CYNGOR BWRDEISTREF SIROL
RHONDDA CYNON TAF
COUNTY BOROUGH COUNCIL

COMMITTEE SUMMONS

C Hanagan
Service Director of Democratic Services & Communication
Rhondda Cynon Taf County Borough Council
The Pavilions
Cambrian Park
Clydach Vale CF40 2XX

Meeting Contact: Claire Hendy - Senior Democratic Services Officer (01443 424081)

YOU ARE SUMMONED to a meeting of **HEALTH AND WELLBEING SCRUTINY COMMITTEE** to be held at the **Council Chamber, The Pavilions, Cambrian Park. Clydach Vale, Tonypandy, CF40 2XX** on **TUESDAY, 7TH JANUARY, 2020** at **5.00 PM.**

Non Committee Members and Members of the public may request the facility to address the Committee at their meetings on the business listed although facilitation of this request is at the discretion of the Chair. It is kindly asked that such notification is made to Democratic Services by Friday, 3 January 2020 on the contact details listed above, including stipulating whether the address will be in Welsh or English.

AGENDA **Page No's**

1. DECLARATION OF INTEREST

To receive disclosures of personal interest from Members in accordance with the Code of Conduct

Note:

1. Members are requested to identify the item number and subject matter that their interest relates to and signify the nature of the personal interest: and
2. Where Members withdraw from a meeting as a consequence of the disclosure of a prejudicial interest they must notify the Chairman when they leave.

REPORT OF THE SERVICE DIRECTOR DEMOCRATIC SERVICES & COMMUNICATIONS

2. CONSULTATION LINKS

Information is provided in respect of relevant consultations for consideration by the Committee.

REPORT OF THE GROUP DIRECTOR, COMMUNITY & CHILDREN'S SERVICES

3. MENTAL HEALTH UPDATING REPORT

To consider what support is available for people suffering with Mental Health within the County Borough

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4. DELAYED TRANSFERS OF CARE UPDATE

To assess the progress of the Cwm Taf Social Services and Wellbeing Partnership Board in respect of Delayed Transfers of Care and review the work of RCT Social Services.

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5. REPORT IN RESPECT OF THE NOTICE OF MOTION RE: MOTOR NEURONE DISEASE (MND) CHARTER NOTICE OF MOTION

To consider the report in respect of the MND Charter Notice of Motion

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6. URGENT ITEMS

To consider any items, which the Chairman, by reason of special circumstances, is of the opinion should be considered at the meeting as a matter of urgency

Service Director of Democratic Services & Communication

Circulation:-

The Chair and Vice-Chair of the Health and Wellbeing Scrutiny Committee (County Borough Councillor R Yeo and County Borough Councillor G Holmes respectively)

County Borough Councillors:
Councillor A Roberts, Councillor M Forey, Councillor J Davies, Councillor J Williams, Councillor P Howe, Councillor G Stacey, Councillor M Tegg, Councillor G Hughes, Councillor D Owen-Jones, Councillor C Willis, Councillor W Jones and Councillor E Griffiths

County Borough Councillor G Hopkins, Cabinet Member for Adult & Children's Community Services

RHONDDA CYNON TAF COUNTY BOROUGH COUNCIL
MUNICIPAL YEAR 2019/20

HEALTH & WELLBEING SCRUTINY COMMITTEE

7TH JANUARY 2020

REPORT OF THE GROUP DIRECTOR, COMMUNITY & CHILDREN'S SERVICES

Agenda Item No: 3

MENTAL HEALTH AWARENESS

Author: Neil Elliott, Director of Adult Services. Tel No. 01443 444603.

1. PURPOSE OF THE REPORT

1.1. This report has been prepared to provide the Health and Wellbeing Scrutiny Committee with an overview and update on the Together for Mental Health (TfMH) Strategy by considering the information provided in the Annual Regional TfMH Statement for 2018/19 and the progress made against the key priority actions in the TfMH Delivery Plan: 2016 to 2019.

2. RECOMMENDATIONS

It is recommended that the Health and Wellbeing Scrutiny Committee:

2.1. scrutinise and comment on the information provided

2.2. consider whether there is any further information or matters contained in the TfMH Strategy and Delivery Plan that the it wishes to receive relating to Mental Health Awareness and scrutinise in the future

3. REASONS FOR RECOMMENDATIONS

3.1. To provide the Health and Wellbeing Scrutiny Committee with an opportunity to examine the progress made against the TfMH Strategy and Delivery Plan: 2016 to 2019 and identify any other matters relating to Mental Health Awareness that Members may wish to further consider in the future.

4. BACKGROUND

4.1. At its meeting on 12th December 2018, the Health and Wellbeing Scrutiny Committee requested an overview the current measures in place to raise awareness and support people experiencing emotional distress in order to

assess this information and identify the most appropriate way in which to further promote existing Mental Health services and provide support to staff and residents by means of increased awareness, following adoption of a notice of motion at the Council meeting on 24th October 2018.

4.2. At its meeting on 12th December 2018, Scrutiny Committee received a presentation providing an overview of the Mental Support provided or commissioned by Social Services. On 19th March 2019, Scrutiny Committee received a report to provide it with an overview of the work carried out by the Human Resources Department in addressing the issue of mental health in the Council.

5. TOGETHER FOR MENTAL HEALTH

5.1. TfMH, is the Welsh Government's 10 year cross governmental strategy to improve mental health and wellbeing across all ages. Published in October 2012, following significant engagement and formal consultation with stakeholders, the strategy has been supported by a series of detailed delivery plans.

5.2. The first delivery plan covered the period 2012/15 and the second covers the period 2016/19 and is included as Appendix 1 to this report. The final and third delivery plan for the period 2019/22 is due to published by Welsh Government following consultation earlier this year.

5.3. Implementation of the strategy is assured through TfMH Partnership Boards at National and Regional levels, and progress is reported publicly through annual reports produced by the Welsh Government and Regional TfMH Partnership Boards - the Regional TfMH Partnership Board Statement for 2018/19 is included at Appendix 2.

5.4. TfMH sets out a number of high level outcomes aimed at achieving a significant improvement to both the quality and accessibility of mental health services for all ages. The strategy recognises that the causes and effects of poor mental health are complex, challenging and multi-faceted and therefore require an integrated, cross government and cross sector partnership approach if we are to achieve these outcomes. The six high level outcomes underpinning the 10 year strategy are:

- The mental health and wellbeing of the whole population is improved
- The impact of mental health problems and /or mental illness is better recognised and reduced
- Inequalities, stigma and discrimination are reduced
- Individuals have a better experience of the support and treatment they receive and feel in control of decisions
- Improved quality and access to preventative measures and early intervention to promote recovery
- Improved values, attitudes and skills of those supporting individuals of all ages with mental health problems

6. EQUALITY AND DIVERSITY IMPLICATIONS

6.1. This is an information report - there are no equality and diversity implications associated with this report.

7. CONSULTATION

7.1. This is an information report - there is no consultation required for this report.

8. FINANCIAL IMPLICATION(S)

8.1. This is an information report - there are no financial implications aligned to this report.

9. LEGAL IMPLICATIONS OR LEGISLATION CONSIDERED

9.1. This is an information report – none at present

10. LINKS TO THE CORPORATE AND NATIONAL PRIORITIES AND THE WELLBEING OF FUTURE GENERATIONS ACT

10.1. This report links to the Council's Corporate Plan Priority People – 'Promoting independence and positive lives for everyone'.

