. Spending on mental Health Services Delivered on the Prison Estate

There are two prisons with the Health Board area at Usk:

- Usk Prison a 250 population Category C closed prison for adult male vulnerable prisoners, and

- Usk Prescoed a 230 population open establishment housing Adult Male Category D Prisoners.

The Health Board provides a small in-reach prison service costing £52k per annum.

The Wales Offender service initiative provides a service to probation officers to help with the management of patients with personality disorder problems, and to avoid re-offending. The funded service is £115k per annum.

In addition, the Health Board is experiencing growing numbers of patients requiring specialist mental health services including continuing healthcare in low secure services, including prisoners at the end of their sentence with Ministry of Justice restrictions.

6. Patterns of Demand and Expenditure on Mental Health Services in the Last 5 Years

The Health Board has seen a £4.7m increase in spend on adult mental health services over the last 5 years, with the increase over the last two years proportionately higher. Service pressures from increasing number of patients with acute mental illness and those with long term continuing healthcare needs are putting services under pressure.

Continuing Health Care (CHC) costs have risen sharply over the last 2 years with adult mental health care costs rising by £1.6m (17%). Plans for a new Low Secure and High and Dependency Unit are being developed to provide

more local, accessible services and reduce the reliance on out-of-county placements.

Elderly Mental Illness (EMI) CHC costs have almost doubled between 2012/13 (£8.9m) and 2016/17 (£17.1m). The number of patients with dementia is growing, placing additional pressure on mental health services across the Health Board.

The Health Board has experienced a shortage of mental health junior doctor posts from the Deanery and has had difficulty recruiting to some registered mental health nursing posts.

CAMHS services have experienced increased demand for its services over the last 5 years and responded with specific investments in more capacity to reduce waiting times.

7. Details of the operation of the ring fence for the mental health budget, including the extent to which it has determined spending on mental health; and the purpose and value of the ring fence.

The ring fenced allocation acts as a check in the system. However, the Health Board actively commissions to improve health and deliver improved healthcare services for the whole of its population, including those with mental health needs.

Financial Performance

- **Detail of overspend/underspend and reasons for this & key pressure areas and plans in place to make improvements**

Over the preceding three year IMTP period 2014/15 – 2016/17 the Health Board has achieved its statutory financial duties including delivery of a break-even financial position and has a track record of delivery in relation to financial performance. For 2017/18, the Health Board has received approval of its 2017/18 IMTP by Welsh Government and is forecasting a break-even position for the 2017/18 financial year.

On an in-year basis, as at the end of July 2017, the Health Board has an in-year deficit of £3m, with actions being put in place to deliver the forecast break-even position described. Key pressure areas for the Health Board include:

- Variable pay – in particular the premium cost of agency nursing and medical staff supporting challenges in workforce supply,
- Medicines management – in particular the cost of growth in existing treatments in secondary care,
- Increased costs in relation to growth in specialised services and cancer treatments, and
- Delivery of premium cost activity and demand solutions to support improvements in performance delivery and sustain service delivery.

There are a number of actions in place to improve this position including recruitment, stabilisation of rates of pay, actions to manage growth in demand, and delivering on further opportunities for improvement.

- **Views on the perceptions that there remain opportunities for the NHS to make further efficiency savings**

The Health Board recognises and acknowledges the evidence base outlined by the Health Foundation's 'Path to Sustainability' report, which outlines the planning assumption that Health Board's should be planning on around 1.5% efficiency savings per annum to retain financial balance over the next 10 year period (provided additional funding is sustained and the current share of UK GDP). Historically, the Health Board has delivered in the region of 1.5% - 2% per annum, and there remain opportunities to deliver this level of improvement through:

- Technical efficiency – including use of premium workforce costs, non-pay efficiency, medicines optimisation (e.g. loss of exclusivity)
- Allocative efficiency – optimising high vs low value interventions relative to outcome gain
- Productivity – delivering improvements in productivity and efficiency in line with best performing organisations and healthcare systems.

Whilst progress is being made on delivering improvements in each of these areas there remain opportunities to deliver further savings. Increasingly however, opportunities afforded by technical improvements are reducing and there is a need for a greater contribution from allocative efficiency approaches and gains.

- **Any projected spend on technology and infrastructure to support quality and efficiency**

The Health Board is utilising technological and infrastructure developments to support improvements in quality and efficiency, supported through both capital and revenue programmes which will deliver both quality improvements and future savings. There are examples of local schemes to support Health Board priorities and regional and national developments to support consistent solutions across Wales. From a local Health Board perspective such examples include developing the Digitised Health Record (DHR), use of automated stock control systems in pharmacy (and looking to expand into other clinical areas), and developing Text Remind services to deliver significant improvements in missed outpatient appointments. At a national level, developments include the development of Welsh Community Information System (WCCIS), and the national patient flow system which are envisaged will deliver improvements in productivity, and release clinical time through increased automation to increase available direct patient care.

The Health Board is also developing its system infrastructure in relation to capturing patient related outcomes, which will allow the continued

development of a Value Based Healthcare approach and maximising the opportunities associated with developing a clear alignment and understanding of the relationship between costs and outcomes.

- **Response to Welsh Audit Office (WAO) report on the implementation of the NHS Finance (Wales) Act 2014 (introducing 3 year financial plans to enable longer term planning)**

The Health Board considers that through the implementation of the NHS Finance Wales Act 2014 this has helped to provide:

- Greater clarity on future funding levels,
- A clear planning and delivery framework
- An environment to support the development of robust plans, and
- An IMTP approval mechanism.

Independent work such as the Health Foundation and Nuffield Trust reports have also contributed to understanding and providing clarity around future funding and spending outlooks.

The WAO report reflects a positon the Health Board recognises. In addition, the Health Board would support that there is a need to shift towards a three-year delivery environment aligned with approved IMTPs, but recognises the challenges associated with ensuring in-year delivery in large complex organisations.

- **Views on the effectiveness of the 3 year plans**

The Health Board considers that the 3 year plan system is an improvement on the previous planning arrangement, and through the IMTP process a clear planning and delivery framework has emerged which provides the Health Board with a clear framework and mechanism to plan and deliver its services and associated strategic objectives and key performance targets. In addition, the Health Board is incentivised to ensure it has an approved 3 year plan with Welsh Government in relation to the increased autonomy that this enables, and incentives this may bring such as increased discretionary capital allocations.

In developing 3 year plans however, there remains a natural inclination to have an increased focus on the first year and ensure in-year delivery of key performance deliverables and service quality improvements in addition to financial balance. Through each annual IMTP process the Health Board is developing its approach to ensuring that future year's plans are developed with the same degree of robustness as the first year component and focus on medium term financial sustainability as well as in-year financial balance.

- **The reasons why none of the NHS bodies have so far made use of the new financial flexibilities under the Act**

Given the Health Board's ability to achieve its statutory financial duty in recent years there has been no detailed consideration of the need to use some of the new financial flexibilities under the Act. In relation to the position of NHS Wales as a whole, a key consideration in exploring the use of the financial flexibilities under the Act is how the system as a whole would retain financial balance, and how longer term plans are developed with a sufficient degree of assurance and robustness that future flexibility can be planned with certainty and any risks mitigated.

The pace of change

- **Views on how effective current funding mechanisms are in driving transformational change**

The Health Board recognises that Welsh Government are allocating funding for specific purposes which at a national level is intended to support transformational change in areas such as developing out of hospital services, integrated care, use of technology to support increased efficiency, and mental health services. Whilst this approach is positive in support of those particular areas, having additional funding allocated in a defined way reduces Health Board flexibility to allocate additional resources in line with local priorities developed through the IMTP process. In addition, new funding whilst welcomed is relatively modest in comparison to the Health Board's total allocation, and the main focus for delivering transformational change needs to be delivered through Health Board approaches and utilisation of its total resource.

- **The extent to which a preventative approach to funding services is currently possible**

There is evidence of funding services to support a preventative approach, both through Welsh Government directed policy and funding, and through local priorities as determined through the Health Board's IMTP. For example, the Health Board's Living Well Living Longer programme, and other programmes to support improved public health are key developments in looking to secure improvements in the population health. However, the ability to invest significant at scale in preventative health programmes is constrained by short term financial pressures and targets taking priority, and ensuring the Health Board remains in a sustainable financial position. The Health Board's Value Based Healthcare approach considering outcomes aligned to cost of services is a key strategic lever in considering relative outcome gain and ensuring this plays a greater part in prospective resource allocation and utilisation.

- **Actions NHS bodies would like to see from Welsh Government to address these issues**

The Health Board's value based approach focuses on greater allocation of resources to improve the health outcomes for its population. The Welsh

Government's revenue resource allocation formula, in part, recognises population health. Refining this further, to reflect current population health challenges would enable prospective funding allocations to be greater aligned to the health needs of the population. This should also enable a focus on where the need for preventative approaches is greatest, recognising that balancing long term investment in prevention versus short term investment in immediate priorities will always present a challenge.

Workforce Pressures

- **Details of particular pressures and staff shortages, and plans to address this;**

The Health Board has particular challenges in relation to the workforce which is consistent with the rest of NHS Wales and the wider NHS in the UK:

- Registered nursing workforce supply with a reliance on premium rate agency staff
- Secondary care Medical workforce supply with a reliance on premium rate agency staff
- General Practitioners demand to sustain existing service models
- Sustaining specialised workforce in key specialties and sustaining multiple services on various sites

Plans to address these issues include recruitment (including innovative approaches to recruitment), developing increased pay standardisation in relation to premium rate temporary staff, and developing alternative roles ensuring all professions operate at the top of their licence and capacity where appropriate is released.

- **Any planning / assessment undertaken on future funding needs post-Brexit, for example given possible changes in agency staff costs**

The potential risk of lower economic growth, as a result of Brexit, leading to lower tax revenues and public spending is understood. Alongside this, the Health Foundation (Path to Sustainability) reported that approximately 6% of NHS Wales's staff are from other EU countries, representing a risk to sustaining an appropriately skilled workforce. There is already a significant focus on workforce pressures, as outlined previously. Whilst these are potential significant threats, at this stage the impact of Brexit negotiations is not clear.

Glyn Jones
Director of Finance & Procurement
September 2017

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GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

CS/EW/AE

29 September 2017

Ms Nesta Lloyd-Jones
Policy & Public Affairs Manager
Welsh NHS Confederation
Ty Phoenix
8 Cathedral Road
Cardiff
CF11 9LJ

Dear Nesta

Health, Social Care and Sport Committee.

The following provides the responses of Powys THB to the Health, Social Care and Sport Committee consultation questions:

Mental Health

Powys THB has received an allocation of £28.875m. In the 2017/18 financial year to provide Mental Health services to the population of Powys. The following table provides an analysis of the expenditure by Powys THB on Mental Health services over the previous 4 years:-

Year	Primary	Secondary	Total
2013-14	£2,664,232	£24,104,111	£26,768,343
2014-15	£2,854,718	£25,943,073	£28,797,791
2015-16	£3,007,306	£26,190,800	£29,198,106
2016-17	£3,119,808	£31,340,779	£34,460,588

The Mental Health strategy, 'Together for Mental Health' provides a commitment to investing in the Mental Health services across Wales. Additional resources have been committed by Powys THB in specific area's to support and improve services and patient experience. The Mental Health strategy aims to deliver improved care through initiatives in mental health from our patient's wellbeing through to severe mental illness. The strategy is implemented through three-year delivery plans and the current delivery plan 2016-19 includes the funding listed below.

Allocation recurring 16/17	**2016/17 - £**	**2017/18 - £**
Dementia Link Nurses	13,114	13,114
Psychiatric Liason Nurses	174,555	174,555
Total	187,669	187,669

New allocations 16/17	**2016/17 - £**	**2017/18 - £**
Local primary MH Support services	31,458	83,286
Local Memory Clinics	80,358	36,147
Inpatient Psychological Therapies	24,561	52,908
Flexible Resource Teams	31,600	116,653
MH - DOLS		3,000
Dementia Support Workers (Non Rec)	43,715	0
Total	211,692	291,994
Grand total	**399,361**	**479,663**

In terms of the Mental Health measure, spending has increased within the Community Mental Health Teams, due to the introduction of the Measure in relation to restricting Care Coordination to qualified Mental Health Practitioners. Prior to the measure, suitably experienced yet 'unqualified' (in terms of Mental Health Practitioner status) members of staff undertook some care coordination duties of less complex cases. Overall, we have seen a small increase in the number of care coordinators since the introduction of the measure, however as demand for secondary care is increasing significantly, there is a requirement to expand the capacity of CMHTs to respond to this need. The health board has increased spending on advocacy since the introduction of the Measure. Specifically within Powys, the Welsh Government funding allocation linked to Part 4 was insufficient to cover the advocacy service in Powys. The Health Board has allocated additional funding to ensure that advocacy coverage provides parity of access across Powys, especially in our very rural and isolated communities.

In terms of part 3, (reassessment requests) Powys has seen a very small increase in the number of patients requesting a reassessment of their needs following a previous discharge from secondary care.

For the majority of the last 5 years, Mental Health services in Powys were delivered by three Welsh Health Boards. The repatriation of the service was completed in June 2017, consequently we do not hold accurate data in relation to demand for service during the period 2010 to 2015 (for North Powys) and 2010-June 2017 for South Powys. However, the perception of team managers who have delivered services within Powys during this period is that demand for service is increasing overall for Mental Health services, and specifically amongst patients presenting Mental Health difficulties in relation to trauma. There is a clear increase in the number of patients presenting with Personality Disorders and Older Adults with complex and challenging needs (with significant numbers of high cost placements. There is a reduction in the demand for residential rehabilitation and complex presentations of traditional psychiatric conditions.

Financial Performance

1. The allocation received by the Powys THB in 2017/18 supported the existing cost base of the services provided to our residents and the service cost increases forecast for 2017/18, such as Pay Increases, Non-Pay inflation, Growth in CHC costs and new high cost drugs. The Powys THB financial plan for the 2017/20 IMTP established a 1.5% cost savings targets on all spend areas in order to prepare a balanced 3 year financial plan. Not all the new 2017/18 resource was distributed in the Allocation Letter and there remains the opportunity for further funding for key WG strategic objectives.

2. Powys THB achieved the 3 year financial duty in 2016/17, whereby the Health Board had achieved a balanced financial out turn in 2014/15, 2015/16 and 2016/17 financial years. The Health Board has an approved IMTP for the 3 year period from 2017 to 2020.

3. The Health Board utilised the recent Health Foundation report in considering the appropriate savings targets to incorporate within its plans for the current year and that for the period covered by the IMTP. The Health Foundation report highlighted that '*Without any action to reduce pressures or increase efficiency, NHS spending would need to rise by an average of 3.2% a year in real terms to keep pace with demographic and cost pressures, and rising prevalence of chronic conditions.*' Furthermore, it stated that the '*Sustainability of the NHS is intertwined with the sustainability of other public services, crucially social care. Pressures for adult social care are expected to rise faster than for the NHS, by an average of 4.1% a year.*' It is evident that in order to sustain current services and adequately address the growing demand, that there is a need for

sufficient additional funding to meet the increased costs in 2018/19 of both Health and Social Care services. The expectation that 1% to 1.5% of savings can be achieved will always be present and was reported by the Health Foundation as being broadly achieved in the recent past. It has been the recent experience of Powys THB that it is unrealistic to consider that higher savings levels than the 1% to 1.5% can be consistently achieved to bridge the gap between the cost pressures that are present and insufficient new funding. It is necessary therefore to match realistic savings and funding levels to the cost pressures that do present.

4. The 2017/18 financial will remain extremely challenging because of the continuing growth in demand, new high cost drug and the need to increase commissioned activity in order to meet access target expectations. Whilst plans are in place to meet expected levels, there are always challenges that present themselves in year. At Month 05, the HB is £0.88M overspent but is forecasting a breakeven position at year end, subject to successfully manging the risks that are present over the remainder of the year.

5. It is expected that the NHS will continue to focus on identifying opportunities that improve the efficiency and the effectiveness of its services and thereby savings will remain a feature of future plans. This will require services to identify cash savings opportunities through benchmarking service costs and identifying new opportunities and pathways for service provision that make better use of our resources. It is important however, to recognise that the value based care approach could be more effective in identifying the improvement opportunities that should be pursued. This approach targets the relationship between costs and patient outcomes and engages clinicians in redesigning services to improve Value For Money. Continuing to progress the Prudent Health Care approach will also make a valuable contribution to containing costs to the funding available by ensuring that health care resources are targeted effectively.

6. Planning for future years is challenging, particularly in relation to coping with changes to provider services whereby pathways have to change to a different, possibly more distant provider because of service sustainability issues. The HB attempts to address these by looking for new opportunities to provide more local services, but these very often depend on clinicians being prepared to travel into Powys to staff local clinics and services. The availability of new staff to support new services or to fill vacancies is also a major challenge for the future and is a major determinant of whether services are sustainable and can be planned for the foreseeable future. Changes in external factors such as pension regulations, overseas recruitment

and availability of training courses may also impact on future service plans because staff may change their career intentions in response.

7. It is also considered that there is merit in targeting resources for new spending initiatives on preventative measures that promote better health and well being. The case was made in the recent Public Health Wales report 'Making a Difference'. It is imperative that new initiatives are pursued in this area in order to reduce the future growth in demand for health care. There is an evidence base for the cost effectiveness of a broad range of preventive approaches, including smoking cessation, immunisation and brief intervention.

Workforce Pressures

1. Recruitment of sufficient qualified and trained staff remains a challenge for Powys THB as it is for other NHS organisations. A recruitment task and finish group has been established to pursue a range of initiatives to address the turnover of staff with the health board. The health board has 32 vacancies currently for registered nurses, which does create operational difficulties across the organisation. As at 31st of August 2017, the health board's 12 month rolling staff turnover stood at 11%.