11. CONCLUSION

11.1. This report aims to update Scrutiny Committee on the TfMH Strategy and the progress made against the key priority actions in the TfMH Delivery Plan: 2016 to 2019 in order for it to identify the most appropriate way in which to further promote existing Mental Health services and provide, where required, support to staff and residents by means of increased awareness.

CWM TAF MORGANNWG
Together for Mental Health Update
For the period of Oct 2018- Oct 2019

This represents the final submission from Local Partnership Boards for the 2016-19 Delivery Plan. Please comment on how LPB partners feel they have delivered against the key priority actions in the plan over the past 3 years – what has improved in each area? Please include perspectives from all partners (Local Authorities, Third Sector, Service Users & Carers, Health Board etc)

Priority Area One:
People in Wales are more resilient and better able to tackle poor mental well-being when it occurs.

1.1 To enable people in Wales to have access to appropriate information and advice to promote mental well-being and to help them understand / manage their conditions.

There are a number of interventions across Cwm Taf Morgannwg such as:

- Mindfulness and stress control
- Social Prescribing
- Information, Advice and Assistance resources that can be accessed online and at drop in centres.
- Peer support groups
- Developing an outreach model to empower people to set up peer support groups using community venues.
- A variety of counselling services.
- Talking therapies
- Developing a cohort of Peer Mentors to co deliver courses for the Recovery College.

These services are currently provided or commissioned by CTMUHB or primary care clusters. They continue to evaluate well with service users. Moving forward our new service model for community mental health places a stronger emphasis on prevention and earlier intervention with an enhanced range of services at universal or 'tier 0' level, and it is therefore intended that such services will continue to feature strongly in our service model.

1.2 To prevent and reduce suicide and self-harm in Wales:

- Prior to the transition of services from Bridgend County Borough. Rhondda Cynon Taf and Merthyr Tydfil SSH Group developed a Suicide and self-harm action Plan (#Project34+) to focus on priorities for the localities. Bridgend County Borough currently have their own action plan. Both action plans are currently in place until 2020-21. Partnership working is currently taking place to ensure all three localities within Cwm Taf Morgannwg are working closely together. The intention is to have one action plan, which will also support priorities within each area, in line also with the six objectives in Talk to Me 2.
- Ground-breaking work to reduce suicide rates in the Bridgend area has led to a nomination in this year's Police and Crime Commissioner Partnership Awards. A taskforce comprising representatives from South Wales Police, Public Health Wales, Bridgend County Borough Council and the Local Health Board was put together last year to look at what could be done to prevent suicides in the Bridgend area. Subsequently, suicide rates have fallen in the area and remain low despite a general rise elsewhere. There are two parts to the work, an operational group and a review group. The review group meet quarterly to review any suicides that have taken place in the preceding quarter to see if there were any lessons to

be learned. We will ensure we apply the learning from this achievement in Bridgend to the rest of the CTM area, and wider South East Wales region.

- The theme for World Mental Health Day 2019 was around Suicide prevention, so in the Suicide and Self-Harm meeting in September a Samaritans Volunteer attended the meeting where they delivered a presentation around the work they complete and also resources available through them; Working with Compassion Toolkit, DEAL (Developing Emotional Awareness and Listening), Media Guidelines Booklet, Men's Suicide Report and their Dying from Inequality Report. The group also looked at the Samaritan website which we encouraged members to access as it is packed full of free information and resources that they can access and support the Talk 2 Me Too agenda.
- In October 2019, the sub group supported a joint organisational application and a Service User Representative's application to be considered as part of the local Suicide and Self Harm Sub Group's action plan. Proposals are to deliver various projects and activities around Post Suicide Bereavement Support, Raising Awareness and Training which will support the Talk 2 Me Too Strategy.

Following Welsh Governments announcement to provided additional funding to regional approaches to Suicide Prevention 2019-20, the following proposals submitted through the Suicide prevention and Self-Harm Group, have been approved by Welsh Government. Welsh government have requested their finance colleagues to process the resource uplift of £30,490 to CTMUHB, which is allocated as follows:

- The organisation "Mind" have confirmed that they want to promote further "Suicide prevention and self-harm" awareness campaigns across CTM community, targeting 5000 men, which will include an evaluation of the impact of the campaigns reach.
- 'Project 66/99' is a campaign that is in the early stages of its development. The campaign will make it easier for people to talk about suicide, and to raise awareness of the issue, through the use of the arts and creativity. Welsh Government have approved funding to support the production of short films and media clips for use in venues with a focus on men. Films will support awareness raising across CTM communities.
- "Mental Health Matters Wales" and "New Horizons" put in a joint bid to support Third Sector collaborative working across CTM communities. Such work will include Peer Support groups, talking therapies sessions, Self-Harm awareness courses, recovery college. They will use outcome measures to evaluate progress.

1.3 To promote mental well-being and where possible prevent mental health problems developing.

NB – responsibility for this action was allocated to Welsh Government and Public Health Wales.

However all of the above mentioned activities support the local promotion of mental well-being and where possible prevent mental health problems developing.

1.3 (i) Mental Health in the Workplace – Organisations across CTM signed up to the Time to Change campaign, and have recently renewed this pledge.

1.3 (ii) the local Public Health team have recently been involved with the Bridgend Ford Taskforce to help support workers and families affected by the proposed closure of the Ford plant.

CAMHS additional information:
From an early years perspective an assessment of resilience (FRAIT) is undertaken on every family with a new infant and at set developmental stages until their 5th birthday. The aim is to undertake an early identification of low resilience and ensure appropriate support referrals as soon as practical.

It is anticipated that the new co construction pilot within RCT and an e-frait will further support an increase in family and individual resilience.

See response to priority area 6 below for more information re: focus on prevention/ resilience

Directory of Services that promote local agencies is provided to all GP's and families referred to the PCAMH service; this promotes self-help if/when issues arise in the future and reduce referrals.

Bibliotherapy and Better with Books is routinely promoted and lists of self-help resources that are available via all libraries is shared with all families referred to the service.

PCAMHS has recently commenced a joint service with Youth Service to a discrete population in Ferndale area after a circle of vulnerable young people was identified following a number of completed suicides in the area. The young people have identified a number of issue based topics that they would like training on, and PCAMHS is helping them access this to promote resilience and empower them. PCAMHS has worked collaboratively with school staff, Eye to Eye, Educational Psychology and Youth Engagement Service to plan a supportive response following this critical incident.

PCAMHS has delivered Part 1 group intervention to promote resilience and problem solving amongst young people with, for example, anxiety and ASD so that they are better able to emotionally self-regulate. Support, advice and training has been provided to parents so that they are able to support the young person

Priority Area Two:
The quality of life for people is improved, particularly through addressing loneliness and unwanted isolation.

2.1 To improve the health and well-being of people in Wales by reducing loneliness and unwanted isolation.

Bridgend County Borough's Well-being Plan 2018-22 , Ageing Well Plan and the Cwm Taf Well-being Plan 2018-23 all aim to combat isolation and loneliness in our communities. This represents a key strategic priority for the respective Public Service Boards.

PCAMHS has delivered Part 1 group intervention to promote resilience and problem solving amongst young people with, for example, anxiety and ASD so that they are better able to emotionally self-regulate. Support, advice and training has been provided to parents so that they are able to support the young person

Priority Area 3 – Service Meets the needs of the diverse population of Wales

3.1 To reduce inequalities for vulnerable groups with mental health needs, ensuring equitable access and provision of mental health services.

In November 2018 Diverse Cymru were invited to the RCT and Merthyr Mental Health Forum to talk to members and raise awareness about their work. Diverse Cymru provides support, services and advice to Black and Minority Ethnic (BME) people throughout Wales who are affected by mental ill health.