2. For the first 5 months of this year, Locum and Agency staff costs has accounted for 6.3% of total pay costs, amounting to £1.7m to date. Efforts are being made to secure the temporary staffing from contracted agencies where the costs are substantially lower than for 'off-contract' agencies.

3. The health board is pursuing a range of measures to attract new staff to Powys including a presence at this year's Royal Welsh Show, establishing links with a number of universities and thereby attending career fairs and including vacancies direct on university websites. The health board is also involved with the development of the national campaign and is a part of the promotional exercise that is underway. Two 'one stop shop' recruitment events for registered nurses are taking place in September and October 2017, whereby people will be able to complete the recruitment process on the day up to a provisional offer of employment. The health board has been featured in a recruitment brochure produced by Rural Health and Care Wales where the prime focus was to promote health and social care careers in rural mid Wales.

I hope the above information is useful to the Committee in its deliberations.

Yours sincerely

Carol Shillabeer

Carol Shillabeer
Chief Executive

CLILC • WLGA

ADSS Cymru
Leading Social Services in Wales
Yn arwain Gwasanaethau Cymdeithasol yng Nghymru

WLGA and ADSS Cymru evidence to the Health, Social Care and Sport Committee on the Welsh Government Draft Budget 2018-19

About us

1. The Welsh Local Government Association (WLGA) represents the 22 local authorities in Wales, and the three national park authorities and three fire and rescue authorities are associate members.

2. It seeks to provide representation to local authorities within an emerging policy framework that satisfies the key priorities of our members and delivers a broad range of services that add value to Welsh Local Government and the communities they serve.

3. The Association of Directors of Social Services Cymru (ADSS Cymru) is the professional and strategic leadership organisation for social services in Wales and is composed of statutory Directors of Social Services, and the Heads of Service who support them in delivering social services responsibilities and accountabilities; a group of more than 80 social services leaders across the 22 local authorities in Wales.

Introduction

4. Since the introduction of austerity measures in 2010 local public services have faced at least £1bn in cuts across Wales. At the same time the public sector workforce has been impacted, initially by a two-year pay freeze, followed by a 1% cap over the last five years. In this setting the WLGA's new Leader, Cllr Debbie Wilcox, has argued that "the philosophy of austerity that has dominated political discourse since 2008 has collapsed, to the point where hardly anyone still believes it."

5. We fully recognise the scale of the cuts to the Welsh Government budget over this period. We also recognise the concerns of the Cabinet Secretary for Finance and Local Government about the potential for another £3.5 billion of cuts. If this was actioned, it would have a £175m impact on the Welsh budget. With massive service pressures the financial position is becoming unsustainable. Councils are using their medium term financial strategies to plan for future savings requirements but there are clearly risks in terms of financial resilience, not least the burgeoning costs of social care. Social care has been identified as a sector of national strategic importance by Rebecca Evans AM, the Minister for Social Services and Public Health and it is vital that funding is provided to reflect this view.

6. The WLGA and ADSS Cymru are firmly of the view that the current levels of financial stress faced by councils cannot continue. The Cabinet Secretary has expressed an ambition for greater financial certainty and the principle of multiyear financial settlements that will have to be balanced against UK-level uncertainty. This is vital in the next period as cuts become more difficult to deliver and the construction of a deal on this principle would be welcomed.

7. Faced with the biggest budgetary challenges of any part of the Welsh public sector, local authorities have continued to demonstrate good financial management, effective stewardship of public money and the delivery of efficient public services. However, this process cannot be indefinite. For example, if the inescapable costs attributable to payroll that are highlighted later are realised then there will be inevitable cuts to frontline services, and this will be evident to the public.

8. Considering the above it is vital that we construct a clear pathway forward over the next period to mitigate the potential of further cuts. This has been recently confirmed by the Wales Audit Office who in their report 'Savings Planning in Councils in Wales' concluded,

> "With the majority of future savings likely to come from service change and new ways of working, which are harder to achieve and require longer lead-in times, this situation may worsen and compromise councils' financial resilience in the longer term."

Financial Performance of Social Services in Wales

9. Pressures due to social care continue to pose the most risk to council's financial sustainability in the medium to long term. Indeed, there is a growing consensus that social care is such a significant challenge that new thinking on funding is required. The recent paper for the IWA, Solving Social Care, both Professor Gerry Holtham and Tegid Roberts suggest a common insurance fund to pay for the growing costs into the future. Another suggestion by the Financial Times commentator, Merryn Somerset Webb proposes capping the fees of the asset management industry to free up funds for social care. Both are interesting interventions into this debate and need serious examination.

10. The wider challenges facing social care have been well documented. As a result of demographic changes primary and community care services are facing increasing and more complex demands; more people are diagnosed with one or more preventable health condition; and frail, older people increasingly have more complex needs. This comes at a time when we will continue to experience severe austerity in funding for public services across the UK. Population projections estimate that by 2035, the number of people aged over 65 living in Wales will increase by 35%. The largest increase will be in the number of people aged over 85 which is forecast to rise by 113% according to the Institute of Public Care's Daffodil system. Currently around 29% of those aged 85 and over are in receipt of support from social services, compared with under 3% of people aged over 18. Several authorities are also reporting a big spike in the number of looked after children due to increased referrals and court judgements which have a significant financial impact. The average cost per child of provision of looked after children services, including placement, is approximately £43k.

11. The recent Health Foundation report 'The path to sustainability: Funding projections for the NHS in Wales to 2019-20 and 2030-31', recognises that the health of the population depends on far more than just the quality of health care services. Key determinants of health are largely outside the control of health services and so the quality of, and spending on, social care has one of the strongest impacts on the demand for health care. It has been estimated that pressures on adult social care alone will rise by around 4.1% a year in real terms

between 2015 and 2030-31, due to demography, chronic conditions and rising costs. This will require the budget to almost double to £2.3bn by 2030-31 to match demand.

12. The most recent report from Wales Public Services 2025, 'A delicate balance? Health and Social Care spending in Wales' focused on the difficulties local authorities are having keeping pace with spending. The report complements the findings from the Health Foundation analysis, recognising the twin challenges of financial and demand pressures faced by health and social care in Wales.

13. The report identifies that spending on social care for the over 65's is not keeping pace with the growth in the population of older people. The increasing over-65 population in Wales means that whilst day-to-day spending on local authority-organised adult social services has remained broadly flat in real terms, spending per older person has fallen by nearly 13% in real terms over the last five years in Wales, inevitably leading to impacts on services for older vulnerable people. Spending per head would have to increase by at least £134 million (24%) between 2015-16 and 2020-21 to return to the equivalent level of spending in 2009-10, which amounts to a 3.7% year-on-year increase.

14. In addition to the demographic pressures suggested by these national reports, local authorities continue to highlight specific challenges being faced by both Adult and Children's Services which collectively add significant additional financial pressures. A survey has been undertaken of WLGA members and there are some common issues emerging:

    Price pressures associated with National Minimum Wage increases – This leads to upward price inflation to areas including residential / nursing home rates, domiciliary care rates and supported living rates. This pressure will continue to increase over the medium term. Whilst the additional funding identified from WG will help, there is still likely to be a significant shortfall which will add to the uncertainty already being experienced across the market for social care provision.

    Pressures associated with changes to the Social Service Charging Framework - One local authority for example is anticipating a pressure of £100k associated with respite placements, following changes introduced under the Social Services and Well-being Act. Despite additional funding of £4.5m included in the WG settlement to meet changes in the residential care capital threshold some local authorities are forecasting potential shortfalls, which will increase as the capital limit rises in future years. One local authority is forecasting a potential shortfall of £175k for 2017-18.

    Changes to Deprivation of Liberty Safeguards (DoLS) following the Cheshire West Judgement – This has resulted in a significant increase in the number of DoLS assessments required of people living in care homes and in the community. The settlement included additional funding of £184k to cover this additional responsibility, however some authorities have identified that this is insufficient to meet the additional costs.

15. Another significant factor highlighted by local authorities is around the increases in numbers of Looked After Children (LAC). Over the last decade the number of children in the care system in Wales has risen, with a 25% increase in children looked after and a 32% increase in children placed in the child protection register compared with 10 years ago. This increase has been reflected in the expenditure on Children's Services over the same period. Between 2007 and 2016 the revenue expenditure on children's and families' services has increased by 51%. This increase has brought spend on children's and families' services in line with that of expenditure on both adults under 65 and older people, with children's and families'

services now making up a third of social services expenditure. The most significant area of spend within children's and families' services is in relation to services for Looked After Children, which has seen a 66% increase in expenditure over the same period of time. This increase in spend demonstrates the commitment that has been made by local authorities to meet the demands being placed on services by the rising numbers of looked after children, but highlights the significant challenges in being able to maintain this level of funding going forwards, particularly in light of the increasing pressures being faced. Although recent years have seen a stabilising of overall numbers of looked after children a number of authorities are reporting substantial increases in the number of looked after children in their care which continues to place significant pressures on budgets. Additional pressures are seen around the increasing complexity of cases as well as increases in cost for foster placements due to increased demand and the need for specialised placements. Other elements such as increases to the national minimum allowance for foster carers further increase financial pressures being placed on authorities.

16. In response local authorities are looking at different ways of mitigating these additional costs including the use of reserves and additional funding to support the development of preventative 'Edge of Care' Teams. Local authorities have also revisited their prevention strategies as well as their LAC strategies in recent years. This has been a necessity, not only to face the increase in LAC population but also increasing financial pressures facing local authorities and more latterly in order to plan for and implement the Social Services & Well--Being (Wales) Act 2014. Considerable investment has been put into support teams which work directly with Children and Young People and their families to work at levels of need at intensive and remedial intervention levels. Most of these work with families to try to prevent children coming into care, work with families to return children home within weeks of becoming looked after as well as working with rehabilitation plans for those children who have been in long term care.

17. Despite local authorities' strong commitment to ensuring placement choice and stability most have struggled to recruit foster carers in sufficient numbers to provide the range and choice of placements needed, particularly for those young people with challenging behaviour and with additional needs. Local authorities also report similar shortages in the independent sector. This apparent deficit in the foster carer market raises complex challenges across Wales.

18. We have welcomed the additional funding for social services announced in the budget for 2017-18, however, we also need to acknowledge that whilst helpful this will not cover the expected increases in cost and demand facing social services. Despite the 2017-18 budget including £59m of measures to support local government (made up of: £25m of additional funding to local authorities; £25m specifically for social services; £4.5m towards the raising of the capital people can keep when entering residential care; £3m for a pilot to end town centre car parking charges; £1.5m for school transport and safer routes to schools) the local revenue funding for local government only saw a £10m increase compared with 2016-17. The remainder was made up of ring-fenced funding within the pre-existing resource envelope.

19. The additional funding that was made available as a result of consequential funding from the UK government's March budget was awarded for specific areas of work with restrictions placed on what it could be used for, rather than providing local authorities with flexibility to meet local demand and needs. The £10m funding for social services announced for 2017-18 to help meet the extra costs associated with the introduction of the national living wage has been welcomed along with the additional £9m from the further £20m announced in May.

However, if part of this additional funding is for new responsibilities then it cannot be said to be funding any existing pressure.

20. A knock-on impact of the pressures being faced within social care has meant that the provider market has been fragile for some time and all the signs are that the difficulties will only increase. For example, 13 of the 22 Welsh local authorities have reported domiciliary care contracts being handed back to them. For some areas of Wales it can be very difficult to access domiciliary care to respond to complex cases or because of the rurality of the area, with local authority provision having to fill the gap, often with difficulty.

21. There are a series of factors that have increased or will further increase the costs of providing care services, including:
    - National Living Wage
    - Sleeping in judgement
    - Pension changes
    - Travel costs
    - Impact of HMRC changes

22. On-going financial austerity measures for local authorities mean that there is little scope for cost pressures to be reflected adequately in prices paid for care in the near future. Increases in costs cannot be absorbed by care providers indefinitely (nor cross-subsidised by self-funders) and unless a more strategic and sustainable solution is found, there will be significant consequences across the social care market.

23. Social Care Wales have developed a five-year strategic plan covering care and support at home in Wales. This plan recognises the need for a systematic change to the way care and support at home is provided. The strategy identifies the need for Welsh Government to realign funding and to explore the options available to increase and maximise the resources invested in care and support at home.

24. CSSIW's review of domiciliary care supports this view, noting that whilst simplifying and standardising processes will make some parts of the system more efficient and may save some money, it will not be enough on its own. More money needs to be made available in the system so that in years to come there is a resilient, competent workforce and quality provision of care.

25. While medium-term financial planning is firmly embedded and improving in local authorities, longer term thinking is still at a nascent stage, though there are positive signs the Wellbeing of Future Generations Act is proving to be a useful lens through which to view future service provision. Some authorities are starting to undertake strategic programmes of 'whole-authority' work. For example, 'Future Monmouthshire' aims to pose a set of questions about the authority's core purpose, relationships with communities, citizens and stakeholders and its appetite for economic growth and local prosperity.

26. One of the aims of programmes like this is to develop a new operating model in order to equip authorities to meet their goals amidst increasing change and uncertainty. The new operating model will have a clear purpose: to create the capacity and foresight to develop solutions to some of the biggest challenges, ensuring that authorities understand the shifting needs and priorities of communities and positioning themselves as enablers for change.

27. As an Association we believe that long-term planning is under-developed in the Welsh public sector and this is one of the reasons that we collaborate with a number of other public sector bodies to fund Wales Public Services (WPS) 2025.

Integrated Care Fund and Preventative Care

28. We retain a firm belief that investment in preventative services must be the core priority for Welsh Government, in line with the philosophy of both the Social Services and Well-being Act and the Wellbeing of Future Generations Act and in terms of sound budgetary policy. Many preventative services in local government, such as leisure centres, parks, adult education, youth work and community facilities are provided at the discretion of local councils. Unfortunately, in recent years it is these services that have faced the brunt of cuts to local authority budgets as statutory services such as education and social services have been protected. At the same time in the NHS, available funds have been targeted at delivering improved performance in secondary care services, most notably to address referral to treatment waiting times. Pressure on hospital services has never been greater and NHS organisations have therefore struggled to redirect resources into preventative services based in primary and community settings.

29. It is imperative that we stem the decline of local preventative services and that we find a way to make some significant investment into new and existing preventative services based in primary and community settings. The WLGA has previously called for the establishment of a new Preventative Integrated Care Fund for Wales. This fund, focussed throughout the life-course, would enable some double running of new investment in preventative services alongside 'business as usual' in the current system until savings are realised and reinvested back into the system.

30. Preventative spend requires an understanding of the root cause of the problem and tackling that, not just the symptoms of the problem. If there is a lack of understanding and a lack of willingness to address the root causes then services will be faced with a never ending and increasing number of these cases for future generations. Simplistically, common root causes if not addressed will exacerbate the situation and if addressed and funded there will still be a 'backlog' of those currently affected by their conditions which also needs funding until the preventative measures have their full effect.

31. Another issue is the time that it takes to realise significant savings or improvements in social outcomes. One of the few studies that attempts to quantify the preventative impact of the Social Services and Well-being Act is the LE Wales' Paying for Social Care report. Over a 24-year period the costs of Adult Social care are estimated to increase by 114% in the base line scenario, under the preventative scenario they increase by 108%. Whilst this should provide some savings in the long term holding off the need for more costly interventions, which are worth realising, these preventative services still need to be supported and developed, requiring additional investment. It is unlikely however that they will release the significant savings expected, particularly within the context of a population living longer, increasingly with multiple conditions which need support for longer.

32. The Welsh Government's investment in the Intermediate Care Fund (ICF), now the Integrated Care Fund, has been welcomed by local government and has led to the introduction of a number of preventative services across Wales. All regions have reported that the ICF has developed a culture of collaboration with improved communication and decision making across all sectors. There is an enhanced understanding of what different

partners can provide, with improved knowledge of good practice within the region that can be developed and shared more widely. The fund has also increased capacity to improve outcomes for people and to deal with demand for services. Some areas of good practice include single point of access, the establishment of intermediate care teams (ensuring the provision of co-ordinated services across health and social care), rapid response teams, social care or third sector staff working alongside health staff in hospital to prevent delayed discharges, extending the range of rehabilitation / reablement services (including the use of intermediate care flats as part of a wider health, social care and community complex).

33. Its success comes from providing dedicated resources, supported by focused leadership, joint decision-making and governance, to enable public services to concentrate and deliver transformational change. But in comparative terms it does not equate to the resource base of the £5.3 billion Better Care Fund in England or at a city region level the £450 million transformation fund of the Greater Manchester combined authority. The introduction of the ICF has evidenced the benefits of joint planning and joint decision making and we believe more can be done. For example, by bringing oversight of the Primary Care Fund under the newly established Regional Partnership Boards, as the ICF currently is, to enable us to fully examine opportunities for integrated working.

34. All accept that it is not just about chasing pots of money. It's about identifying money and people that are not already entangled in sectorial pressures or rules that can be used to achieve something new while at the same time trying to at least maintain, if not improve the level and quality of existing services.

35. In terms of the Welsh Government's agenda around wellbeing, the WLGA believe that the time is right for a full examination of the transfer of the public health improvement role, into local government. This would provide an opportunity for local authorities to have a significant influence and more joined up approach over the broader determinants of people's health – their local environment, housing, transport, employment, and their social interactions – all of which are linked to local authorities core roles and functions and can play an important part in improving the health and well-being of their citizens.

36. We also believe there is a need for the Welsh Government to identify additional un-hypothecated transformation and transition funding over the medium term for investment in development and implementation of preventative services.

The Pace of Change

37. One of the WLGA's concerns is the WG approach to financial planning, which has been very limited to annual incremental budget setting. The previous administration, despite being committed to an ambitious legislative programme that was driven by the First Minister's Delivery Unit, did not have a medium term financial strategy in place. The back-drop over this period was one of deep austerity where Local Government Budgets were being subjected to unprecedented cuts.