They explained that a number of reports have highlighted that although there is an over-representation of BME adults within the mental health services there is also an under-representation of BME young people accessing mental health services. Furthermore, BME people are less likely to be referred by a GP for support despite this leading to higher percentages than average later being admitted to hospital with chronic mental health problems.

It is Diverse Cymru's mission to make positive differences in these statistics, using their unique position to raise awareness both within Wales' BME communities and among healthcare professionals, of the additional issues and barriers that face BME people around accessing mental health services.

They went on to explain that a BME Mental Health Workplace Good Practice Certification Scheme and a Cultural Competence Tool Kit had been developed to support organisations and as a result some of our members enrolled on the training programme.

Within the Health Board 'Treat me Fairly' equalities e-learning package remains a mandatory training requirement for all staff and compliance is monitored monthly. Compliance rates have increased gradually month on month and as at 1st October is at 79%.

3.2 To ensure that Welsh speakers access services through the medium of Welsh when needed and to increase welsh language capacity in the workforce.

The UHB can confirm that

- All new policies and services complete an Equality Impact Assessment including Welsh language. (There are plans to update this to include the Welsh language standards)
- Welsh speaking staff are provided with uniforms with a work Welsh logo on them, or lanyards so that patients are able to identify the staff who can offer a service through the medium of Welsh.
- The Equality and Welsh language team have carried out Welsh Language Standards Compliance Audits on all Wards across the Health Board which includes ensuring patients are asked their language preference on admission.

- In-patient language choice is noted on a digital screen so that staff are aware of Welsh speaking patients.
- The Health Board offers an online Welsh language interpretation service for patients and have an internal Welsh interpreter if needed
- There is a list of Welsh speakers on the intranet to enable other staff to locate a Welsh speaker if required.
- The Health Board offers a range of Welsh lessons free of charge for staff.
- All new staff including Junior Doctors receive a Welsh language awareness training during the induction process.
- A new bilingual skills strategy will ensure new vacancies are assessed for the need to advertise as Welsh Essential or Desirable.
- A programme of job description translation is currently being undertaken by NWSSP and Trac recruitment system will be bilingual from 30th November 2019.

PCAMHS is now offering a service in community based venues, that is convenient for families, reduces stigma, and is compliant with legislation (Mental Health (Wales) Measure 2010). This has improved networking opportunities, and promoted collaborative working with Tier 1 professionals including 3rd sector, GP's and schools.

One PCAMHS practitioner is Welsh speaking

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Priority Area 4: People with mental health problems, their families and carers are treated with dignity and respect

4.1 To ensure that all services are planned and delivered based on safety, dignity and respect.
Cwm Taf Morgannwg Safeguarding Board structure and governance arrangements are well established and includes statutory partners and Third sector colleagues from Bridgend, Merthyr Tydfil and Rhondda Cynon Taf County Boroughs.

There is service user and carer representation at the CTP monitoring group. They have an equal voice in the group . Each locality has held engagement events or have outreached into service user groups to obtain feedback on our service. Responses and themes have been collated and actions are currently being fed back to service users in writing and through poster displays in waiting areas.

In June 2019 there was a recruitment process to increase the number of Together for Mental Health Service User and Carer Representatives on the Cwm Taf Morgannwg Together for Mental Health Partnership Board. As a result, based on lived experience there is now a representative that attends each of the Together For Mental Health work streams and sub groups.

In August 2019 it was agreed that Carer representatives would complete a piece of work to gather Carers Stories to share their views, opinions and experiences of Mental Health services and the support they've received during their caring journey. This piece of work has being undertaken to help inform practice and service development in order to help improve people's experience and support they receive.

The Third sector forum is working with statutory partners on a Service User and Carer Representative Engagement Strategy. They were involved in designing a workshop for Health, LA,

TSO and Service Users and Carers to review the current engagement of Representatives across Cwm Taf Morgannwg Health Board to identify similarities and differences. From that workshop a task and finish group has been established to start developing a Service User and Care Representative framework.

Service Users and Carer Representatives have been involved in the recruitment of a number of staff including the Locality Manager for Rhondda and Taff Ely, psychotherapists and one high intensity psychotherapist. A number of Representatives were also invited to talk with Psychology Masters Students to share their experiences of mental health services.

Together for Mental Health Representatives were asked by the Head of Psychology to support a service user led audit of therapeutic service and have developed the audit tools. The audit will be carried out in the next reporting period.

Dementia related training and awareness raising for staff and unpaid carers is now being taken forward by a Dementia Workforce Development group, in line with the Dementia Action Plan for Wales and Good Work Framework.

All capital developments comply with age friendly requirements, and a particular review has been undertaken of our primary care premises and older adult mental health wards and departments to ensure compliance with best practice for dementia friendly environments (eg Kings Fund)

4.2 To ensure that there is a concerted effort to continue to sustainably reduce the stigma and discrimination faced by people with mental health problems.

In January 2019 a group of the Together for Mental Health Partnership Board Representatives worked alongside colleagues in former Cwm Taf UHB (at the time) and Local Authority to develop a Dignity and Respect Pledge which is now being displayed at; In-patient Mental Health Wards and Units, Outpatient, Primary Care and Community Mental Teams venues. Partnership working continues to take place to ensure such work is equally distributed across all areas within Cwm Taf Morgannwg.

4.3 To ensure that service users / carers feel listened to and are fully involved in decisions about their own care / family member's care.

The Part 2 Mental Health Measure audit tool is being built into the Cwm Taf Morgannwg Redcap IT system by the audit department to enable timely audit reporting. We are still awaiting completion of update to All Wales Part 2 Audit tool prior to computerised tool. Completion date amended to April 2020.

Service User Engagement Events have been held in all localities annually and the latest findings will be reported back to the next Together for Mental health Partnership Board.

Other updates to the Together for Mental Health Partnership Board:

- A questionnaire designed to gather consistent service user satisfaction ratings around the CTP process has now been developed and is available both online and in paper copy. The survey is promoted alongside the annual CTP review.
- Of 113 people who have so far given responses across adult services, 79% reported that they felt very or quite involved in their care and treatment plan. A further 81% reported that they felt very or quite satisfied with their Care and Treatment Plan. There has been a

very slight decrease in these satisfaction ratings since the last report. This is mostly due to the increase in responses from the Outreach and Recovery teams (ORT's) who work with people who are more difficult to engage in their care and treatment and are likely to feel less satisfied. The fact that service users of the ORTS's are completing the surveys is viewed as positive and these findings have been fed back to the Outreach and Recovery teams to aid their engagement work. The survey will continue to be promoted and findings will be monitored via the CTP lead and CTP monitoring group to ensure that developing themes are actioned as necessary.

4.4 To ensure that service users, families and carers are fully involved in service development.

Service User Engagement Events:

- Annual service user events are held and a snapshot of feedback is now available from events held across the adult CMHT's between May and August 2019. Feedback is awaited from some stakeholders and any additional themes will be reported when received.
- The quality of information received was exceptional, the top themes are detailed below:

1. Service users really value the relationships with their care coordinator and the friendly, respectful attitudes of the CMHT workers. There were lots of positive comments about the CMHT workers and the services they provide.
2. Service users would like to see more consistency with medical staff and are concerned about the amount of cancelled Outpatient Clinic appointments and quality of Care and Treatment Plans developed from Outpatient Clinics.
3. It is important to be informed beforehand when a different worker will be visiting – better communication.