38. In his Financial Resilience Report, the Auditor General has calculated that between 2010-11 and 2016-17, there was a real-terms reduction of £761 million (17%) in aggregate external finance (core grant) for local government. This has had varying impacts across local public

services with some experiencing real terms reductions of over 50%, and spending at levels not seen since the 1990s.

39. There is no doubt that local public services continue to bear the brunt of austerity in Wales and this is looking likely to continue well into the next Parliament. Legislation needs to be planned in a co-ordinated and coherent way recognising that significant funding or savings for new functions and responsibilities is unlikely to materialise soon. If funding for new responsibilities is required it should be very clear where the funding is coming from.

40. Many authorities are having to juggle a number of unfunded pressures with unprecedented reductions in funding. We believe that there should be full and early engagement with all stakeholders in the formulation of legislation and that the financial impacts should not be assessed in isolation but part of the whole programme. The Welsh Government should be budgeting for the whole of the Assembly term and this should be the basis of the planning horizon. There also needs to be a clear reinstatement of a set of core principles for funding new burdens.

41. The impact of legislation should also be assessed after it has been implemented so that the estimation techniques and approach might be improved. This should be done independently of government. The Finance Committee is currently undertaking an inquiry into the accuracy and reliability of estimated costs provided by the Welsh Government in the Regulatory Impact Assessments accompanying legislation and it will be important that their findings are considered in order to identify any learning that can be taken from this inquiry.

Overall Cost Pressures faced by local government

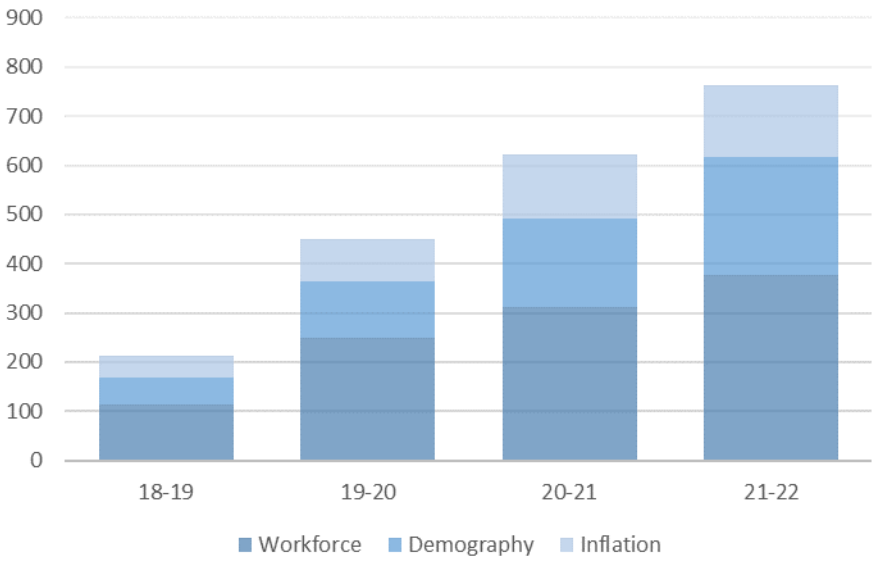
42. A large proportion of supply side pressures over the coming years are attributable to either direct workforce costs for councils, or indirect costs of third party providers. In previous years, there have been substantial cost increases such as £60m in employers' National Insurance payments as a consequence of the introduction of Single Tier Pensions in 2016-17, and £18m for the Apprenticeship levy in 2017-18. Looking forward, there are significant pressures from both increased employer contributions to the Local Government Pension Scheme (£100m by 2021-22) and to the Teachers' Pension Scheme (£19m by 2021-22).

43. While the future of public sector pay is currently a matter of national debate, anticipated 1% pay increases are compounded by the National Living Wage.

44. The potential impact of the Pay Spine Review could add a combined 2.5% to the costs of payroll each year over a two-year period depending on the negotiations between Employers and the Unions. Altogether payroll costs will be £378m higher by 2021-22.

45. Figure 1 below shows the current assessment of expenditure pressures for local government. Total expenditure pressure for 2018-19 is higher than previous estimates at £212m. Just over half of this is the unavoidable financial pressure of pay and pensions. By 2021-22 this is estimated to rise to £762m with workforce pressures (£378m) higher than demographic pressures (£239m). Other inflationary pressure will account for £145m at the end of the same period.

Figure 1: Cumulative pressures up to 2021-22, by source, £m

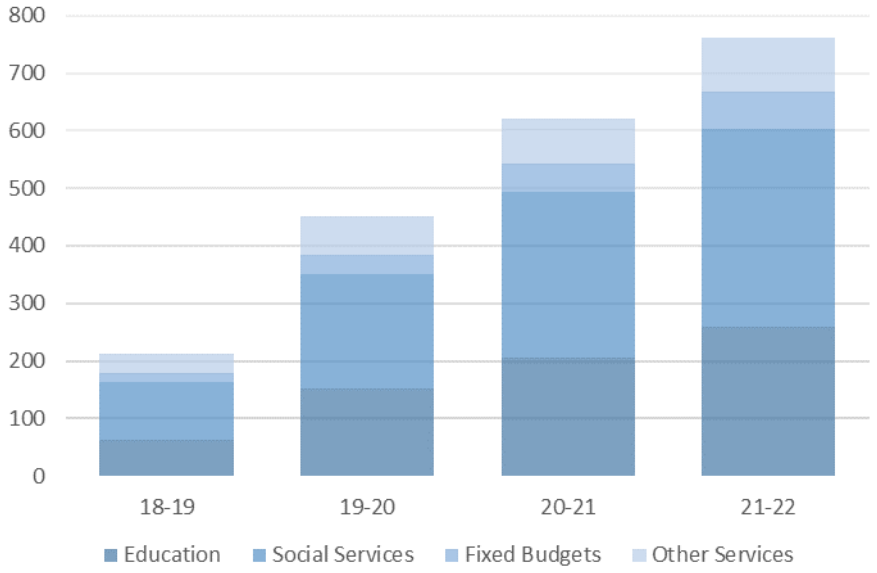


Source: Base estimates: RO and RA returns (2014-15 to 2015-16)

46. Figure 2 below shows that a greater proportion of pressure is building up in social services. An additional pressure of £99m next year becomes £344m by 2021-22. Cost drivers in the education service rise from £64m next to £258m over the same period. Fixed elements of the budget – capital financing, fire levies and the Council Tax Reduction Scheme (CTRS) – rise from £17m to £66m by the end of the period. The remaining services are the ones most at risk and areas that have borne the brunt of austerity.

47. Additional costs for what remains of these services will rise from £33m to £94m by 2021-22. However, these are the services that are currently being squeezed. They currently account for around 15% of net revenue spend. To accommodate the pressures highlighted in this report, that would drop to 5% under certain funding assumptions.

Figure 2: Cumulative pressures up to 2021-22, by service, £m



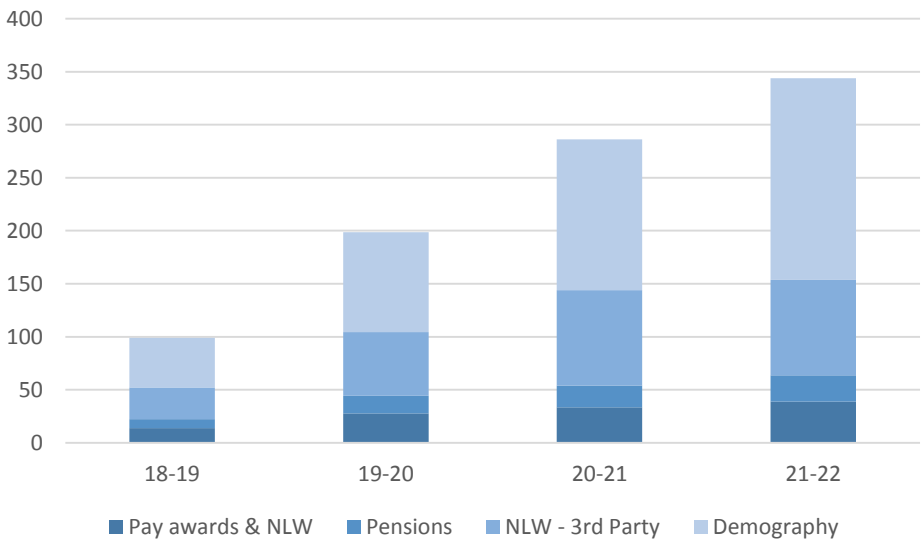
Source: Base estimates: RO and RA returns (2014-15 to 2015-16), NLW impact: WLGA Survey (2016)

Pressures specific to social services

48. The greater part of demand pressures are driven by well-documented demographic pressures. The work done for Wales Public Services 2025 demonstrated that pressures in social services budgets drive around 2.9% growth each year, which is around £47m annually up to 2021-22. This includes pressures in Children's services.

49. Figure 3 below shows that within social services budgets, demographic pressures account for roughly half of the forecast growth next financial year, a proportion that increases gradually up to 2021-22. Direct and Indirect workforce pressures account for the remainder.

Figure 3: Elements of social care pressures up to 2021-22, by service, £m



50. Across both the health and social care sectors we are dealing with staff shortages and retention difficulties. The absence of an agreed long term vision for health and social care in Wales leads to short term planning and resourcing decisions, which poses significant problems for local government and NHS organisations in planning the workforce of the future. The fragility of the social care market impacts on care quality and is contributing to discharge delays in hospitals and years of public finance constraint have led to reductions in education and training placements, increasing our dependence on overseas recruitment.

51. The interim Parliamentary Review report published in July identifies that in many areas of Wales, the viability of the social care system is being put at risk by shortages of domiciliary and residential care staff. This is largely due to pay and conditions often being less competitive than low-skilled jobs in other industries that offer a more comfortable working environment. The interim report also identifies a number of key areas that stand out as requiring attention in relation to workforce planning but recognises that the data is not strong enough, which makes workforce planning difficult. There is a need for a co-ordinated, whole-sector approach to making improvements to our health and social care workforce.

52. Policy makers and local leaders need to agree a joint long term workforce strategy for health and social care that will deliver a resilient, reshaped, well trained workforce with the necessary skills and capacity to meet the changing needs of the Welsh population.

53. The work undertaken to help shape the priorities of Social Care Wales has identified the need for a joint training programme to support multi-disciplinary approaches. This work has identified the need for Social Care Wales to include education, transport, employers, businesses, third sector, independent sector, families, carers and individuals and build a consensus approach to delivering outcomes for people. This means fresh and innovate approaches to models of care, a stronger preventative agenda, exploring integrated roles and cross sector career progression opportunities and more equitable access to training and development.

54. Long term workforce planning needs to take account of the system that we are aiming to create and should encompass the whole health and social care workforce across the public, independent and third sector. There is a pressing and increasing need to develop a workforce in both health and social care with the skills mix required to work effectively within multi-disciplinary teams and this therefore needs to be built into the education and training of health and social care professionals, including more integrated training opportunities.

Conclusion

55. We call on the Welsh Government to recognise and address the immediate funding pressures facing the social care sector. Whilst the relative protection in funding provided to local authority social services has been welcomed, on too many occasions the approach to providing additional funding for the NHS has been to take from one to pay for the other, with social care experiencing reduced budgets in order to protect the NHS. The demand for NHS services cannot be isolated from the quality of other public services – the sustainability of the NHS is intertwined with the sustainability of other public services, most crucially social care.

56. We recognise all the built-up pressures and demands on the Welsh budget. The position in the NHS is also fully acknowledged. It is the case however that the health budget has had a level of significant protection which has seen increases over the past 5 years. The local government budget alternatively is now back at its 2004-05 levels. Bearing in mind the scale of the pressures in this paper this fact must be at the forefront of budget considerations over the next five years.

57. Social services are one of our most vital public services, supporting people of all ages across a wide spectrum of need to live as independently as possible and providing valuable protection from harm in vulnerable situations. In a world of increasingly limited resources and ever increasing demand, there is a need for the Welsh Government to turn their ambition of social services being a sector of national strategic importance into a reality. Investment will improve outcomes for the most vulnerable people in society helping to ensure the sustainability of the social care market and having a significant positive impact on people's lives.

Dai Lloyd AM
Chair, Health, Social Care and Sport Committee

3 October 2017

Annwyl Dai,

The Finance Committee has agreed to undertake an inquiry into the cost of caring for an ageing population. The inquiry will focus on the related demands on social care services, and not the integration of health and social care services. The terms of reference for the inquiry are:

The purpose of the inquiry is to assess, in the context of the major economic and strategic challenges facing the Welsh Government in its development of policy, the financial impact of the cost of caring for an ageing population:

- To examine patterns in demand for social care services for those of pension age and the related costs of delivery of residential and non-residential care, taking account of the role of informal carers who provide unpaid services to those requiring care;
- To examine the financial pressures on the social care system, such as increases in wages, automatic pension enrolment and staff recruitment and retention difficulties, including the related financial impacts arising from the UK leaving the European Union;
- To consider the financial impact of current Welsh Government policies – including recent social services legislation and reforms to social care funding – on local authorities, care providers and service users;
- To consider future social care needs and related costs, including the projected increase in the proportion of the population of Wales of pension age;
- To assess the fiscal levers available to the Welsh Government to reform the arrangements for funding social care. This will include the consideration of alternative models, including international examples, for the funding of social

care to ensure a good quality, fair and sustainable service in a time of increasing demands on the health and social care systems; and

- To consider the findings and conclusions of the Parliamentary Review.

The Committee has agreed to issue a request for written evidence from interested parties and to hold oral evidence sessions early in 2018.

Given your Committee's interest in this area, we would be happy to keep you informed as the inquiry progresses. A representative of your Committee would be welcome to observe our evidence sessions, however I realise that timetabling constraints may prevent this.

Please let me know if you would like any further information about this inquiry, the Clerk will ensure that all relevant information is shared with the Clerk to your Committee.

Yours sincerely

Simon Thomas AM

Chair

Croesewir gohebiaeth yn Gymraeg neu Saesneg.

We welcome correspondence in Welsh or English.

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon
Cabinet Secretary for Health, Well-being and Sport

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref MA-P/VG/3433/17

Dr Dai Lloyd AM
Chair
Health, Social Care and Sport Committee

4 October 2017

Dear Dai,

I am writing with regard to recommendation 1 of the report following the Committee's review of Medical Recruitment, which requested that I set out an action plan and timeline for establishing the new single body, Health Education and Improvement Wales (HEIW).

I was pleased to note the support from the committee for the opportunities that the creation of HEIW presents, but also acknowledge the concerns regarding information in relation to progress towards its creation.

I remain committed to HEIW becoming operational on 1st April 2018. That will mean that we have in place the underpinning legislative framework, a properly constituted board, a chief executive, staff transferred from existing bodies and a budget agreed alongside a remit letter from the Welsh Government.

Significant steps have been taken towards implementation since the publication of the Committee's medical recruitment report. In July, I made a written statement which announced the name of the new body – Health Education and Improvement Wales - and set out some of the thinking in relation to a number of key aspects, including:

- Functions and Remit – Building on those areas of work set out in both the Mel Evans and Professor Robin Williams reports, and the key functions of both the Wales Deanery and WEDS, I confirmed that the new body would also have a responsibility in relation to the widening access agenda; a strengthened workforce intelligence function, building on the work currently undertaken within WEDS; and would also consider other bodies in relation to potential transfer including the Wales Centre for Pharmacy Professional Education and NHS Liaison Unit.

- I confirmed that HEIW would be established as a Special Health Authority, making clear that HEIW will be an equal partner around the table of the NHS Wales Executive. This position will provide a platform to take forward a strategic approach, not just to the education and training of the health workforce, but also to how workforce planning is taken forward in the future, to better meet the needs of the people of Wales.

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- Governance – I also announced my intention to appoint Dr Chris Jones as an interim Chair to the new body, as I recognised the importance of early leadership through the transition period. Dr Jones takes up that role from 5 October for a period of 12 months; and I know that he will bring with him his wealth of experience within the NHS in Wales and will help to guide the new body to successful implementation in its early stages. HEIW will of course need a permanent Chair in place, and as such I also confirmed that there would be a full public appointment process undertaken prior to the end of September 2018.

As I said in my statement, the transition to HEIW is being managed through a Programme approach led by my officials. A Programme Board has been established, comprising members from across the sector, overseeing the work of nine workstreams. These are Finance, Governance, Functions, Organisational Development, People, Location, Communications and Engagement, IT Systems and Legislation. These workstreams bring together key stakeholders from the bodies involved and from health and social care partners.

Additionally an agreement on the transferring functions between Cardiff University, Shared Services and HEIW has now been made. These include the functions under WEDS, the Wales Deanery and the Wales Centre for Pharmacy Professional Education (WCPPE).

We have also begun the recruitment of the Chief Executive and independent members of the Board. This should mean that the successful candidates will take up post as soon as possible in 2018, but prior to April, to aid in the transition and early decision making.

In terms of legislation, I laid the HEIW Establishment and Constitution Order and Regulations last month. These will establish HEIW as a Special Health Authority, provide for the constitution of the Board and the appointment of its members. It is anticipated that they will then come into force in the first week of October.

Finally there have been a number of developments to provide information on progress towards April 2018. Events for stakeholders and staff have been supported by a dedicated web presence and a regular newsletter. Further stakeholder and staff events are planned for the coming months.

The timescales for the delivery of HEIW remain ambitious. Following on from the progress to date set out above, attached is an annex which sets out the timeline and a number of key milestones over the coming months. I will, of course, keep you, and the Committee, updated on developments over the coming months.