This feedback is helping to inform our redesign of outpatient services, the process for which will continue to involve service users and carers.

4.5 To ensure that all people in crisis and in contact with police are treated with dignity and respect.

All partners across CTM signed up to the Crisis Care Concordat. The health board's Head of Mental Health Nursing has been particularly active in working with partners to implement the Concordat, and in the revision of the Action Plan for 2019-22. Multi-agency meetings are planned to establish the baseline against the revised Action Plan, and to agree priorities for action.

Good progress across CTM includes:

- All crisis services are available 24/7 meaning our population have timely access to emergency services
- South Wales Police have direct access to our mental health crisis teams
- No children or young people have been taken to a police station or place of safety in the past year
- A Mental Health Act audit of people receiving their rights showed excellent practice
- The UHB hosted a South Wales PSC Mental Health Triage Pilot January 2019-June 2019. An evaluation report examining the quality of the service, its design and impact on police and health staff and services showed that overall triage is considered to be a valuable service that provides police with additional support in the management of MH related incidents. The expertise of triage staff was praised and considered to be of benefit to both the police and those in need of support. On the whole, police staff considered triage to have a positive impact on their practice, particularly in terms of confidence building when dealing with

incidents they consider outside their area of expertise. This opinion was shared across police and health, and interviewees across the services indicated a strong desire to continue triage beyond the pilot.

CAMHS additional information:
Improved access to mental health services via appointments in local community venues has been well received; comments include the reduced cost of public transport makes it easier to attend.

Families are invited to complete service user questionnaires when intervention is concluded, and encouraged to be honest in their comments so that developing services can be more tailored to need

The CAPA model that is in operation in CAMHS has Choice (young people and families choice) and partnership working at its heart. The model also uses goal based outcomes to ensure that (point 4.3) young people feel listened to and are fully involved in decisions about their own care.

The development of a dedicated Crisis team and ongoing provision of out of hours on call medic rota ensures that young people in crisis receive rapid and appropriate intervention when this is required.

Priority Area 5: All children have the best possible start in life which is enabled by giving parents / care givers the support needed

The focus of the Children and Young Person's sub group of the Together for Mental Health Partnership Board has been the development of a Statement of Intent for support for children young people and their families. This has included getting approval from the relevant executive boards.

The statement of intent was consulted on and coproduced and after further discussion with children and young people further work is being facilitated with them to produce a system and structure of coproduction and participation that will be embedded into the Children and Young Peoples sub group. The Children and young people's group with the agreed statement of intent has now an agreed strategic direction and clarity of purpose. The third sector are equal partners within the Children and Young Peoples sub group.

The sub group have ensured that the children and young people are included and are key components of the developments of the Together for Mental Health Partnership Board transformational agenda for Health and Social care.

The group have also been working on developing priorities for action and how to address some of the barriers and challenges for further joint working when commissioning services for children with complex needs, including emotional wellbeing and mental health. We have an agreed partnership approach to services delivery for children.

5.1 To provide better outcomes for women, their babies and families with, or at risk of, perinatal mental health problems.

The former CTUHB established a dedicated multi-professional community based team who work directly with women and their families by promoting their emotional health and well-being. They ensure that those who require specialist perinatal care have effective integrated care pathways and management plans in place. The team work alongside the public health midwife in Bump Start and Mams (smoking cessation programme), receiving referrals from them and undertaking joint training.

The team has been strengthened as part of the Bridgend County Borough boundary change and a working group has now been established to undertake a full review of the service against the Royal College Standards in order to reduce variation and enable a clear plan for further funding gaps to be progressed through the Health Boards IMTP process. Additional WG funding in 2019/20 is being invested in an additional Community Psychiatric Nurse to complement the team, and help support capacity for training, to support people to connect with local third sector and community groups as part of planning discharge and choice of venues for assessments in line with key Royal College standards.

Proposals are also underway led by WHSSC to commission a Mother and Baby Unit for Wales, potentially at Neath Port Talbot Hospital.

5.2 Parents and carers are supported to promote resilience and positive attachment during infancy and early years.

All schools are active participants in the Health Schools Scheme, with an additional 73 pre-school settings engaged in Healthy and Sustainable Pre-Schools Scheme.

PCAMHS offers Telephone Consultation to all professionals working with children and young people in respect of identifying and managing mild to moderate mental health difficulties. Signposting options are also offered via the Telephone Consultation service.

Priority Area 6: All children and young people are more resilient and better able to tackle poor mental well-being when it occurs

Third Sector Forum members from RCT and Merthyr were thrilled to host a World Mental Health Day event at Coleg Cymoedd. There were 14 organisations who attended and had an information stands set up in the main foyer of the college which helped raise awareness for students and staff.

Support was given to a Forum member to secure funding to deliver a service to support children and young people within an educational setting. The contract will allow both children and young people, who are at risk of poor mental health in comprehensive and some primary schools to access counselling to help improve their well-being.

The Children and Young People's sub group of the Together for Mental Health Partnership Board have agreed to explore and agree to address the barriers and challenges to further joint working in services for children with complex needs. The agreed priority area over the next year are emotional wellbeing and mental health and the development of a more wrap around services and how the services can be commissioned through the partnership. This will cover emotional wellbeing from pre conception through to intensive supports

In July 2019 Together for Mental Health Partnership Board, had the privilege to listen to the young people from "Safer Merthyr Tydfil" presenting to the group the work their youth forum is involved in. There overarching aim was to, support the Youth Mayor pledge to raising awareness of Mental Health. The young people in Merthyr felt that mental health was an issue and that if young people had support early enough then this might help them. They therefore produced a Mental Health First Aid kit which has been widely distributed through schools and youth clubs. More details can be found in the link below:

https://www.youtube.com/watch?v=jxUTwZ7W2CM&feature=youtu.be

CAMHS additional information:
PCAMHS has recently commenced a joint service with Youth Service to a discrete population in Ferndale area after a circle of vulnerable young people was identified following a number of completed suicides in the area. The young people have identified a number of issue based topics that they would like training on, and PCAMHS is helping them access this to promote resilience and empower them. PCAMHS has worked collaboratively with school staff, Eye to Eye, Educational Psychology and Youth Engagement Service to plan a supportive response following this critical incident.

PCAMHS has delivered Part 1 group intervention to promote resilience and problem solving amongst young people with, for example, anxiety and ASD so that they are better able to emotionally self-regulate. Support, advice and training has been provided to parents so that they are able to support the young person

Plans to increase Part 1 groupwork intervention are being formulated which will build upon previous success in promoting resilience

PCAMHS have liaised with Valleys Steps to consider developing Tier 0 services available to ? young people aged 16 – 18 years.

When additional vacancies have been appointed to, a school based service will be introduced that will focus on collaborative working, building capacity within community based services and ensuring systemic planning for families experiencing difficulties. This will commence in Secondary schools, with plans to include primary schools as soon as practically possible.

School will have a named PCAMHS professional that they can access for information, training, consultation etc

Additional funding proposed and agreed will help develop a primary mental health service to work alongside Children Services, Youth Services and Health Visitors so that all agencies will benefit from joint work, bespoke consultation opportunity, training etc that helps professionals identify and manage referrals for thos presenting with mild to moderate mental health difficulties.