Yours sincerely,

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon
Cabinet Secretary for Health, Well-being and Sport

Health Education and Improvement Wales - Implementation Timeline **Annex A**

Workstreams	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Functions & Remit	Detailed description of functions transferring from legacy bodies	Develop detail underpinning additional functions					Remit letter for new body agreed with associated budget.
People – TUPE		Staff engagement	Formal Consultation & Due Diligence		Staff Engagement, Formal Consultation inc issuing of letters		
People – CEO & Senior Team	CEO post advertised		CEO interviews & assessments			Anticipated CEO start date	
			Senior Executive Team roles advertised				Senior Executive Team in post
Governance	Open recruitment of independent Board Member vacancies				Appointment of independent Board Members		
Legislation	Tranche 1 Order & Regs Laid	Tranche 1 Order & Regs in force					Tranche 2 legislation laid

OCCUPATIONAL THERAPY IN NURSING HOME LIAISON SERVICE

The purpose of this report is to provide an overview of the role of Occupational Therapy in a nursing home liaison service. The Alzheimer's Society (2013) estimate that 80% of residents living in care homes have dementia. Given this high number, creating the right environment for people with dementia is relevant to all residents in all types of care homes .Prior to going into a care home it is likely that they will have alongside their cognitive impairment have had several hospital admissions, possibly falls or other frightening episodes, or experienced a period of loss such as bereavement. Can we really expect care home staff to have the expertise and time to address all these issues?

Occupational Therapy Theory and Philosophy

The heart of Occupational Therapy philosophy is that all people share an innate occupational nature which exists in the framework of environment and time. Time reveals itself as a vacuum, inviting us to fill it with 'doing'. Without occupation/activity time weighs heavily on us irrespective of our physical and psychological needs. Occupational Therapy enables people to engage in activities and occupations that provide meaning and satisfaction and that support their physical and emotional well-being (Kielhofner, 2007).

Occupation/Activity

What is occupation and why is it important? Occupation is defined as everything we 'do'. To be emotionally and physically well we need to actively participate in daily life. This is not an added bonus of good care but an essential requirement. When a person is left to sit for most of the day with little movement or stimulation a number of detrimental physical, psychological and social changes can occur.

The provision of meaningful occupation or activity appropriate to individual residents' interests and abilities is a complex process. Sadly, the level of inactivity within care homes remains high and engaging people with dementia a particular challenge. Occupational Therapy assessment and intervention can determine what constitutes 'good' activity provision within care homes for residents with dementia. It can identify a practical, evidence-based benchmark tool to evaluate current practice and promote excellence in care home activities. Quality of life in care homes means encouraging occupational outcomes that help to deliver dignity, respect and personalised care.

Integrated and person centred care is accepted to be the best way to meet their needs, yet 441,000 older people living in nursing and residential care homes in the UK do not have the same access to Occupational Therapy as those living in their own. College of OT (2014)

The Alzheimer's Society's "Home from Home" report identified:

“Availability of activity is a major determinant of quality of life and affects mortality rates, depression, physical function and behavioural symptoms”(2007,p5).
The National Institute for Health and Care Excellence (NICE) states:
”A lack of activity and limited access to essential healthcare services can have a detrimental impact on a person's mental wellbeing” (2013,p1).

However the Alzheimer’s Society’s “Home from Home” report found that the typical person in a care home spent only two minutes interacting with staff or other residents over a six hour period of observation, excluding time spent on care tasks. In addition, some residents with severe dementia had been left alone in their room for hours with no attempt from staff to engage with them (Alzheimer’s Society, 2007). A lack of physical activity puts people at greater risk of falls and other health complications, with social engagement influencing a person’s mortality to an even greater degree. The link between quality care that includes access to occupation and reduced demands on healthcare services is clear.
Commissioning for care homes should take into account this highly vulnerable group who go into care homes for extra support, but not to relinquish the activities they enjoy. There has been progress, the National Institute for Health and Care Excellence (NICE) Quality Standards on mental wellbeing of care home residents, calls for more spontaneous and planned opportunities for people to participate in meaningful activity. These Quality Standards state that:

- Older people in care homes are offered opportunities during their day to participate in meaningful activity that promotes their health and wellbeing (Quality statement 1);

and

- Older people in care homes are enabled to maintain and develop their personal identity. (Quality statement 2).

(NICE 2013)

Care homes will continue to be an important component of care provision for older people with dementia and for 20 per cent of over 85-year-olds; it is their permanent place of residence, their home. They are part of their local communities and should not be left in a vacuum when it comes to proactive care.

‘Care homes can provide an environment for someone to thrive and activity is key to people achieving good health and social care outcomes.’

Enabling Occupation

Occupational Therapists working within nursing home liaison services can offer support and training to staff to recognise how their beliefs impact on their practice and how approach and language can be enabling to a resident, or encourage dependency.

Understanding how to adapt an activity so that someone can participate when they may have cognitive impairment, sensory impairment, frailty, limited range of movement, ongoing pain or discomfort, are skills that we cannot expect from care home staff. and lies in the expertise of the Occupational Therapist.

If asked about their perceptions of a care home, many people will picture a communal room with residents sitting around the sides. The main activity in an older person's day is to go into the communal lounge and sit, leaving only to use the toilet, eat lunch or return to their room. Research by the Alzheimer's Society has shown that many care homes are still not providing person-centred care for older people. One of the major problems identified was that older people in care homes do not have access to enough activities or ways to occupy their time. The Occupational Therapy assessment and intervention in the use of occupation for meaningful activity and environmental factors such as how a communal room is laid out and availability of appropriate seating is vital

The Occupational Therapists role in assessing correct positioning when seated can increase a person's awareness of what is going on around them, help their communication and improve their reach and ability to do activities. This is designed to promote a conversation between management, staff, residents and their family so that they can improve and maintain quality of life in the care home.

When residents experience long periods of immobility, seating can become a health need. Poor positioning can cause skin to break down; pain and discomfort; joint stiffness; poor posture; fixed contractures; and increase the risk of falls. An older person's independence can be influenced by their seating and positioning over the full 24 hours of a day.

However, expanding training and advice by Occupational Therapists would enable residents and care staff to understand:

- the importance of seating and positioning
- how it can enable a resident's awareness of what is going on around them
- manage barriers to occupation
- adapt tasks; and
- increase ability to take part in activities

Assessment for seating and positioning by an Occupational Therapist may only be commissioned for residents in receipt of continuing healthcare funding or a personal budget.

The use of OT specific cognitive functional assessments e.g. Routine Task Inventory, can to determine residents level of cognition and occupational performance .Also, the Pool Activity Level (PAL) Instrument is very helpful in assessment and guiding carer support at the appropriate level for each

individual (Pool,2012).Occupational Therapy believes that occupation/activity is a measure of quality of care.

Putting It into Practice

There are many aspects of Occupational Therapy, the complexities of which are not always appreciated by the lay-person; therefore the care worker team may require training to appreciate the aims, objectives and risk assessment of activities that they deliver, and to help residents reach their full potential and well-being. Research shows that when staff are given such training from an OT it raised their understanding and interest in the importance of graded activities that are appropriate to each resident's ability and interests (Boyd et al, 2014).

Occupational Therapy promotes balance, motor, sensory, perceptual, cognitive, intrapersonal and interpersonal skills, spirituality, self-confidence, self-esteem, mood, and independence to name a few. Through engagement in graded activity, it helps to keep residents mobile and flexible, thereby promoting independence and control. For example, ball games keep arms flexible which helps a resident retain the ability to raise an arm to brush their own hair.

Residents who want to, should be included as much as possible in daily routines and failure free activities. . Meaningful activity is all about correct activity care-planning and finding the 'right fit' for individuals.

When You Get It Right...

The following examples will help to evidence the benefits of activities:

At a Dementia Nursing Home in Devon, a comment from the daughter of a resident demonstrates an Occupational Therapist's intervention and analysis of personalised activities that can make to a person's life*:*

"I think Occupational Therapy activities in a home can be very under-valued by management, other members of staff and visitors. Too many people have the attitude that those with dementia aren't worth bothering with or that 'where's the point they won't remember in a couple of minutes'. Some people don't seem to realise that when a person is made to feel 'Happy' even if they can't remember why they feel 'happy' the wonderful feel good factor can stay with that person for a long time. When you are just sat in a home and there is almost nothing going on around you, you switch off into a world that is a very sad and lonely place. Therefore being part of an activity is so important. My Dad has benefited from your visits because you bring LIFE into his life. You treat him as an individual who has needs, and who needs to know he matters. Your analysis of activities that have been important to him brings emotional and well being into his life and make him 'Happy'. They make him feel that he is ALIVE and that someone cares. Having the ability to participate in an activity that has been important throughout his life allows him to be part of a bigger picture giving him a sense of belonging. You found out what his likes and dislikes are and provide him with stimulation and graded activities to suit his needs. Besides football Dad loves music, singing and dancing. You found that out. Dad has lost the ability to have a conversation but you found that you can communicate with him and make him happy by singing with him. You always make him smile and give

us as family glimpses of my Dad as he used to be and that's irreplaceable. Thank you so much."

Occupation is at the heart of the Occupational Therapy profession. Presently, there are few Occupational Therapists employed in nursing home liaison teams but it is an emerging role for Occupational Therapists and it makes total sense that Occupational Therapists - specialists in activities, should be playing a larger part in training, guidance and leading the way to 'getting it right'. Every individual in every nursing home deserves to be given opportunities to engage in meaningful activities of their choice as a right not a privilege.

The report has explored some of the benefits, complexities and barriers to person-centred activity provision in nursing homes and promoting good practice.

Areas that may indicate a referral to the Liaison Mental Health Occupational Therapist for support:

- When a person is expressing **"signs of ill being", and/or "expressed needs"** which staff are having difficulties resolving. The OT can explore the possible reasons for the signs being displayed (explore the "unmet need/s" that the individual maybe expressing) and any possible non-pharmacological management of the behaviour. This is in line with the NICE/SCIE, 2007 guidelines which only recommends antipsychotics be used after other approaches have been tried and unless the person is at immediate risk of harming self or others, or severely distressed.
  Note, If urgent an available member of the team will see.
- For assessment of an individual's ability to carry out **activities of daily living (ADL),** e.g. washing, dressing, feeding, leisure activities, productive tasks, where advice is needed on the appropriate care support when a person has cognitive functional difficulties (e.g. difficulties with memory, concentration, orientation, motivation, problems solving and safety awareness).
- Specialist seating and positioning assessments
- When staff need support to implement from theory to practice the principles from the Dementia Awareness Training to promote person centred care.
- When staff need advice on therapeutic home environments to support an individual's wellbeing and ability to manage daily activities.
- When Activities Coordinators need advice and support in their role, including networking.
- Family/carer advice, support and education, and sign posting.

Example:

The resident referred to the Mental Health Occupational Therapist in the nursing home liaison team. The referral noted that the resident was “verbally aggressive and agitated”. More information was taken from care home staff and family regarding the residents behaviour/ communication to staff/ expressed need e.g. when, where occurs, how it occurs, frequency that it occurs. The resident’s cognitive functional level was determined by a combination of carer report, skilled observation and standardised assessment tools. Personal history including past job, family, personality, likes/dislikes and interests, habits and routines was obtained. Possible physical reasons such as undetected pain, mood and side effects of medications were also considered and addressed.

The resident previously worked as a carpenter and was also in the army. The person was assessed to be functioning within Allen’s cognitive Level 3. From this understanding of their cognitive functioning level it was determined that the individual can carry out one step repetitive tasks with close supervision or verbal prompting. Verbal aggression and agitated highlighted by staff maybe due to inappropriate stimulation, for example daily activities not being matched to the individuals remaining abilities and personal preferences. The OT may advise on adapting tasks and activities to enable an individual to utilise their remaining skills and strengths. The advice given may include one step activities such as sanding wooden items; polishing shoes and/or listening to a favourite piece of music for a short period; utilising shorter instructions; giving extra time to complete activities; where appropriate placing items for activities in the resident’s hand i.e. hand cloth; starting the action with items to support participation; prompting the resident to change the area that they are attending to. Change of environment may also be helpful i.e. quieter lounge, out door walk.

JanetBevan/PrincipalOT/CwmtafUHB/OPMH/June15

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Clinical Interventions in Aging

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ORIGINAL RESEARCH

Prescribing of psychotropic medication for nursing home residents with dementia: a general practitioner survey

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Objective: The aim of this study was to identify factors influencing the prescribing of psychotropic medication by general practitioners (GPs) to nursing home residents with dementia.

Subjects and methods: GPs with experience in nursing homes were recruited through professional body newsletter advertising, while 1,000 randomly selected GPs from south-eastern Australia were invited to participate, along with a targeted group of GPs in Tasmania. An anonymous survey was used to collect GPs' opinions.

Results: A lack of nursing staff and resources was cited as the major barrier to GPs recommending non-pharmacological techniques for behavioral and psychological symptoms of dementia (BPSD; cited by 55%; 78/141), and increasing staff levels at the nursing home ranked as the most important factor to reduce the usage of psychotropic agents (cited by 60%; 76/126).

Conclusion: According to GPs, strategies to reduce the reliance on psychotropic medication by nursing home residents should be directed toward improved staffing and resources at the facilities.

Keywords: dementia, nursing homes, general practitioners, antipsychotic agents, benzodiazepines

Impact statement

The findings of this research suggest that, according to general practitioners (GPs), reforming the prescribing of psychotropic medication in nursing home residents with behavioral and psychological symptoms of dementia is best achieved by increasing the availability of non-pharmacological, diversional and other behavior modification resources.

Introduction

Behavioral and psychological symptoms of dementia (BPSD) occur in up to 90% of patients with dementia over the course of their illness, lead to distress to patients and caregivers, and increase health care costs associated with hospitalizations.[1]

Guidelines routinely suggest non-pharmacological interventions as the first-line therapy for BPSD, with certain psychotropic agents, such as antipsychotic medication, being second line due to the limited benefit and risk of serious adverse effects.[2] The use of antipsychotics in these patients has been associated with an increased risk of mortality, hip fractures, thrombotic and cardiovascular events, and hospitalizations.[3] Psychosocial approaches are preferred, tailoring them to the needs of the patient and creating a physical environment to reduce distress.[4]

There are concerns that there is a significant gap between guideline recommendations and practice in nursing home facilities when managing BPSD in Australia.[5,6]

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Internationally, similar concerns have also been echoed recently.[7] The factors involved in prescribing and withdrawing psychotropic agents by general practitioners (GPs) in the nursing home setting include GPs having a very low willingness to discontinue antipsychotics for fear of worsening symptoms[8] and an overexpectation of benefit from antipsychotic therapy in BPSD.[9] One study found that GPs were critical of their knowledge and management in this area and suggested that efforts should focus on educational interventions for GPs.[10] In Australia, however, there are no published papers on the barriers to the evidence-based prescribing of psychotropic medication for people with BPSD in nursing homes.

We aimed to identify the factors influencing the prescribing of psychotropic medication to residents of Australian nursing homes with BPSD, and therefore determine strategies to promote more appropriate use of these medications.

Subjects and methods

Participant recruitment

Three iterative strategies were required to recruit enough Australian GPs to ensure an adequate sample size. Initially, GPs with experience in patient care in nursing homes were recruited through professional body advertising in newsletters in the state of Tasmania. This strategy had limited success. Next, 1,000 GPs mostly from southeastern Australia were randomly selected from an Australian Health Directory and mailed, with a follow up email sent to the surgeries with listed email addresses. Finally, a targeted group of 273 GPs in Tasmania who were known to have patients in nursing homes, based on their previous involvement in clinical activities, was invited by mail to complete the survey. While the GPs in this study were from only two states in Australia, their demographics were similar to the wider GP population in Australia.[11] This study received ethical approval from the Tasmanian Social Sciences Human Research Ethics Committee (ethics reference number H0014615). Consent was assumed through completing the survey.

Questionnaire development

The anonymous 26-question survey was self-completed through either a paper-based version or an online version using Lime Survey.[12] Participants were invited to enter a prize draw for an electronic device as an incentive.

This original questionnaire was developed from the clinical experience of the researchers and the results of international research.[8–10,13,14] The questionnaire was piloted in a small group of GPs and pharmacists and refined based on their feedback.

Analysis

The outcomes of interest included GP perception of the factors that are most important to reduce psychotropic prescribing and barriers to using non-pharmacological techniques for BPSD, based on those found in the literature. The self-reported prescribing habits in BPSD and expectation of benefit were also of interest, with a Likert scale used to determine how effective the GPs believed the medication to be in practice. The survey relied on the GPs' definition of settled and stabilized patients.

Data were analyzed using SPSS version 22 (IBM Corporation, Armonk, NY, USA).[15] Chi-square tests were used, with a P-value of <0.05 considered significant. Responses to a 5-point Likert-type scale were collapsed into two categories. The first category included "rarely to some patients," while the second category included "50% to most or all patients," as given in Table 1. Reponses to ranking questions were presented with the top two ranked questions, as shown in Figures 1 and 2.

Results

Demographics

In total, 177 responses were returned. The majority (89%; 158/177) of the respondents were from Victoria and Tasmania, with most (61%; 109/177) having been registered as a medical practitioner for 20–40 years (Table 2). The uptake of the survey was probably limited by needing access to GPs with the appropriate patients. Response rates were difficult

Table 1 Prescribing habits

Variable	50% to most or all patients	Rarely to some patients
Thinking about your patients, what do you believe is the extent of positive benefit (such as a reduction in behaviors) for the following agents in BPSD?		
Second-generation antipsychotics	63% (112/177)	36% (63/177)
First-generation antipsychotics	25% (44/177)	70% (125/177)
Benzodiazepines	23% (41/177)	76% (134/177)
Antidepressants	35% (62/177)	65% (113/177)
In the following situations, would you prescribe an antipsychotic in dementia?		
Physical aggression	63% (111/177)	37% (64/177)
Verbal aggression	32% (56/177)	66% (116/177)
Agitation and unsettled	43% (76/177)	56% (100/177)
Calling out	14% (24/177)	85% (150/177)
Wandering	10% (17/177)	89% (157/177)
In your experience, to what extent do adverse effects from the following agents limit their prescribing in BPSD?		
Second-generation antipsychotics	32% (56/177)	68% (121/177)
First-generation antipsychotics	65% (112/177)	35% (59/177)
Benzodiazepines	54% (96/177)	45% (79/177)
Antidepressants	23% (40/177)	77% (136/177)

Abbreviation: BPSD, behavioral and psychological symptoms of dementia.

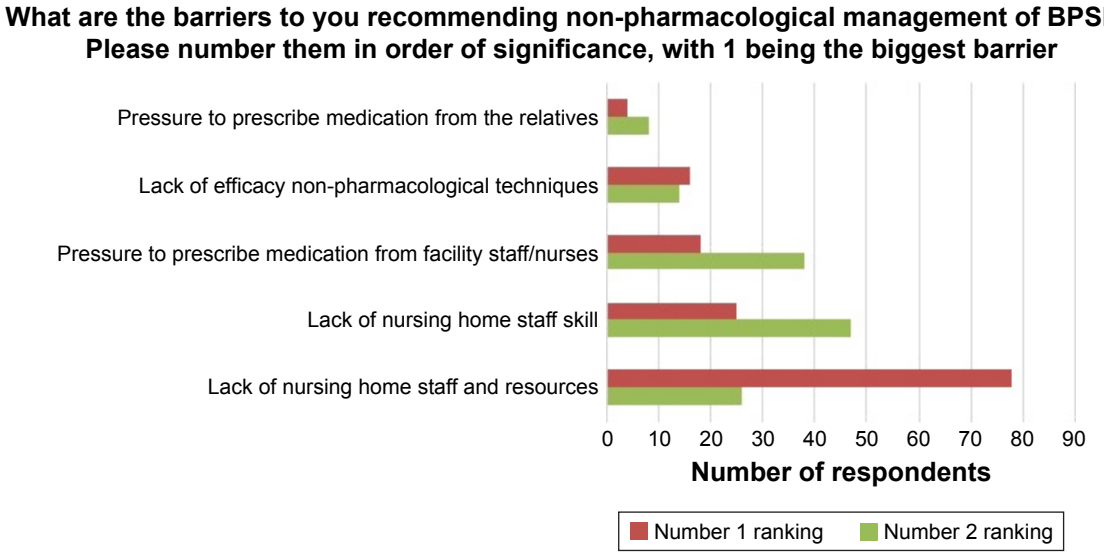

Figure 1 Barriers to non-pharmacological management of BPSD.
Abbreviation: BPSD, behavioral and psychological symptoms of dementia.

to calculate, with an unknown number of GPs ineligible to complete the survey because they did not have nursing home patients under their care at the time of the study. Of the 1,000 randomly selected GPs, it is expected that approximately half would have been eligible to complete the survey, based on a 2015/16 survey indicating 49% of GPs have provided care in a residential aged care facility in the previous month.[16] This suggests that a response rate of ~21% was

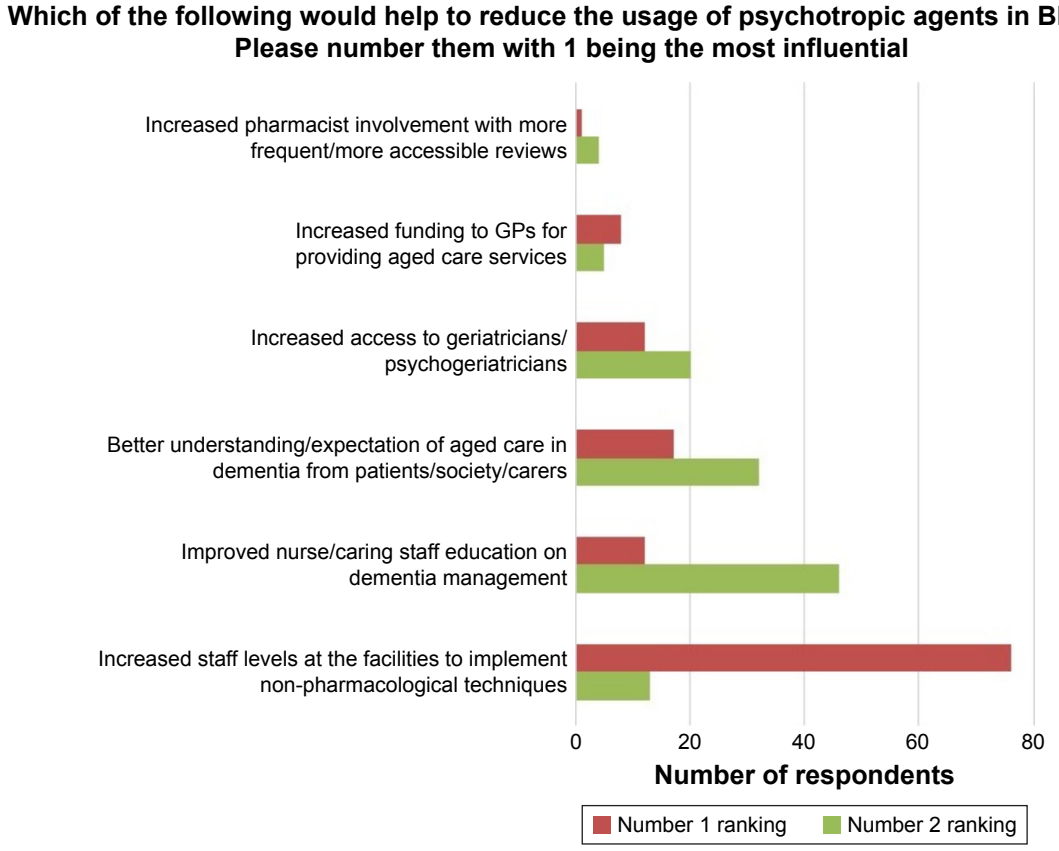

Figure 2 What would help reduce the usage of psychotropic agents in BPSD?
Abbreviations: BPSD, behavioral and psychological symptoms of dementia; GPs, general practitioners.

Table 2 Demographics

Variable	Percentage/number
Total number of responses	177
Female	43% (76/175)
Male	57% (99/175)
Length of time registered as a medical practitioner	
For <5 years	10% (17/177)
For 6–10 years	6% (10/177)
For 11–20 years	15% (27/177)
For 20–40 years	62% (109/177)
For ≥40 years	8% (14/177)

achieved (105/490). For the 273 Tasmanian GPs known to have residents in nursing homes, the response rate was 23% (64/273).

Barriers to non-pharmacological interventions and psychotropic medication reduction

"Aged care facility staffing and resources" was clearly highlighted as the number 1 barrier to non-pharmacological methods being utilized in BPSD. Likewise, directing funding to adequately staff facilities was the preference to reduce psychotropic usage in aged care (Figures 1 and 2).

Prescribing habits

Responses to selected questions concerning prescribing habits are given in Table 1. The vast majority expressed a desire to reduce psychotropic medication in completely settled or stabilized patients. When asked what they would do if a patient had been taking an antipsychotic for 6 months with no ongoing difficulties, 76% (135/177) indicated they would reduce the dosage of an antipsychotic with a view to cessation if possible. Similarly, when asked about benzodiazepine prescribing for BPSD in settled patients, 90% (159/176) indicated they would be likely to reduce or cease the benzodiazepine.

Management of BPSD

When asked if they routinely recommend non-pharmacological interventions before considering medication in BPSD, 81% (144/177) agreed or strongly agreed. About half (47%; 84/177) agreed that they feel they require more training to improve how they manage BPSD, with 24% (42/177) disagreeing.

The majority of respondents, 71% (126/177), indicated that they review their aged care residents' medication three-monthly or more often, with 19% (34/177) reviewing the medication six-monthly, and the remainder annually or less.

Influences on prescribing for BPSD in nursing homes

Most GPs indicated that nurses (91%; 160/177) and family of residents (59%; 105/177) influence their prescribing. Interestingly, only one-third (33%; 58/177) indicated that nurses have requested psychotropic dose reductions and about the same from family (36%; 64/177). The majority of GPs (81%; 143/177) reported having had to decline a request from family or staff to prescribe an antipsychotic, with 39% (69/177) having to regularly refuse. Experienced GPs (20–40 years of experience) were significantly less likely (5%; 9/109) to rate pressure to prescribe from aged care facility staff as a barrier to non-pharmacological techniques than GP practising <5 years (29%; 5/17). Pharmacists were cited as the most likely health profession to request dose reductions (51%; 91/177); however, they were stated to only influence the actual prescribing by 28% (50/177). Over half of GPs (56%; 100/177) were confident that pharmacist-conducted residential medication management reviews (RMMRs) are beneficial in BPSD management, with a further 25% (44/177) who were unsure.

Concern for a reduced quality of life when withdrawing psychotropic agents received a mixed response, with 42% (75/177) agreeing they were concerned that withdrawing medication would impact negatively on the quality of life, leading to a return of challenging behaviors and disturbing psychological symptoms. About the same number (41%; 73/177) disagreed with this statement.

Confidence to reduce dosing after a failed first attempt was quite variable, with 35% (62/177) stating they did not feel confident to trial a second dose reduction, 23% (41/177) were undecided, and 42% (74/177) feeling confident to trial a second reduction attempt.

Discussion

Our findings imply that reforming the prescribing of antipsychotic medication in nursing homes is best targeted toward staffing levels and increasing the availability of diversional and other behavior modification resources. Similarly, a study from the Netherlands found staffing issues as a factor related to psychotropic drug prescribing.[17]

In this study, increasing funding to GPs was not shown as priority to reduce psychotropic prescribing in nursing homes. This contrasts with other studies into servicing nursing homes in Australia[18] and the USA[13] which found that levels of reimbursement and time were important barriers to GPs providing a range of services in this setting. It is possible that in our study GPs perceived that increased funding to

them would not improve access to behavioral and support therapies in dementia care as they are not fund holders for these services.

GPs in our study, and similarly in a Dutch study,[9] overestimated the benefit in symptom relief of second-generation antipsychotics compared with symptom outcomes in field studies[19] and therapeutic guidelines,[2] with 63% of GPs expecting benefit in half of all patients. The number needed to treat for second-generation antipsychotics in dementia is expected to be 5–14.[19] This overexpectation of benefit, as given in Table 1, could be contributing to overusage. Better dissemination of practice guidelines cautioning about the limited benefit of antipsychotic medication in BPSD may prompt practitioners to more rationally prescribe these medications.

The preference for more training was expressed by around half of the respondents in our study. An educational solution to this problem is also supported by research from Ireland which found that efforts should focus on supporting GPs by means of educational interventions and health services promoting collaboration.[10]

Our research found a strong willingness, in principle, to reduce psychotropic medication in BPSD with, for example, two-thirds of GPs being confident to try a second reduction attempt after a failed attempt. Concern about a negative impact on the quality of life after drug withdrawal was evenly split among respondents. This contrasts to a study from Belgium, which found GPs resistant to reduce antipsychotic medication, including after a failed attempt, and their concern for a negative effect on the quality of life are a large barrier to discontinuation of antipsychotics.[8]

Our results suggest that nursing staff have the largest influence on prescribing psychotropic medication in this setting, indicating the importance of nursing home staffing and resources for non-pharmacological interventions. This is consistent with suggestions that any reforms to improve the treatment of mental illness and BPSD in nursing homes will need to begin with considering the physical design, staffing, and skills of staff within nursing homes.[20] A Senate inquiry into the care of Australians living with dementia and BPSD in 2014 heard that staffing levels and training are inadequate, with no legislated staffing ratios in nursing homes.[21] Stakeholders reported that restraints are being used too readily to cover staff and resourcing limitations. In the inquiry, the Australian Medical Association (AMA) indicated that, with under-resourced aged care facilities and limited qualified nursing staff and sufficient numbers of carers, the need for restraint is an unfortunate reality.

Research internationally is mixed in relation to staff numbers and qualifications, and the quality of nursing homes in general. A systematic review found that focusing on the numbers of nurses fails to address the influence of other staffing factors, including training and care organization, with quality being a difficult concept to capture.[22] It goes on to state that further research is needed to determine the most cost-effective manner to utilize the combination of nursing skill levels. Another study found that there was no association with caregiver professional training and the care given, with a complex relationship between staffing and the quality of care provided.[23] While our study demonstrates the perceived need for increased staffing and resources at the facility, further research is required to determine the best models for the delivery of cost-effective and efficient non-pharmacological interventions in BPSD. This dementia care redesign in nursing homes could be informed by Effective Practice and Organization of Care (EPOC) methodology.[24] Repeating a similar survey in nursing staff to assess their experiences would also be worthwhile to help determine whether these perceptions are shared across professions.

Limitations of this study include the relatively small sample size and the apparent low response rate. A further limitation is relying on the GPs' recall of what they would prescribe or withdraw in certain situations. This limitation is likely to bias the responses toward the perceived best practice; however, it will provide an idea of what the GPs would like to do if there were no barriers to this practice. Although the questionnaire was not validated, it was sampled in a small number of GPs before use and refined based on their feedback. In addition, the types and severity of dementia did not form part of the survey.

Conclusion

GPs described inadequate nursing staff levels and resources as the main factors that limit the use of non-pharmacological interventions and their ability to reduce the usage of psychotropic agents in nursing homes.

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Disclosure

The authors report no conflicts of interest in this work.

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ORIGINAL RESEARCH

A scoping review of crisis teams managing dementia in older people

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Background: Research on crisis teams for older adults with dementia is limited. This scoping review aimed to 1) conduct a systematic literature review reporting on the effectiveness of crisis interventions for older people with dementia and 2) conduct a scoping survey with dementia crisis teams mapping services across England to understand operational procedures and identify what is currently occurring in practice.

Methods: For the systematic literature review, included studies were graded using the Critical Appraisal Skills Programme checklist. For the scoping survey, Trusts across England were contacted and relevant services were identified that work with people with dementia experiencing a mental health crisis.

Results: The systematic literature review demonstrated limited evidence in support of crisis teams reducing the rate of hospital admissions, and despite the increase in number of studies, methodological limitations remain. For the scoping review, only half (51.8%) of the teams had a care pathway to manage crises and the primary need for referral was behavioral or psychological factors.

Conclusion: Evidence in the literature for the effectiveness of crisis teams for older adults with dementia remains limited. Being mainly cohort designs can make it difficult to evaluate the effectiveness of the intervention. In practice, it appears that the pathway for care managing crisis for people with dementia varies widely across services in England. There was a wide range of names given to the provision of teams managing crisis for people with dementia, which may reflect the differences in the setup and procedures of the service. To provide evidence on crisis intervention teams, a comprehensive protocol is required to deliver a standardized care pathway and measurable intervention as part of a large-scale evaluation of effectiveness.

Keywords: dementia, home treatment, crisis resolution, crisis, mental health, community mental health services

Introduction

The Dementia UK report[1] identified people with dementia as significant users of health and social care services. People with dementia occupy a third of beds in acute medical wards, and reducing the stay of people with dementia in hospital by 1 week could generate savings of approximately £80 million a year.[2] Yet dementia care is frequently being delivered in an ad hoc and inefficient manner, and consequently older people in the community can experience a "conveyor belt" of care, resulting in residential care, particularly after a crisis incident and subsequent hospital admission.[3] A crisis can be defined as "a process where there is a stressor(s) that causes an imbalance requiring an immediate decision which leads to a desired outcome, and therefore crisis resolution. If the crisis is not resolved, the cycle continues (pg.2)".[4] A key failing of service provision is the lack of information and support for people with dementia and

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their carers requiring immediate help.[5] The Prime Minister's Challenge on Dementia 2020 recognizes the importance of support provided post-diagnosis.[6] Support for family carers and the provision of rapid, simple interventions or professional support for long-term care home placement can avoid crisis hospital admissions.[7]

Mental health services available for younger people intend to provide coping strategies, attempt to address social and family factors that can lead to a crisis, and encouragement to draw on pre-existing support networks to manage their condition and avoid hospital admissions.[8] Similar services for older people with dementia are not provisioned as equitably,[9] and there is a lack of formal evaluation of the provision of these services.[10] Through joined up preventative and coordinated health care, services can be tailored to enable people with dementia to stay in their own homes, avoiding hospital admissions and crisis situations.[11] Previous survey research exploring the provision of Crisis Resolution Teams (CRTs) across 79 Trusts in England found that while 99% of responding Trusts provided acute mental health services, less than a third of Trusts offered the same CRT across age groups through a specialist team, adult CRT, or intermediate care team.[10] People with dementia were only able to access crisis services in a tenth of areas, with just one in six teams frequently providing services to older people. An exploration of the attitudes of staff working with older people experiencing mental health issues[12] highlighted the following: a lack of staff training in dementia, crisis work taking longer to manage, and pressure on resources. However, McNab et al investigated on older people's home treatment teams (HTTs) that provided support to carers and signposted the person with dementia to local services and reported high patient satisfaction and a reduction in bed occupancy.[13] There is, however, a systematic review of crisis teams that identified only low-level quality evidence for the effectiveness of such teams in reducing admissions to hospital,[14] suggesting a gap in the current literature. Potentially, a separate service for older adults is necessary as there is an increased likelihood that ill health impacting mental health requires specialized care.

Overall, the evidence surrounding older people's services that work with people who have dementia and are experiencing a crisis is dated, and it is unclear if anything has changed. This literature review intends to identify studies specifically targeting older people with dementia who experience a crisis to provide an update and highlight where future research is required. The online survey allows for an update of current knowledge on services that are working with people with dementia in crises.