PCAMH service includes access to a trauma specialist in EMDR

PCAMH offers a service to those referred who are children looked after, have sensory difficulties, learning difficulties, are young carers, experienced trauma eg, exposed to Domestic Violence, experienced abuse, have multiple Adverse Childhood Experiences (ACE's) - promoting resilience is a fundamental focus of any therapy offered, and parents / carers are always included in planning so that systemic support continues when the formal therapeutic intervention is concluded

As the RCT / Merthyr area is recognised as being highly deprived, many families live in poverty consequently delivering a service within community based venues reduces the challenges they face in accessing mental health service

The Health Board is working at an all-Wales level within the 'Whole School Approach' group

The PCAMHS team has recently had investment to recruit dedicated staff to focus on liaison work, a significant part of which will involve working with schools

The Health Board is working with the Local Authorities on the design and implementation of an emotional well being service, seeking to enhance resilience and support professionals to help young people as early as possible in order to avoid deterioration and future requirement for more specialist services.

The Health Board is also working with the Local Authorities on the design of a MAPPS team, to work with young people in care to ensure that they receive the care that they require.

Developments in the Family Therapy service mean that there is now a service available across PCAMHS, SCAMHS and CiTT and this approach is designed to ensure resilience of young people and their families.

6.1 To develop the resilience and emotional wellbeing of children and young people in Wales in educational settings. (WG and Education)

- **Welsh Government and Education section for response.**

6.2 To support children and young people aged 0 to 25 with additional learning needs, including those who have mental health needs.

- **Welsh Government and Education section for response.**

6.3 To improve the well-being of children and young people at raised risk of poor mental well-being, with particular attention given to children in vulnerable groups such as children with sensory impairments, Learning Disabilities, children and young people who offend, children who have experienced trauma, those looked after, those living in poverty, young carers and those no longer in education.

- **Welsh Government and Public Health Wales section for response.**

Priority Area 7: Children and young people experiencing mental health problems get better sooner

7.1 To enable all children and young people experiencing mental health problems to access appropriate and timely services as close to their home as practical and to ensure that transition to adulthood is effectively managed.

Crisis Services – additional WG funding for band 7 practitioners has been secured to enable the CAMHS Crisis Liaison team to be extended to offer a 7 day service.

Primary Children Adolescents Mental Health Services - Primary CAMHS operates against a target for 80% of young people to be seen for their initial assessment within 28 days of referral and for their intervention to begin within 28 days of this assessment. The service is currently not meeting the assessment target however the intervention target is consistently met, meaning that once young people enter the service they then quickly receive the intervention that they require.

The service has plans to achieve the assessment target by the end of April 2020. The total patients on the waiting list has reduced significantly since April 2019 and the longest wait has also reduced over time.

Additional WG funding has been secured to enhance the PCAMHS service with 3 band 7 Schools Liaison Specialists. This will help ensure an earlier assessment and meeting of needs and help reduce referrals to SCAMHS.

Specialist Children Adolescents Mental Health Services - Specialist CAMHS operates against a target for 80% of young people to be seen within 28 days of referral. To-date there has been significant improvement in this performance during 2019/20, with the target currently being met and exceeded.

Significant additional WG investment in SCAMHS this year is helping to provide a more appropriately resourced and resilient SCAMHS service and implementation of the CAPA model.

In Bridgend a Transition team has being developed that will support children and young people aged 0-25 who require support because of a physical disability, sensory impairment, learning disability, mental health difficulty or are on the autistic spectrum. The team will also support young people who are vulnerable to or at risk of exploitation or harm. A project has been underway for the last 18 months and the team will become permanent by April 2020.

One of the Third Sector forum members was able to secure funding through their central grants scheme to offer talking therapies to 84 children and young people who are identified as pre-CAMHS which was launched in September 2019.

The Children and Young Peoples Sub group have meet with the youth forums in both RCT and Merthyr Tydfil. It was agreed that they need to be at the fore front of services development and supports have been provided to the groups to establish systems and structures to allow this to happen. They also felt that emotional wellbeing and mental health was a priority.

CAMHS additional information:
All PCAMHS assessments / interventions are solution focused, tailored to need, and regularly reviewed to promote efficient, effective programmes of intervention.

Offering convenient appointments at community venues helps support families in their management of mental health difficulties; this includes some evening /week end / after school appointments.

The CAMHS service is set up to deliver a range of services to ensure access to appropriate and timely services, including-

- Crisis team – to see young people in crisis very quickly
- Community Intensive Therapy Team (CiTT) – to offer intensive support to young people to avoid admission to inpatient unit and support earlier discharge

- Primary CAMHS – to offer assessment and intervention for those with mild to moderate mental health needs
- Specialist CAMHS - to offer assessment and intervention for those with mild to moderate mental health needs. Within this dedicated Eating Disorder sessions are delivered and the service is focussed on seeking to deliver services as close to the WG recommendations as possible within the available resource
- First Episode Psychosis – to offer rapid assessment and intervention for young people presenting with possible Psychosis
- Neurodevelopment – offering assessment for ASD and ADHD and ongoing monitoring/ medication for young people with ADHD
- Young People Drug and Alcohol Service (YPDAS) – to offer substance misuse services to young people
- Out of hours on call doctors to ensure that crisis's occurring out of hours can receive a rapid response
- Child and Adolescent Learning Disabilities service
- Working with the third section including MIND offering interventions within Primary CAMHS and commissioning Halcyon to work with families with young people presenting with challenging, difficult and often anxiety related behaviours

Aligned to the above, 3 Cwm Taf CAMHS offers a wide variety of therapies including CBT, Systemic psychotherapy, DBT, ACT, CFT and EMDR

Developments in the Family Therapy service mean that there is now a service available across PCAMHS, SCAMHS and CiTT, when previously this was only available for SCAMHS.

A significant piece of work has been undertaken with Adult Mental Health to develop a transition protocol and this has recently been approved and should help to ensure that transition for young people is managed effectively.

Priority Area 8: People with a mental health problem have access to appropriate and timely services

8.1 To enable people experiencing neurodevelopmental conditions, (such as autistic spectrum disorder and attention deficit hyperactivity disorder) to access timely assessment and treatment that supports their continued social and personal development.

CAMHS hosts the Neuro Development Service which aims to deliver a coordinated and robust service for those children and young people requiring it within the Cwm Taf area, with input from a range of professionals. The service was initially established on limited resources and as a result there is an ongoing demand and capacity gap, resulting in a waiting list of approximately 52 weeks against a target of 26 weeks and ongoing failure to achieve the 80% target for this. The current position is only being sustained due to ongoing investment in WLI clinics at significant expense and with the staff in the team becoming increasingly fatigued with this approach. A bid was made to WG against the new MH funding made available during 2019/20, however this was only funded non-recurrently with the response from WG advising that the recurrent investment required in the service should be identified through the IMPT process. Further investment in the ND service has therefore been highlighted as a priority in the 2020/21 IMTP.

8.2 To ensure that mental well-being is given equal priority with physical well-being in the development and delivery of services.

Psychiatric Liaison services are in place in each of our general hospitals, and shared care arrangements are being discussed with our community hospitals to ensure the needs of inpatients with co-occurring dementia and cognitive impairment are met.

'Frequent attender' groups have been established on each acute hospital site to identify and work with people who regularly attend A+E to prevent recurring admission. The groups involve staff from the A&E departments, WAST, psychiatric liaison services and mental health crisis teams.

8.3 To ensure people with an identified mental health problem are able to have timely access to a range of evidence based psychological therapies.

The recent investment in psychological interventions has been very welcomed and is starting to realise benefits. The local psychological therapy group has matured significantly and is now very focused on Matrics Cymru and priority areas where gaps have been identified. New investment in Psychological Therapies is helping increase access to these services and enabling the development of a more psychologically minded workforce.