Aims

- To conduct a systematic review to investigate the impact of crisis teams on outcomes, such as reducing hospital admissions for people with dementia, in comparison with usual care.
- Use an online scoping survey of teams managing crisis in people with dementia in England to broaden our understanding of what is currently working in practice.

Methods

Systematic review

A previous systematic review on the effectiveness of older adult crisis teams was carried out for the Home Treatment Programme study as part of the Support at Home Interventions to Enhance Life in Dementia project (RP-PG-0606-1083) led by Professor Orrell. The grant for the Achieving Quality and Effectiveness in Dementia Using Crisis Teams (AQUEDUCT) study was awarded to Professor Orrell and is developed from the Home Treatment Programme study. So, the updated systematic review is built on the original work carried out,[14] whereas the scoping survey aims to fill the gap in the existing literature by demonstrating the current use of older adult crisis teams in England.

Types of articles included in the review

All methodological designs were eligible for inclusion in this review, such as controlled comparison studies, including randomized controlled trials (RCTs), controlled before and after studies, interrupted time series, observational studies, theoretical papers, and government frameworks and policies. Studies were included if a crisis experienced by a person with dementia met the criteria of "an urgent need for an assessment and intervention for a person living in the community".[15]

Types of comparison groups

Experimental intervention: Older people with dementia in receipt of any mental health crisis resolution/home treatment intervention.

Control: Control groups included "treatment as usual," standard community treatment, waiting list controls, and matched controls.

Types of outcome measures

Primary outcomes included the number of hospital admissions, length of hospital stay, maintenance of community residence, and patient quality of life. Secondary outcome measures included the patient's cognition, activities of daily living, mortality rates, use of medication, level of patient

and/or carer satisfaction, level of service use, and health and social care costs.

Types of participants

Participant inclusion criteria for the studies were participants aged 65 years or older, with a diagnosis of dementia, and living in the community.

Search methods for identification of studies

Electronic searches of databases searched on July 27, 2015 included MEDLINE, EMBASE, PsycINFO, CINAHL, and LILACS, and gray literature sources were also included. A previous systematic search identified studies dating back to 1965–2008, and consequently this search period ranged from January 2008 to July 27, 2015.[14] The search terms used for database searches included old*, elder*, aged, patient care management, patient care team, case management, intensive case management, care management, managed care programs, community mental health team, specialist mental health service, community mental health, community mental health services, community mental health centers, community care, long-term care, community based long-term care, dementia care, intermediate care, crisis resolution, crisis intervention, home treatment, home care, home nursing, home care services, care coordination, care pathway, managed care, outreach, assertive outreach, disease management, carer support, family intervention, admiral nursing, assessment and service arrangement, health services for the aged, geriatric health service, and family-based therapy. The search terms were identified in a previous systematic review,[14] and the review was updated. A large number of search terms were used to be as inclusive as possible of potentially relevant work being undertaken in practice.

Data collection and analysis

In accordance with the defined inclusion criteria, titles, and abstracts of citations obtained from the search were examined by a researcher (AS) and irrelevant articles discarded. For the citations considered potentially relevant the full text was obtained and further information was sought from study authors if required. Two independent reviewers (AS, JY) assessed the methodological quality of papers using the Critical Appraisal Skills Programme Centre (CASP) checklists for cohort and case–control studies.[16] All studies were assigned a level of evidence of low, acceptable, or high according to the criteria included in the checklists. Where there was difference of opinion, the two reviewers discussed the study using the checklist until an agreement was reached.

Online scoping survey

Service identification procedure

The online survey was developed drawing on the Memory Clinics Audit 2014 template. The NHS England website was used to identify all appropriate NHS Trusts, and these were entered onto a Microsoft Excel spreadsheet. Internet searches were carried out to determine if each Trust had a specific dementia crisis service, and where contact details were available, a follow-up telephone call to the service was made to confirm the manager's contact details. There were, however, many Trusts where the existence of specific dementia crisis services was unclear. In these instances, each Trust website was accessed to identify contact details for the Community Mental Health Team (CMHT) and/or memory clinic. When contact was made, it was explained that contact details were being sought for a crisis service working with people with dementia, with the intention of disseminating a survey to all managers of these services across England. When the older adult or adult service was contacted, the researcher clarified that the demographic of patients included people with dementia. The name of the service lead or manager and email address were collected for each service within every Mental Health Trust in England. Wherever possible, the contact person within the service was also asked to identify other services within their Trust that worked in a similar capacity, and any other contacts were followed up. The AQUEDUCT (RP-PG-0612-20004) programme manager used her direct work email to contact each service manager to encourage completion and to provide a point of reference for the survey.

Survey design

Information was provided prior to entering the survey, including an introduction to the AQUEDUCT study, the purpose of the survey, definition of a crisis, and how the results would inform the research study. The survey included 29 questions and was conducted using SurveyMonkey software; it was designed to be completed by the manager of the service. Screening questions included the type of service that the manager was responsible for and whether they provided specialist interventions for people with dementia and their carers in the community. If the respondent stated that crisis was not within the scope of their service, they were automatically exited from the survey.

The online scoping survey collected responses on what type of service the respondent was responsible for, whether it was a specialist service for older people in crisis, employer type, job role, work grade, and years in practice. In terms of organizational details, questions related to days and hours of operation, composition of team, service eligibility criteria, referral process, primary diagnosis and primary needs of those entering the service, and time spent in profession specific versus generic working. In relation to referrals, this included the average number of referrals per week, average number of service users on a person's caseload, whether the service follows a care pathway, interventions and assessments used, and the challenges and benefits to delivering home treatment. The respondents were also asked if their service participated in research and whether they would like to be contacted in the future.

Ethics

Ethical approval was not required for the scoping survey as the work carried out was not considered to be a research study. All questions required for the survey were sent to Research and Innovation, Nottinghamshire Healthcare NHS Foundation Trust to determine the suitability of questions asked. The scoping survey was approved by the sponsor Trust, with staff member informed consent deemed unnecessary as individuals were not directly interviewed and identifiable information was not collected, unless the person completing the survey volunteered his/her contact details after having completed the survey.

Results

Systematic review

Included studies

A total of 5,344 references were identified in the initial search of the databases; after duplicates were removed (n=1,759), 3,509 were excluded by screening of title and abstract only. A further 71 papers were excluded on the basis that either 1) they did not include people with dementia or 2) they did not include working with people with dementia experiencing crisis. Three papers from this search and a further four studies identified in a previous search were included in this review (Figure 1).[14] These comprised six cohort studies,[17–22] and a non-randomized concurrent control treatment outcome trial.[23] Table 1 summarizes the key points of each study.

Quality assessment

An overall CASP assessment of each study considered whether the evidence was high quality (++), acceptable (+), or low (0) and is reported in Table 2. One study provides high methodological quality,[18] four studies provide acceptable methodological quality,[17,20,22,23] and two studies were considered to have low methodological quality.[19,21]

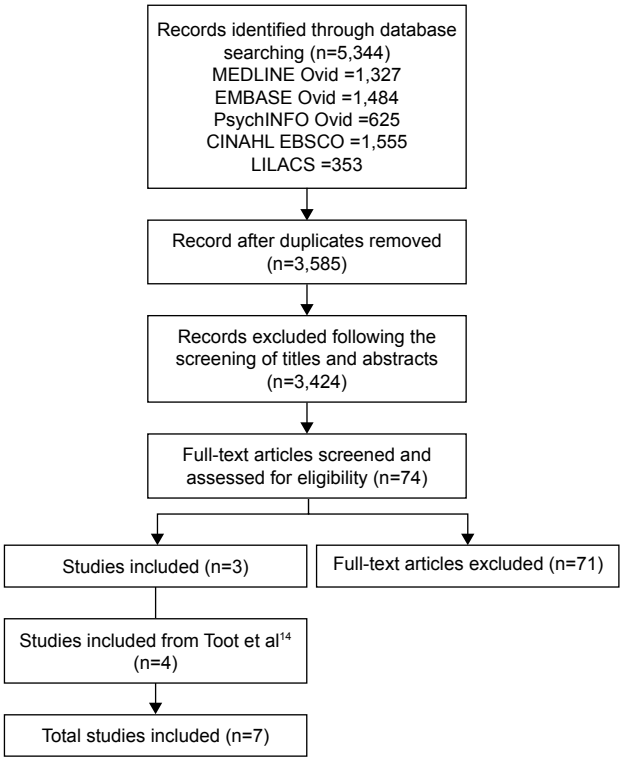

Figure 1 Consort diagram of included studies.

Studies comparing hospital admissions for people with dementia with or without access to a crisis service

Villars et al[22] reviewed a geriatric team in Toulouse providing an individualized care plan for people experiencing behavioral and psychological symptoms of dementia (BPSD) based on observations during the person's hospital stay, through telephone support. The main outcome included early emergency room rehospitalization. The results suggested a reduced length of stay over 2 years but this difference was not significant (p=0.56) for those in receipt of telephone support compared to the previous year.

Johnson et al[23] engaged a specialist multidisciplinary team to provide support to people with dementia experiencing psychiatric complications with the intention of reducing psychiatric hospitalization in Kansas. The results were compared to a control group of participants previously hospitalized in an inpatient psychiatric hospital. For those in receipt of the intervention, there was a decrease in mortality rates and significant decrease in rehospitalization with people remaining in their homes for longer and significant improvements in caregiver outcomes ($p \leq 0.001$) and

Table 1 Included studies and study features

Study reference and type of study	Description of intervention and participants (n)	Description of control group	No of follow-ups and follow-up points	Results control group	Results intervention group	Summary of results
Ratna[17] cohort study	Community orientated old age psychiatry service; providing intensive 24-hour crisis support in the community. Intervention group n=142 Sainsbury et al;[24] Chichester comparison group n=216 Sainsbury et al:[24] Salisbury comparison group n=121	Two retrospective cohorts from the Sainsbury et al[24] study where there was no crisis services	Referral (intervention group n=142; Combined comparison groups n=337) Follow-up 1; 24 months (intervention group n=142; combined comparison groups n=119	Total number of admissions, n, % Combined comparison groups at referral n=132, 39% Combined comparison groups at follow-up n=71, 60% Average length of hospital stay (mean stay in days) Combined comparison groups at follow-up n=101 Maintenance of community residence, n, % Combined comparison groups at follow-up n=42, 35% Mortality rates (%) Combined comparison groups at follow-up 44%	Total number of admissions, n, % At referral n=41, 29%. At follow-up n=48, 34% Average length of hospital stay (mean stay in days) At follow-up n=22 Maintenance of community residence, n, % At follow-up n=69, 49% Mortality rates (%) At follow-up =29%	Reduction in numbers of hospital admissions (at referral follow-up) Reduction in length of hospital stay at follow-up Increase in proportion of people remaining in community at follow-up Improvement in mortality rates at follow-up
Doyle and Varian[18] cohort study	Crisis intervention service operating through Community Mental Health Team (CMHT) Intervention group n=70	The 24-hour community orientated old age psychiatry service as described in Ratna[17]	Referral Follow-up 1; 36 months	Refer to Ratna[17]	Total number of admissions, n, %: At referral n=22, 31% Maintenance of community residence, n, % At follow-up n=22, 31% Mortality rates (%) At follow-up =30%	No difference at referral compared to Ratna[17] Lower proportion of people remaining in community at follow-up compared to Ratna[17] No difference in mortality rates at follow-up compared to Ratna[17]
Richman et al[19] prospective descriptive study	Outreach support team based within a day hospital, providing support in crisis waiting list for an inpatient bed (n=40)	No comparison group	Referral 3 months	Assumption of 100% admission rates for crises	Total number of admissions, n, % Referral n=10, 25% Follow-up n=10, 25%	Reduction in number of hospital admissions
Dibben et al[20] cohort study	Crisis resolution home treatment team (CRHTT) Pre CRHTT (n=65) Post CRHTT (n=102)	6 months pre CRHTT data were collected	Data were collected 6 months pre CRHTT and 6 months post CRHTT	Total number of admission: n=65, 100% Average length of hospital stay; mean (SD) days: 49 (45.62)	Total number of admissions: n=70, 69% Average length of hospital stay: mean (SD) days: 53 (46.40)	Reduction in number of hospital admissions (statistically significant) No difference in length of hospital stay
Ginsburg and Eng[21] cohort study	Mental and Behavioral Health (MBH) team pre, during, and post set up of team	Previous year to set up of MBH	Yearly follow-up for 4 years (2004, 2005, 2006, 2007)	2004, patients served =1,082 Admissions =11 Psychiatric bed days =140	2005, patients served =1,107 Admissions =2 Psychiatric bed days =30 2006, patients served =1,214 Admissions =3 Psychiatric bed days =50	Significant reduction in psychiatric inpatient days from 129.4 days per 1,000 patients per year in 2003 to 23.6 days per 1,000 patients per year in 2007. Significant increase in percentage of enrollees receiving routine mental

(*Continued*)

Table 1 (*Continued*)

Study reference and type of study	Description of intervention and participants (n)	Description of control group	No of follow-ups and follow-up points	Results control group	Results intervention group	Summary of results
					2007, patients served =1,227 Admissions =3 Psychiatric bed days =29	health services growing from 10.1% of enrollment in 2004 to 24.4% in 2007
Villars et al[22] cohort study	Individualized care plan targeting the problems observed during the hospital stay	Previous year early ER admissions	Early ER rehospitalization 1 month after discharge	Total number of early ER admissions 2007=8.39%	Total number of early ER admissions 2008–8.02% 2009=7.47%	No statistical significant decrease in ER rehospitalization rate at 1 month after discharge. Vocal disruptive behavior is significantly more prevalent in the readmitted population
Johnson et al[23] non-randomized concurrent control treatment outcome trial	Kansas Dementia Crisis Bridge Project Intervention group n=77 Control group =52	Psychiatric hospital with catchment area of rural and suburban residents	Data collected before and during crisis period	5.8% reported psychiatric rehospitalization following hospital discharge	1.2% rehospitalization	Following intervention the Neuropsychiatric Inventory Questionnaire showed a reduction in symptoms $p<0.001$. Delayed nursing home placement due to the BRIDGE intervention

caregiver-reported neuropsychiatric symptoms in people with dementia ($p \leq 0.01$).

Ginsburg and Eng[21] reviewed a new Mental and Behavioural Health Team for older people with dementia or mental illness in the community compared to the previous year when there was no team in San Francisco. The primary outcomes include number of patients seen, psychiatric admissions, and bed days. The study demonstrated a reduction in psychiatric inpatient days compared to previous years.

Dibben et al[20] examined the effectiveness of a Crisis Resolution HTT service including working with older adults with a functional or organic diagnosis in West Suffolk. The service was extended to include older people due to the closure of a dementia ward and 2-day hospitals. The study found a significant reduction in hospital admissions post-setup of the crisis resolution HTT ($p \leq 0.001$), but there were no significant changes in the other outcomes of bed days and level of satisfaction of service user.

Richman et al[19] conducted a naturalistic evaluation of a community outreach support team for older adults with mental illness in crisis in Cheshire and Wirral Partnership NHS Trust. The team was introduced in response to the closure of 20 beds in the geriatric ward, aiming to reduce hospital admissions and bed occupancy, encourage early discharge, and support patients at home. Thirty participants were supported in the community and 10 participants were admitted to hospital over the timeframe of the study, suggesting that this type of service might be beneficial in reducing the number of hospital admissions.

Doyle and Varian[18] compared a 24-hour crisis service offered in Folkstone, Kent with a 9:00 to 17:00 crisis intervention team (data from Ratna[17]) for older people with mental health problems, including dementia. The main outcomes included number of psychiatric hospital admissions, maintenance of community residence, and mortality rates. There was a greater referral rate in the 24-hour service ($p \leq 0.01$), a lower proportion of people remaining in the community in the 24-hour service at follow-up compared to the control group ($p \leq 0.001$), and no difference in mortality rates.

Ratna[17] provided a community-based psychogeriatric service in North London for older people with mental illness, including dementia. The main outcomes included number of psychiatric admissions, length of hospital stay, maintenance of community residence, and mortality rates. A previously conducted study provided their control group data.[24] Ratna[17] demonstrated a reduction in number of hospital admissions and bed days, an increase in proportion of community residence, and decreased mortality rates.

Online scoping survey

Demographics

Two hundred and thirty-four individual services potentially managing crises in people with dementia were identified across England, 200 of which had available contact details for managers or service leads who ran the service or ran a number of services. Sixty-two managers, representing 23 English counties, began the online questionnaire, although two managers did not provide consent at the start of the survey and were automatically exited and three people voluntarily exited. The survey was completed in full by 22 respondents (35%), and the median number of questions answered by respondents was 13 (out of 29).

The names of services varied and included Dementia and Intensive Support Team, Mental Health Service for Older People, Memory Assessment Service (MAS), Mental Health Intensive Recovery, Dementia Crisis Support Team, Dementia Rapid Response Team, and Intensive Recovery Intervention Service. Overall, 49 of the respondents (86%) considered their service to provide a specialist intervention/support for people with dementia and their carer experiencing an acute crisis at home. Twenty-seven respondents listed their managerial role as responsible for a CMHT (or similar) (47.4%), 24 as responsible for a HTT (or similar) (42.1%), and six as responsible for a memory service (10.5%). Table 3 and Figures 2 and 3 summarize the characteristics of these three models.

MASs

Of the six teams who identified themselves as a MAS, four teams indicated their employers (three NHS and one local authority). All teams operated Monday–Friday between 9:00 and 17:00, all used eligibility criteria and had a screening process, and only one team used a standardized care pathway or protocol.