Matrics Cymru has been a really helpful tool in focusing the progression of a psychologically focused service with recognised standards and competencies necessary for delivery. In line with this the Cwm Taf Morgannwg region have been keen to get the stepped care model embedded and people choosing wisely early to access low intensity interventions. Last year's new psychological intervention has gone a long way to strengthening tier one and tier 2 services in the stepped care model. The funding secured in 2019/20 is helping to support a well-regarded service at the foundation tier 0 level (Valleys Steps) to become sustainable.
Valleys Steps offer psychologically focused courses to the population on an easy to access basis. The service has become well established and well regarded in recent years and will have a long term approach to building mental wellbeing and resilience in the population of Cwm Taf Morgannwg and having a reduction on the need for individual psychological intervention. The service has been expanded to cover the new Health board area and funding has secured the whole service long term. This is a critical priority locally and in Matrics Cymru to ensure we are Improving high volume, low intensity services for people with common and stable, severe mental health problems, in line with the requirements of Part 1 of the Mental Health (Wales) Measure 2010.

8.4 To ensure timely and appropriate services for people with first episode psychosis.
An Early Intervention in Psychosis (EIP) has been in place in the Bridgend area for several years however a very limited service was available in the rest of the CTM area. A multi-agency working group has been established to develop services further within Cwm Taf Morgannwg, learning from best practice in Bridgend. The aim is to develop a framework that takes existing patterns of service delivery and ensuring that clinical leadership and governance arrangements are in place. Whilst also taking into consideration national guidelines, assessment needs of our population and workforce requirements.

8.5 To ensure that public services and third sector work together to provide an integrated approach.

The Mental Health Third Sector Forum are key members of the Together 4 Mental Health Partnership Board and its members act as the Third Sector Representative at all of the T4MH work streams and sub groups. The representatives ensure that the views of forum members are shared at the meetings and will also feedback and provide updates at the Forum's quarterly meetings.

Forum members have attended a series of workshops hosted by the Health Board in 2019 to review the Community Health Teams and explore the work of the Universal Services. Forum members recently gave a presentation at one of the workshops to share with partners what Third Sector Mental Health Services exist in Cwm Taf Morgannwg and also to help identify gaps in services.

The Forum supported the Health Board in the recruitment of a Locality Manager by working with a number of third sector organisations and service user representatives to develop a stake holder panel interview.

The Health Board commissions a range of Third Sector organisations to provide mental health support to the population. A Commissioner/Provide has been in place for the last 2 years to share good practice and enable good relationships.

Population Needs Assessment was completed for the SSWBA Wellbeing Plan, inclusive of work with mental health service users and carers through Interlink facilitated workshop in September 2016. The workshop consulted with people on the new T4MH Priorities and to gather information for the Understanding our Communities in order to feed into the PNA work undertaken by the PSB. Advertised via Service User network and attended by approximately 20 participants.

8.6 To ensure that there are robust links between primary care and mental health services.
As part of our redesign of community mental health services across CTM, a key enabler to effect the shift to universal services is our investment in cluster based Mental Health Practitioners who offer mental health assessment, medication monitoring, advice and information within primary care, as well as connections to other appropriate services.

Offering a rapid response to GP referrals, appointments can also be made directly with the Practitioners without the need to see the GP first. The Practitioners will also be able to refer directly to primary and secondary mental health services should they feel the patient is in need of more intensive and specialist mental health care and support. Funded initially via the Stay Well in Your Community Transformation Programme, ongoing funding will be secured through the Mental Health Transformation Fund and by shifting resources through anticipated released capacity in the LPMHSS/CMHT service.

8.7. To ensure people of all-ages experiencing eating disorders are able to access appropriate and timely services.
The Eating Disorder service is being enhanced with a Service for High-risk Eating Disorders (SHED Team) which will focus on providing early intervention for adults at their first presentation to mental health services within Cwm Taf Morgannwg UHB as requiring treatment for a severe eating disorder within the Tier 3 SHED Team.

The aim of this work will be prevention of chronicity developing within the first 3 years of the onset of a severe eating disorder and prevention of functional and social disability with loss of employment/education and social/community engagement resulting from a severe eating disorder.

New investment is being used to develop an up-to-date library of relevant resources and literature on early intervention for eating disorders and training provision for new staff.

Outcomes will be monitored as follows:

- Monitoring of key clinical indicators of progress for target cohort of individuals within 3 years of first presentation to services for treatment of a severe eating disorder eg BMI, frequency of abnormal blood results relating to purging behaviours (Potassium levels), other key indicators of medical risk and overall clinical presentation
- Comparison of need for inpatient admission within first 3 years of presentation to services for treatment of an eating disorder with historical data of comparative cohort
- Comparison of frequency of individuals leaving employment/education as a result of having an eating disorder with historical data of comparative cohort
- Service user and carer satisfaction with service provision

Mental Health Matters run a peer support group (SORTED) and have developed an Eating Disorders awareness booklet which has been well received by schools and colleges.

8.8 To ensure mental health services for Veterans in Wales who are experiencing mental health problems are sustainable and able to meet that populations needs in a timely and appropriate manner.

There are a range of veteran's services in place in line with WG guidance and reflective of local need.

8.9 To ensure timely and appropriate Mental Health services for people with mental health problems who are in contact with the criminal justice system.

- **Welsh Government and Prisons section for response.**

8.10 To ensure timely and appropriate services for people who require a secure mental health setting.

- **Welsh Government and WHSSC section for response.**

8.11 To ensure co-occurring mental health and substance misuse problems are managed effectively

The Cwm Taf Morgannwg Co-Occurring Group has developed a local action plan with a focus on improving pathways between mental health and substance misuse services, an ongoing training programme for current staff, and education for student nurses in conjunction with the University of South Wales.

CAMHS additional information:

The waiting time for Part 1 assessment is becoming timelier.

The waiting time for Part 1 interventions has been in adherence to the Welsh Government target of 28 days

Part 1 Group work intervention is being planned for those diagnosed with ASD who present with anxiety – this will build on previous groups delivered, and incorporate feedback via evaluation. This will promote a more timely response for those referred, and improve efficiency.

Working with Merthyr and The Valleys MIND has introduced a more collaborative approach, with those deemed sub threshold to PCAMHS, who were signposted to Eye to Eye Counselling Service now offered an additional signposting service

As above, the health board and the local authority have invested in Haycyon, a third sector organisation to work with families with young people presenting with challenging, difficult and often anxiety related behaviours (often with Neurodevelopment disorders).

Priority Area 9: People of all ages experience sustained improvement to their mental health and well-being through access to positive life chances

One of the T4MH Rep's successfully passed Level 3 in Teaching and Learning and is now qualified to teach adults in educational establishments. They have also started to deliver 'Who Does What in Mental Health' courses via New Horizons Recovery College and Interlinks Training Programme.

An audit report of 10% of adult and older persons CMHT caseloads between Jan and March 2019 from the former Cwm Taf UHB (preceding the merger with Bridgend) has identified significant improvements in the amount of Care and Treatment plans which have identified outcomes in the areas of accommodation, finance and employment. The focus on these areas will remain through supervision and training

9.3 To ensure people with mental health problems have access to advice and support on financial matters.
The need for support with financial issues is considered as part of CTP and we have good evidence about support to individuals in accessing benefit entitlements and work through LPMHSS. This point to continue to be emphasised in CTP training and team managers/leaders to drive with their teams.

9.4 To increase the availability of recovery oriented mental health services.
Our services and those commissioned are founded on the recovery model. The key measures under this action relate to compliance with and quality of CTP, which are on target

9.5 To enable mental health professionals to have a greater understanding of the experience of domestic abuse and sexual violence across all groups and sectors of society, including those of protected characteristics.