The median number of referrals received by memory assessment teams per week was 18, ranging from six to 20. The median percentage of referrals with a primary diagnosis of dementia across teams was 85% ranging from 20% to 100%. Teams received referrals from general practitioners (GPs), consultant psychiatrists, outpatients, acute mental health, acute physical health, liaison psychiatry, other health or social care, self-referral, and carer referral. Team leaders were nurses with the exception of one who was an occupational therapist (Figure 3 for team composition), and on an average team members spent 80% of their time carrying out profession-specific work.

The highest ranked primary care needs of patients referred to the services were behavioral and psychological (eg, anxiety or low mood, delusions, hostility or aggression, and wandering) and the lowest ranked were environmental factors (eg, physical hazards around the home, unable to access essential amenities). The highest ranked intervention utilized by teams was specialist, professional health care practitioner input (eg, medication review, occupational therapy assessment, and clinical psychology input), and the lowest ranked intervention was home care support (eg, provision of home care services).

CMHTs

Of the 27 teams who identified themselves as a CMHT, 19 teams indicated their employers were the NHS. Sixteen teams indicated their operational hours, 15 of which operated Monday–Friday 9:00–17:00, with one team operating Monday–Sunday and offering an extended hours service. Seven teams used eligibility criteria and three teams stated that they did not. Ten teams indicated that they had a screening process, with four teams using a care pathway/protocol and five teams indicating that they did not use a care pathway or protocol. The median number of referrals received by CMHTs per week was 10, ranging from zero to 25.

The median percentage of referrals with a primary diagnosis of dementia across teams was 72.5%, ranging from 20% to 100%. Teams received referrals from GPs, consultant psychiatrists, outpatients, acute mental health, acute physical health, liaison psychiatry, community mental health recovery/community recovery teams, HTTs, the voluntary sector, other health or social care, self-referral, carer referral, primary care liaison teams, and memory services; one indicated that they operated an open referral system. Team leaders included mental health practitioners, nurses, occupational therapists, psychologists, and social workers (see Figure 3 for more details and team composition), and on an average team members spent 40% of their time carrying out profession-specific work.

The highest ranked primary needs of patients referred to the services were environmental factors and the lowest ranked were behavioral and psychological factors. The highest ranked intervention utilized by teams was environmental (eg, equipment, communication devices, and assistive technology) and the lowest ranked was specialist, professional health care practitioner input.

HTTs

Of the 24 teams who identified themselves as HTT, 21 indicated their employer type (20 NHS, 1 social enterprise). Twenty teams stated their operational hours, one of which operated Monday–Friday 9:00–17:00. While 19 teams operated Monday–Sunday, 17 of these offered an extended hours service, with two offering a 24-hour service. Out of the 17 teams who responded, 16 of these specified they had

Table 2 Quality assessment of included studies

Study	1. Did the study address a clearly focused issue?	2. Was the cohort recruited in an acceptable way?	3. Was exposure accurately measured to minimize bias?	4. Was the outcome accurately measured to minimize bias?	5a. Have authors identified all important confounds?	5b. Have they taken account on the confounds in the design/ analysis?	6a. Was the follow-up of subjects complete?	6b. Was the follow-up of subjects long enough?
CASP checklist cohort studies:								
Dibben et al[20]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Ginsburg and Eng[21]	Yes	Yes	Yes	Yes	No mention of what common mental disorders are experienced Number of ppts with dementia not reported	No	Yes	Yes
Doyle and Varian[18]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Richman et al[19]	Yes	Yes	Yes	Yes	No control group identified	No control group	Yes	Yes
Ratna[17]	Yes	Yes	Yes	Not known	Yes	Yes	Yes	Yes
Villars et al[22]	Yes	Yes	Yes	Yes	Yes	Analyses have not differentiated between severe and mild dementia	Yes	No

Study	1. Did the study address a clearly focused issue?	2. Did the authors use an appropriate method to answer their question?	3. Were the cases recruited in an acceptable way?	4. Were the controls selected in an acceptable way?	5. Was exposure accurately measured to minimize bias?	6a. What confounding factors have the authors accounted for?
CASP checklist case–control studies:						
Johnson et al[23]	Yes	Yes	Yes	Yes	Yes	Differences between control and intervention groups No reporting of participants family situation

Abbreviations: CASP, Critical Appraisal Skills Programme Centre; CRHTT, crisis resolution home treatment team; CMHT, community mental health team; ER, emergency room; NP, neuropsychiatric; ppts, patients.

7. What are the results of this study?	8. How precise are the results?	9. Do you believe the results?	10. Can the results be applied to the local population?	11. Do the results of this study fit with other available evidence?	12. What are the implications of this study for practice?	Rating
Admissions reduced by 31% General trend for greater satisfaction in carers and service users No difference in involuntary admissions No odds ratios	Quite	Yes	Yes within reason – all health care contexts are different	Yes	Recommendation of use of CRHTT for older people	+
Increased access to mental health services Reduction in admissions and psychiatric bed days High staff satisfaction with treatment	Not very	Yes	Potentially, in supported living environments	Not a lot of other evidence is discussed in relation to the findings	Mental health professionals should be a part of integrated living teams	0
Patients in long stay hospital beds similar for both groups Both services good at predicting when hospitalization needed and mobilizing support to prevent further admissions More people in residential care in office hours group – although more residential care also available in this group	Good	Yes	Yes	Yes	Crisis teams operating within office hours can be as effective as 24-hour teams	++
30 admissions to inpatient psychiatric care were avoided through the establishment of this team.	Quite	Yes	Yes in areas where CMHT exists but domiciliary crisis services do not	Yes	This kind of intervention may reduce admission to inpatient psychiatric care	0
The population seen in crisis was similar to that referred to other services Assessments made in the home are as effective in determining who should go to hospital and who can be managed in the community This model is effective at stabilizing patients to enable care in the community	Good	Yes	Yes – but few areas would be able to support a 24-hour crisis service	Yes	Crisis services are able to support people at home	+
No significant differences in early ER rehospitalization	Quite	Yes	Yes	Yes	This type of intervention was welcomed by families and nurses but did not prevent or reduce rehospitalization	+

6b. Have the authors taken account of the potential confounds in design/analysis?	7. What are the results of this study?	8. How precise are the results?	9. Do you believe the results?	10. Can the results be applied to the local population?	11. Do the results of this study fit with other available evidence?	Rating
No statistical adjustment	Reduction in NP symptoms, 79% resolution in crisis, less hospital admissions than control group, delayed nursing home placement	Quite – no confidence intervals and no reporting of ppts who declined	Yes	Can be applied in areas where complete lack of services. Not sure how well these findings integrate into UK health system	Yes	+

Table 3 Characteristics of survey respondents according to team model

Characteristic	Memory assessment service (%)	Community mental health team (%)	Home treatment team (%)	Total responses for each survey question
Employer type				
NHS	3 (75)	19 (100)	20 (95)	44
Local authority	1 (25)	0	0	
Social enterprise	0	0	1 (5)	
Days of operation				
Monday–Friday	3 (100)	15 (94)	1 (5)	39
Monday–Sunday	0	1 (6)	19 (95)	
Hours of operation				
9:00–17:00	3 (100)	15 (94)	1 (5)	39
Extended eg, 7:00–22:00	0	1 (6)	17 (85)	
24 hours	0	0	2 (10)	
Eligibility criteria				
Yes	3 (100)	7 (70)	16 (94)	30
No	0	3 (30)	1 (6)	
Referral/screening process				
Yes	3 (100)	10 (100)	16 (94)	30
No	0	0	1 (6)	
Pathway/protocol				
Yes	1 (33)	4 (44)	9 (60)	27
No	2 (67)	5 (56)	6 (40)	

eligibility criteria for their service. Sixteen teams indicated that they had a screening process and one did not. Nine teams used a care pathway/protocol and six teams indicated that they did not use any form of care pathway or protocol.

The median number of referrals received by memory assessment teams per week was 10, ranging from zero to 50. The median percentage of referrals with a primary diagnosis of dementia across teams was 60%, ranging from

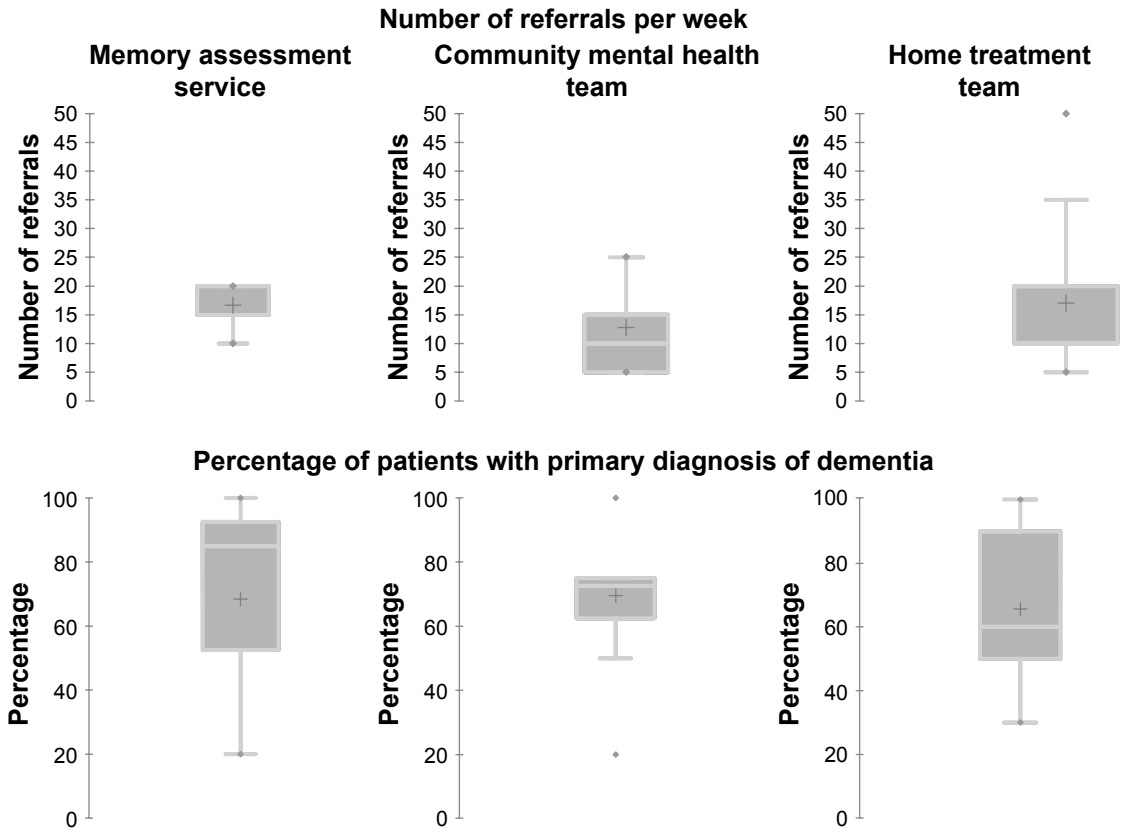

Figure 2 Referral characteristics for each model of team managing crisis in dementia.

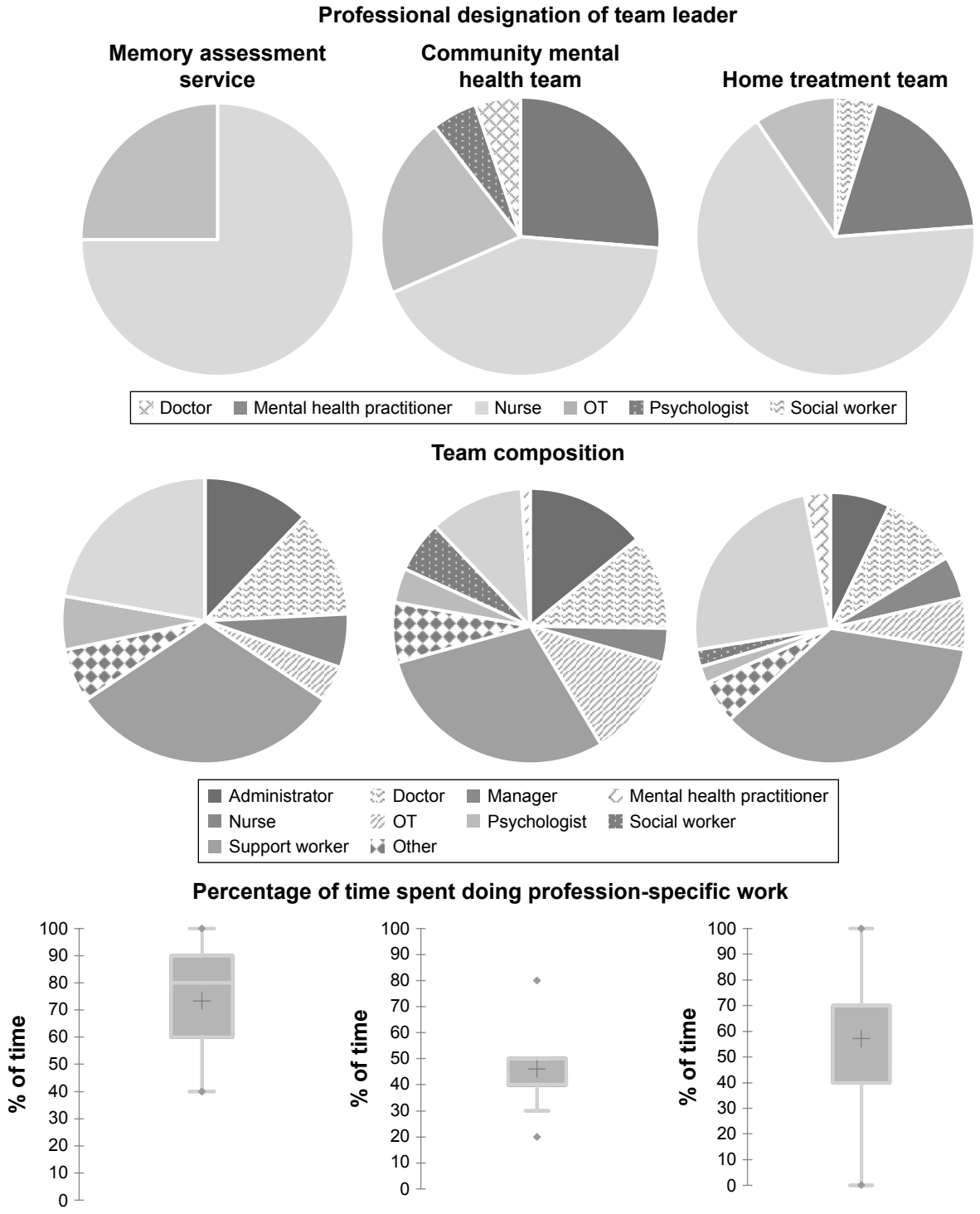

Figure 3 Characteristics of teams managing crises in people with dementia.

30% to 100%. Teams received referrals from GPs, consultant psychiatrists, outpatients, acute mental health, acute physical health, liaison psychiatry, community mental health recovery/community recovery teams, HTTs, the voluntary sector, other health or social care, self-referral, carer referral, ambulance services, and single point of access; one indicated that they operated an open referral system. Team leaders included doctors, mental health practitioners, nurses, and occupational therapists (see Figure 3 for more details and team composition), and on an average team members spent 70% of their time carrying out profession-specific work.

The highest ranked primary care needs of patients referred to the services were behavioral and psychological factors and the lowest ranked were environmental factors. The highest ranked intervention utilized by teams was specialist, professional health care practitioner input and the lowest ranked was environmental.

Assessment measures

Across the three team models, there were no differences in the standardized assessments used and all models used a range of different assessments. Twenty-six respondents (96.2%) use standardized assessments, and 24 different assessment tools were listed. The measures tended to be cognitive assessment tools, such as the Addenbrooke's Cognitive Examination-III, the Montreal Cognitive Assessment, and the Mini Mental State Examination. Most teams also used an assessment for the presence of anxiety or depression such as the Hospital Anxiety and Depression Scale or the Cornell Scale for Depression in Dementia. Notably, risk assessment was only mentioned by one team and no measures of crisis, quality of life, or caregiver burden were listed.

Challenges and benefits of delivering home treatment interventions

The respondents identified a number of challenges to delivering home treatment interventions. Examples include recognizing the gap between health and social care systems, the desire to have a social worker working within the team, timely nature to accessing social care, lack of access to community services, low staffing levels and high workloads, difficulty associated with the complexity of cases, and the geographical spread of the service. Examples of the benefits of delivering a home treatment include remaining patient centered, improved quality of life for the patient, supporting service users to remain in their own home for longer, avoidance of unnecessary hospital admissions, and the opportunity to provide intensive support to the people with dementia and their carer that could prevent future crises.

Discussion

National policies support the use of similar services for older people with mental health problems,[25–27] and our survey, despite being limited in its response rate, contributes to our current understanding of crisis teams working with people with dementia in practice.

There was, however, a satisfactory initial uptake rate (33.5%) and a good completion rate (35%). This appears to be a similar response rate to a previously reported review of email responses to surveys.[28] The responses indicate that the provision of services is inconsistent and practice delivery varies greatly. This variation includes the naming of services, setup and delivery, policies, and procedures; however, this aligns with previous research.[10,14] This may be a contributing factor to the lack of rigorous evidence and evaluation of these types of services in the literature.[14]

The review has identified more studies than found in the previous systematic review of the literature,[14] which has furthered our knowledge and understanding of crisis teams. Regarding the systematic review in accordance with the Oxford Centre for Evidence-based Medicine used in the previous systematic review,[14] two of the three newly included papers were of grade C.[21,22] There was one paper, however,[23] that was considered grade B, demonstrating a slight improvement in the reported study design. It is important to note, however, that it was only possible to report on the availability of evidence generated from the search and there may have been reports of service delivery in practice that were subsequently missed. However, this search of the literature did not identify high-quality studies such as RCTs, and predominantly cohort studies were included that compared findings to previous years of running the service or to a comparison group from a previously conducted study. In one reported study, the control group was taken from a study published in 1965, and arguably this is too dated as services have changed since this time. The majority of studies used a mixed sample of older people with dementia or mental illness,[17–21] or working age and older age, but only provided analysis of overall results. Also, the reporting of effect sizes for included studies was attempted but not always available from the original paper. Consequently, due to the lack of quality in study design and reporting, it was not possible to synthesize the results across included studies in a meaningful way. In addition, the wide geographical spread makes it difficult to draw assumptions due to the heterogeneity of the included studies.