Health Board staff are encouraged to complete the awareness level 1 e-learning module on gender based violence and abuse. Compliance is at 88%

A range of services are available through statutory and third sector for those affected by domestic violence commissioned through Support People. The MASH works across all sectors to support identified people experiencing domestic violence.

9.1 To enable people with mental health problems to have fair access to housing and related support and promote access to mental health services amongst people who are homeless or vulnerably housed.

- **Welsh Government section for response.**

9.2. To support people with mental health problems to sustain work and to improve access to employment and training opportunities for those out of work.

- **Welsh Government section for response.**

PCAMHS works with those aged up to 18 years, which includes those young people who are unemployed, have left or are not in formal education, those in employment etc. Work has included liaison with for example Job Centre staff etc with a psycho education group for carers of young people with a diagnosis of ASD including a training session from a Job Centre facilitator who advised on career planning, training opportunities and available support.

Priority Area 10: Dementia

NFA - These actions are now subject to oversight as part of the new Dementia Action Plan, which superseded the delivery plan in 2018

Priority Area 11: The implementation of the strategy continues to be supported

11.1 To ensure that the appropriate infrastructure is in place to deliver the requirements of *Together for Mental Health.*

- The Cwm Taf Morgannwg Together for Mental Health Partnership Board is the established forum for local implementation of the Together for Mental Health Delivery Plan.
- Reporting line is currently to Cwm Taf Morgannwg and Bridgend Public Services Boards.
- Terms of Reference including membership to cover Bridgend has been updated and is reviewed annually.
- Carer and service user reps sit on the Partnership Board, supported by SU Involvement Officer, supporting all localities within CTM.
- In August 2019 third sector forum colleagues from across CTM attended a joint workshop h to formulate a Third Sector response to the consultation for the Together for Mental Health Delivery Plan 2019-22. The response helped inform the T4MH Partnership Board collective response.

11.2 To progress the development and implementation of a national mental health core data set capturing service user outcomes.

- **Public Health Wales section for response.**

11.3 To ensure a competent and sustainable workforce that helps people improve health as well as treat sickness.

- IMTP contains full skill mix review – additional focus will be developed on the third sector in the new combined Plan this year.
- Proactive approach to recruitment is maintained

11.4 To ensure that investment in mental health services is sustained.

- Funding for mental health services are ring-fenced as required – annual returns to WG provided
- Spending decisions are made via our IMTP process and our monthly Clinical Business Meetings, supported by our 'Business Partner' Model between Directorates and the corporate services of Human Resource Management, Finance, and Planning and Partnerships.

11.5 To continue to promote and support emotional wellbeing and resilience, providing effective and helpful services at an early stage, as well as ensuring those in need of specialist services receive the highest quality of care and treatment.

- 11.5 (i) Welsh Government (Health and Social Services) and health boards to implement the Duty to Review recommendations arising from the evaluation of the delivery of *the Mental Health 2010 (Wales) Measure* **by March 2019.**

Part 3 reassessment – on discharge all service users are informed of their right to reassessment both verbally and as part of a documented discharge plan within their discharge CTP review. Additionally all service users receive a letter detailing the process of self-referral for part 3 assessment. Copies of the review and part 3 letter are sent to the GP and other persons as appropriate.

Service user satisfaction survey and audit – the directorate has developed a service user satisfaction survey on an online platform. An explanation of this and link to the survey is included within all standard CTP letters. Additionally data will be gathered at ongoing service user engagement events.

The All Wales part 2 audit tool is used on an ongoing basis to gather information

11.6 To continue to support an evidence based approach and ensure active research and evaluation is at the heart of service development.

- **Welsh Government and Public Health Wales section for response.**

CAMHS additional information:
CAMHS services are delivered by a wide range of professionals and this is constantly reviewed to ensure a competent and sustainable workforce.

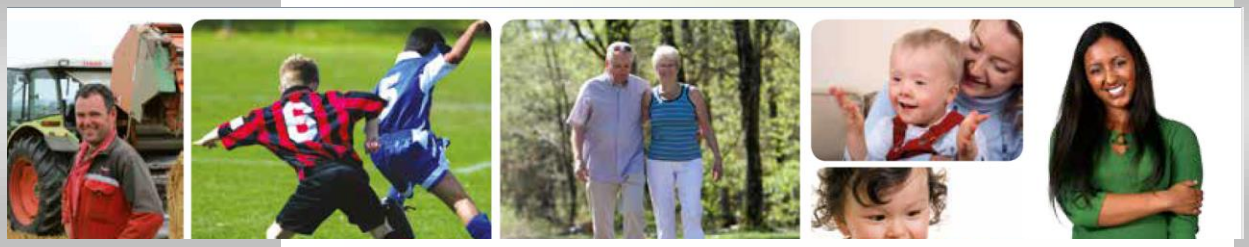
Services for young people are increasingly being designed with prevention in mind. The Health Board is working with the Local Authorities on the design and implementation of an emotional well bring service. There has also been investment into dedicated Liaison posts in Primary CAMHS.

There has been ongoing investment into CAMHS, with Crisis and FEP services being established within the last 5 years and more recently investment into the SCAMHS service to increase capacity, Crisis to expand to a 7 day service, PCAMHS to increase capacity and incorporate more liaison work and ND to add resilience to the service.

Together for Mental Health Annual Statement

Cwm Taf Morgannwg Mental Health Partnership

2018-19



INTRODUCTION

Together for Mental Health is the Welsh Government's 10 year strategy to improve mental health and well-being in Wales. Published in October 2012, following significant engagement and formal consultation with key partner agencies, stakeholders, services users and carers, it is a cross-Government strategy and covers all ages. It encompasses a range of actions, from those designed to improve the mental well-being of all residents in Wales, to those required to support people with a severe and enduring mental illness.

Actions identified in the second Delivery Plan, covering the 2016-2019 period, require a cross-cutting approach, and are implemented jointly by partners, including Welsh Government, health boards, local authorities, the third and independent sectors, education, public health Wales, police, fire, ambulance and others. The Delivery Plan is overseen by the National Partnership Board, and there is a Local Partnership Board in each area.

This public-facing report represents the annual statement that is produced in November each year by local partnership boards, for the October 2018- October 2019 period. The report has been co-produced with service user and carer representatives, and is a summary of progress to date against the actions. The document also provides an overview of future priorities. The third and final delivery plan will be published in Autumn 2019 and will cover the final period of the 10 year strategy, until 2022.

The 2016-2019 Delivery Plan can be found at:

https://gweddill.gov.wales/docs/dhss/publications/161010deliveryen.pdf

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.In 2018/19 the Cwm Taf Morgannwg Mental Health Partnership Board has been focusing on the following priorities.

- **Prevention of Suicide and Self Harm:** Overseeing implementation of the Cwm Taf #Project 34 +and Bridgend SSH action plans, with a view to developing a Cwm Taf Morgannwg SSH action from 2020. Welsh Government funding in 2019/20 is being used to raise awareness of suicide and self-harm within communities and with key staff, and to offer support to those affected.

- **Children and Young People:** Work continues to take place with Youth Forums and Third Sector colleagues looking at developing a system and structure for the young people's involvement in the partnership group. The priority for the coming year will continue to be Emotional Wellbeing and Mental health, looking at the services we want from pre conception to young adulthood.