Most studies provided adequate (+) methodological quality, and there is some evidence for crisis services for older people with mental health issues positively impacting on reducing the number of hospital admissions,[17,19,20] readmissions,[23] length of stay,[21,22] and mortality rates.[17,23] This does, however, need to be interpreted with caution due to the small number of studies, variable study designs, and lack of statistical rigor. Consequently, the systematic review was limited by a lack of good quality studies, leading to lower quality evidence. The literature review demonstrated no significant improvement in the design or reported clinical

effectiveness of studies evaluating crisis team working for people with dementia.

When comparing and contrasting the different models of service delivery, operational days and times varied across models with HTTs tending to offer extended hours across 7 days, and some offering a 24/7 service. By contrast, MASs and CMHTs typically provided services Monday–Friday 9:00–17:00, which may partly be due to the evolution of such teams, for example, in response to ward closures where teams and staff members may have been accustomed to working shift patterns. This is also reflective of the overall team composition across all models where nurses feature prominently both as team leaders and as members of staff. However, differences were seen across models in that social workers were included more so in CMHTs, less so in HTTs, and not at all in MASs. However, the role definition of mental health practitioners featured in all teams is unclear and may overlap with other professional disciplines. Further enquiry into the professional boundaries and responsibilities associated with this role is needed.

The percentage of time spent doing profession-specific work differed both within and across models; yet the MASs were reported as doing the largest proportion of professional-specific work and CMHTs the smallest proportion. Taken into consideration the types of intervention offered by the teams, this is unsurprising as the interventions most frequently used by MASs involved specialist professional health care practitioner input, whereas CMHTs rated environmental interventions as the most frequently used, which may not require profession-specific work to the same extent. MASs and HTTs ranked behavioral needs as the most common type of patient need, whereas CMHTs ranked these as their least common, and in contrast to this they ranked their most common need as environmental, which was the need ranked least common by the MASs and HTTs. This suggests that the three models of crisis services are responding to different patients from diverse circumstances and therefore managing crises differently. It must be acknowledged that all models of service rated family carer factors (eg, burden, physical health, and death of carer) as the second most common type of patient need and also the second most common form of intervention (eg, education, training, and respite), highlighting that despite wide variation there are some elements that straddle all models of care. Much of the research around crisis in older people with dementia considers only BPSD, which could suggest that the work of CMHTs is unrecognized and unresearched due to their focus on environmental and carer-related factors.

Although the median number of referrals per week do not show a large degree of variation across team models, the range suggests that CMHTs and HTTs experience greater variation in the number of referrals. HTTs tended to have more referrals than CMHTs and experienced a greater range of referrals. The MASs and HTTs presented a similar picture of variation in the patients arriving at their service with a primary diagnosis of dementia showing that for some teams in this model all of their patients had a primary diagnosis of dementia, whereas other teams saw as little as 20% of referrals with a dementia diagnosis. By contrast, CMHTs showed much less variation with most teams seeing approximately 75% of their patients with a primary diagnosis of dementia. It is surprising to note that, despite receiving referrals from a fewer number of sources, MASs show a large variety in the type of patients accessing the service. Across all three models of service delivery, the majority of teams used eligibility criteria and a screening process and yet still saw patients with a variety of diagnoses and needs. Arguably, the disparate needs of patients referred to services may hinder streamlined service delivery. In conjunction with this, protocols are not routinely used by teams in any model of service delivery. Potentially, this could be because it would be inappropriate to use a protocol with such a wide variety of service users. A specialized dementia protocol, including appropriate clinical measures, coupled with the awareness of when it is appropriate to use such a protocol, would help to facilitate the selection of a suitable intervention for these patients. Additionally, standardized risk assessment or quality of life measures might be more appropriate than cognitive measures to determine change pre-intervention and post-intervention.

Some methodological limitations exist with the scoping survey. In order to invite Managers to participate, correct contact details were essential, yet were often provided over the telephone and required further follow-ups. Furthermore, some Managers, especially those managing across a number of services, might not be able to provide the most detailed picture of the service as they may not interact with the service frequently enough at ground level. The emphasis of the introduction to the survey was on dementia crisis teams, and consequently some Managers may not have felt that the survey was applicable to them if they also worked across other services such as interventions for older people experiencing functional mental health crises. Since services varied greatly, some of the non-completers may have been eligible to participate in the survey.

The survey, however, was able to identify a variation in the naming and setup of services of teams managing crisis in people with dementia. The survey was designed to enable all teams who manage crisis in people with dementia to participate, whether they were a designated crisis team or a specialist dementia team. This allowed for responses to be gained from teams who may otherwise not have participated and has broadened the understanding of practice in crisis management for people with dementia. Additionally, respondents were able to leave contact details at the end of the survey, which may facilitate recruitment during future stages of the AQUEDUCT research programme. Respondents from a range of areas across England participated, suggesting that responses were gained from a range of teams and were representative of current practice for the country as a whole.

Current research fails to demonstrate full translation of guidelines for crisis resolution teams into practice.[29] Consequently, future research could look to include gray literature, other methods to assess interventions, qualitative work, and service evaluations. A realist review is needed to unpack the complexities of delivering a complex intervention, identify facilitators and barriers to its applicability across settings, and provide an inclusive perspective of crisis teams working in the United Kingdom. The National Dementia Strategy[3] aimed to provide good quality care for people living with dementia in the community including responsive crisis services and this can be carried out through the reporting of simple interventions and professional support with the intention of preventing hospital admissions.

Conclusion

The research evidence for crisis intervention teams for older adults with dementia is predominantly cohort studies. This is problematic in evaluating the effectiveness of the intervention as it is a weaker study design. There is some limited evidence to support the effectiveness of crisis intervention teams for older people with dementia in reducing hospital admissions, but further high-quality evidence is required. The scoping survey revealed a picture of wide variation both within and across the three models of service delivery, and further research is needed to clarify how best to support teams in delivering care for people with dementia who experience a crisis. Clearly defined protocols may be beneficial, particularly when a team's caseload can overlap across functional mental health and dementia, or across ages, in order to clearly define the "best" pathway of care for the person with dementia.

Acknowledgments

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Author contributions

A Streater, DM Coleston-Shields, and M Orrell designed the survey. A Streater, DM Coleston-Shields, J Yates, and M Stanyon analyzed the data. All authors interpreted the data. A Streater carried out the search for the systematic review. A Streater and J Yates carried out the quality appraisal of the included studies. All authors contributed to the drafting of the manuscript and revised and approved the final version.

Disclosure

The authors report no conflicts of interest in this work.

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Community REACT team shortlisted for BMJ award

Tuesday, 2 May 2017

The Health Board's Community REACT team has been shortlisted in the Mental Health Team of the Year category at the 2017 BMJ Awards.

The REACT (Response Enhanced Assessment Crisis Treatment) team was developed in February 2012 to provide a dedicated crisis service for older people with dementia, depression or psychosis. Previously people who suffered a crisis usually ended up being admitted to hospital, and the REACT service has grown rapidly to meet demand.

Between 2012 and 2015 the service received 1057 referrals, and among those 440 would have been admitted to hospital.

Dr Sabarigirivasan Muthukrishnan, consultant to the REACT service said: "The aim is to treat patients safely in their own home environment. Referrals are usually made by secondary mental health services, though recently we've extended that to GPs. We have found that 80% of hospital admissions can be avoided, and we also help in supporting the discharge of those that have been admitted."

Dr Kate Hydon, a former GP who now works full time for the service, says it's the most satisfying job she's ever done. "We're genuinely helping people to get better where they want to be. Having to be admitted to hospital is always a big fear for patients, and they deteriorate and lose independence when they are admitted. My background as a GP has been helpful because I know GPs' problems and I can liaise successfully with them."

The team now has a core of 22 permanent staff and costs around £750,000 a year.

Dr Muthukrishnan continued: "For every pound the service costs, we save £6.34.

"We needed support from the health board to get it started but after that it has been self supporting. Feedback from patients and carers has been overwhelmingly positive."

The BMJ Awards, now in their 9th year, are the UK's leading medical awards. They recognise and celebrate the inspirational work of healthcare teams across the country. The winners will be announced on Thursday 4th May 2017.

GIG CYMRU NHS WALES
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Hywel Dda
University Health Board

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Dai Lloyd AM
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By email only: | [redacted]

Dear Mr Lloyd

RE: Trieste Model of Mental Health Care

Further to your email of 27 September 2017 in which the committee requested a further explanation of the Trieste Model of Mental Health Care.

The requested briefing paper is attached, and providing an overview of the Trieste model and the way in which this will be adapted within Hywel Dda University Health Board.

Yours sincerely

Steve Moore
Chief Executive

HYWEL DDA UNIVERSITY HEALTH BOARD'S RESPONSE TO THE HEALTH, SOCIAL CARE & SPORT COMMITTEE

The Trieste Model of Mental Health Care

(i) Background

- The current organisation of the Trieste Department of Mental Health (DMH) derives from the deinstitutionalisation of the San Giovanni Mental Hospital, which, in its heyday, had approximately 1200 inpatients. While phasing it out a complete alternative network of community services was set up
- Trieste has played an international benchmark role in community mental health care
- Moving from deinstitutionalization, the Department of Mental Health (DMH) has become a laboratory for innovation on social psychiatry, developing a model that can be defined as the "whole system, whole community" approach
- The Trieste DMH provides care through a network of community services but also places great emphasis on working with the wider community with a view to promoting mental health and taking care of the social fabric
- The network of services is based on 24/7 Community Mental Health Services.

(ii) The Model of Care

- Four Community Mental Health Centres (CMHCs) each looking after a catchment area of 50,000 to 65,000 inhabitants, all open 24 hours a day, with four to eight beds each
- One General Hospital Psychiatric Unit (GHPU) with six beds, mainly used for emergencies at night with very short stays of usually less than 24 hours
- A Rehabilitation and Residential Service, which has its own staff and liaises with nongovernmental organizations (NGOs) in managing approximately 45 beds in group homes and supported housing facilities at different levels of supervision up to 24 hours a day, as well as two day-care centres
- A network of 15 social cooperatives and promotes a number of programs provided by NGOs, for example, associations of users and caregivers, such as club-style centres, self-help centres, workshops qualified to provide cultural and educational activities, professional training, and cultural promotion on the issues of rights and citizenship.

(iii) 24 hour Community Mental Health Centres

- CMHCs are responsible for a specific catchment area, and each one is run by a multi-disciplinary team composed of nurses, social workers, psychologists, rehabilitation specialists, and psychiatrists
- Each CMHC directly responds to the full range of psychiatric needs in its catchment area, including acute conditions, which are not referred to a specific service but managed with a view to prevention, treatment, and rehabilitation
- The CMHCs stress a continuity in therapeutic-rehabilitation interventions, especially for persons with severe mental disorders. This approach involves supporting the person in the exercise of their fundamental rights and in accessing social opportunities (housing,

education, occupational training, health management and leisure activities), accompanying them in their rehabilitation processes and orienting them in their relations with other services and institutions

- The 24/7 CMHCs are located in nonhospital residential facilities, usually a two- or three-story house. The homelike quality of their environment is seen as a ‘‘social habitat’’ and is consistent with staff attitudes that mainly focus on flexibility and reasonable negotiation with users, according to their concerns and needs.
- CMHCs are walk-in services and the intake is problem based, rather than diagnosis based. If the problem is urgent, even from the subjective viewpoint of the person or the caregiver, then it is addressed immediately
- From 8 a.m. to 8 p.m., CMHCs can admit patients to their beds directly and informally. Crises occurring overnight are managed at the general hospital casualty department, where they receive psychiatric consultation, and patients may be admitted to the GHPU if needed
- Service users are considered not as inpatients but as ‘‘guests,’’ and they can receive visits without restrictions. They are also encouraged to keep up their ordinary life activities and the links to their environment. Professionals and volunteers do outdoor activities with them every day
- The CMHCs are also a place where users come as outpatients for everyday care and rehabilitation, so that crisis tends to be defused, diluted in everyday life. It is often followed by a period of day hospital attendance, with a view to strengthening the therapeutic relationship and developing an ongoing plan of care.

(iv) **The General Hospital Psychiatric Unit**

- The GHPU is a DMH-run unit housed in the general hospital but directly managed by the community service network, with a quick turnover and low bed occupancy rate. It provides consultation/liaison for the whole hospital and the emergency department (ED)
- A patient coming to the ED may be referred to a local CMHC or kept under observation, especially during night shifts. On the following day, he/she is usually referred to his/her CMHC.
- CMHCs control and manage GHPU activities directly and are responsible for activating community interventions as quickly as possible.

(v) **Principles from the Trieste Department of Mental Health (DMH):**

1. DMH is responsible for the mental health of the community. All psychiatric needs must be met, without any selection.
2. DMH has an active attitude and practices outreach, in particular:
    - There is no waiting list for urgent cases
    - DMH promotes the approach of ‘‘shouldering the burden’’ in the user’s living environment
3. DMH promotes high accessibility, through:
    - Walk-in, drop-in service
    - Quick response after referral
4. DMH guarantees therapeutic continuity in space and time, through:
    - Interventions taking place in the patient’s actual living environments, within social-health institutions, in forensic settings (courts of law, prison, forensic hospitals)

- Time planning of interventions based on need for care and the threefold criteria of prevention, treatment, and rehabilitation

5. DMH responds to crisis in the community through:
    - Alternatives to hospitalization (home treatment, respite at the CMHC)
    - Its organization of CMHCs able to deal with emergencies and, if necessary, effecting compulsory treatments
6. DMH provides comprehensive care, through:
    - Integrated responses between social and health care, making readily available the resources by CMHCs, other health services, social services, and those coming from the person's microsocial context
7. DMH practices team work, through:
    - Collective formulation of therapeutic projects
    - Coordination between various professional figures
    - Multidisciplinary and multiprofessional approaches
    - Constant on-site training and team intervision activities
    - Circulation of information within the service
    - Integration of nonprofessional and volunteer work.

The Proposed Consensus Model for Adult Mental Health Services in Hywel Dda

(i) The vision of care for Mental Health Services in Hywel Dda

The vision for a modern mental health service for provides the opportunity for the much needed cultural shift and one which is aligned in many aspects to the Trieste model of care. The principles set out for this in Hywel Dda are as follows:

- **Be accessible by all 24hrs a day** – The person who needs help or their supporters need to be able to walk into a mental health centre at any time and establish a safe relationship to discuss their needs and agree immediate support.

- **Have no waiting lists** – The first contact should take place within 24hrs after the request with planned meetings to follow that agree the support and treatment which will be available in the context of choice.

- **Move away from hospital admission and treatment to hospitality and time out** – The mental health centre would provide night hospitality as an instrument to address the crisis during periods when there is higher need for care and / or to support the needs of the family. Intermediate access for those "stepping-down" from the central admission units back to the community would be available to support their transition.

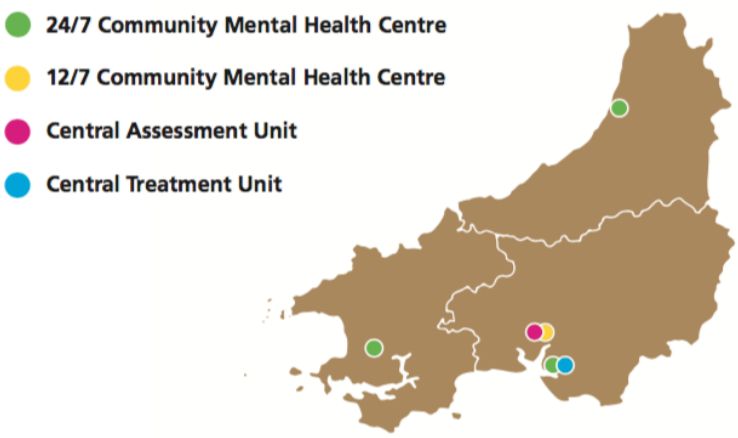
(ii) The Proposed Model of Care for Hywel Dda.

- Extensive engagement brought about the co- design of a model of care which clearly reflected aspects of the Trieste community model. This is as follows:

- The development of 24 hours Community Mental Health Centres in each county. Each 24/7 CMHC will include:

- Central town location for ease of access
- A friendly welcoming environment, unlike traditional clinical centres
- Access to clinicians, outpatient appointments and other health related needs.
- Access to experts in social care, housing and finances
- Co-delivery with other experts with a lived experience of mental health problems, such as peer mentors and family support workers
- Consideration of social enterprises that can add value to the local community as well as offering meaningful engagement and/or employment to people with mental health difficulties
- Four crisis & recovery or 'hospitality' beds within a welcoming environment, supported by staffing from the third sector.
- A local Section 136 facility

- A single point of access with which to contact services or to receive advice, making services more accessible.
- A move to centralise inpatient provision to Carmarthenshire through a:
  - Central assessment unit that has 14 assessment beds and a dedicated Section 136 facility comprising of two additional beds. This allows for a greater provision of senior clinical staff, available through extended hours and at weekends.
  - Central treatment unit with 15 treatment and recovery beds. This will be able to provide a greater presence of senior staff available through extended hours. It will also include people with a lived experience of mental health problems through the provision of peer mentors and family support workers as a core part of the service.
- There are no significant changes to available adult admission beds. The above proposals include a total of 41 adult beds with an additional 2 dedicated Section 136 beds.



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