- **Dementia:** Steering Group continues to oversee the delivery and implementation of the action plan for Wales across Cwm Taf Morgannwg through work streams addressing the 7 themes

- **Co-occurring Mental Health and Substance Misuse**: Work is ongoing to review the services in primary care and pathways to and from substance misuse services. Partnership working with local Universities has resulted in awareness of co-occurring issues being included in undergraduate nurse training

- **Adult services:** Access and Recovery - An extensive stakeholder engagement has led to a service model now being agreed for community mental health services. Extended work is now looking at what "Universal services" looks like.

- **Service User and Carer Engagement**: All of the above work streams have involved service user and carer engagement. Following the transition of Bridgend County Borough a Task and Finish group has been set up to look at a Service User and Carer Framework.

New - Cwm Taf Morgannwg.

On the 1st April 2019 Cwm Taf Morgannwg UHB was established with responsibility for providing healthcare for Bridgend County Borough, Merthyr Tydfil and Rhondda Cynon Taf County Boroughs.

The Together for Mental Health Partnership Board members and subgroups have engaged collectively to ensure that work undertaken to deliver against Welsh Government Delivery plan 2016/2019 has incorporated the Health Boards new footprint, as above.

This has been and still is an exciting time for us all in adapting best practice, innovative ways of working, and building collaborative relationships with both internal and external colleagues.

Service User and Carer Representative Framework
A task and finish group has been set up to look at developing a Service User and Carer representative framework across Cwm Taf Morgannwg foot print. Working co-operatively with Service User and Carers, Third Sector, UHB and Local Authority colleagues has enabled Service User and Carer representative to inform practices they want to see, which is developing more innovative ways of working.

Feedback from various partnership workshops:

- *"Interesting to be able to listen to others view points on how services should look".*
- *"Enjoyed networking, sharing ideas and open discussions".*
- *"Opportunity to talk to a range of people about services".*

Co-Production and Third Sector Involvement

From a number of service user engagement events and Welsh Ambulance Service Team feedback it was identified that there was no appropriate resource for signposting people experiencing mental health problems.

It was agreed that there was a need to develop some form of information leaflet. A task and finish team was set up which consisted of WAST, Service User Representatives and Third Sector Representatives to design a pan-Wales signposting leaflet for Mental Health Support Helplines.

A bilingual leaflet was produced and officially launch on World Mental Health Day in October 2019. The response and feedback to the leaflet has been incredibly positive with other statutory organisations (i.e. South Wales Police) looking to replicate the leaflet with their own logo.

Commissioner and Partner Engagement:

A Commissioning and Partner forum continues to take place within the Mental Health Directorate. Such forum has enabled fundamental and positive relationships with Third Sector colleagues, which enhances continued development and delivery of services for the people who use them. Meaningful dialog and outcomes are achieved through co-production and engagement.

Prior to the transition of services from Bridgend County Borough. Rhondda Cynon Taf and Merthyr Tydfil Mental Health Third Sector forum had developed an Action Plan to focus on priorities for the area. Such priorities identified were: Information, Advice and Assistance, Peer Support, Peer Mentoring and Counselling/Talking Therapies.

Since the transformation of New "Cwm Taf Morgannwg" the forum has increase the number of organisations involved, which now also includes colleagues from the Bridgend County Borough area.

Some of the many achievements to date:

- Partnership working across Cwm Taf Morgannwg.
- WAST, Service User Reps and Third Sector Reps co-produced leaflet for Mental Health Support Helpline.
- The forum supported with the wellbeing event that was led by Spectacle Theater and was delivered as part of Fest y Porth for World Mental Health day 2018.
- The Department of Work and Pensions worked with Third Sector Organisations to host a wellbeing event.

Third Sector support in:

- Mindfulness and stress control.
- Social prescribing.
- Information, advice and assistance resources that can be accessed online and at drop in centers.
- Peer support groups.
- Developing an outreach model to empower people to set up peer support groups using community venues.
- A variety counselling sessions.
- Talking therapies.
- Developing a cohort of Peer Mentors to co deliver courses for the Recovery College.

The services mentioned above are not exhaustive.

Good News stories - Service User Representatives

"One of the Together for Mental Health Partnership Board Service Users Representatives now delivers 'Who does what in Mental Health' as part of the recovery college".

The Mental health Directorate Care and Treatment Planning Training programme has been co- developed and is co-facilitated by a person with lived experience of Secondary Mental Health Services. The feedback from attendees of the training has been extremely positive.

" I have attended a lot of CTP training but never (before now) with a service user with experience of the process. This elevated the training and allowed person centred practice to be promoted."

Key Achievements and Impact – Children and Young People

The focus of the Children and Young Person's sub group of the Together for Mental Health Partnership Board has been the development of a Statement of Intent for support for children young people and their families. This has included getting approval from the relevant executive boards.

The statement of intent was consulted on and coproduced and after further discussion with children and young people further work is being facilitated with them to produce a system and structure of co-production and participation that will be embedded into the Children and Young Peoples sub group. The Children and young people's group with the agreed statement of intent has now got an agreed strategic direction and clarity of purpose. The third sector are equal partners within the Children and Young Peoples group.

We have ensured that the children and young people are included and are key components of the developments of the Together for Mental Health Partnership Board transformational agenda for Health and Social care.

The group have also been working on developing priorities for action and how to address some of the barriers and challenges for further joint working when commissioning services for children with complex needs, including emotional wellbeing and mental health. We have an agreed partnership approach to services delivery for children.

Primary Children and Adolescent Mental Health Services

Primary CAMHS operates against a target for 80% of young people to be seen for their initial assessment within 28 days of referral and for their intervention to begin within 28 days of this assessment. The service is currently not meeting the assessment target however the intervention target is consistently met, meaning that once young people enter the service they then quickly receive the intervention that they require.

The service has plans to achieve the assessment target by the end of April 2020. The total patients on the waiting list has reduced significantly since April 2019 and the longest wait has also reduced over time.

Specialist Children and Adolescent Mental Health Services

Specialist CAMHS operates against a target for 80% of young people to be seen within 28 days of referral. To-date there has been significant improvement in this performance during 2019/20, with the target currently being met and exceeded.

In July 2019 Together for Mental Health Partnership Board, had the privilege to listen to the young people from "Safer Merthyr Tydfil" presenting to the group the work their youth forum is involved in. There overarching aim was to, support the Youth Mayor pledge to raising awareness of Mental Health. The young people in Merthyr felt that mental health was an issue and that if young people had support early enough then this might help them. They therefore produced a Mental Health First Aid kit which has been widely distributed through schools and youth clubs. More details can be found in the link below:

https://www.youtube.com/watch?v=jxUTwZ7W2CM&feature=youtu.be

Key Achievements and Impact - Adults

Redesigning Community Mental Health Services

Through our ongoing redesign of adult community mental health services, involving extensive engagement with staff, partner agencies, service users and carers, we have developed a service model based on the principles of improved integration, a greater focus on prevention and earlier intervention, and a bio psychosocial approach. The new model reflects an increased emphasis on integrated support at 'universal' and local primary mental health service level, enabling secondary mental health services to offer more intense input to a smaller number of people with more complex needs.

We are working in partnership to ensure improved availability of, information about and access to services that promote and enhance emotional and mental wellbeing across our communities. This is being accompanied by a review of the current third sector commissioned services to ensure there is appropriate and equitable access to services at this level across Cwm Taf Morgannwg, and that the services provided are of good quality and can evidence good outcomes.

A key enabler to effect the shift to universal services is our investment in cluster based Mental Health Practitioners who offer mental health assessment, medication monitoring, advice and information within primary care, as well as connections to other appropriate services. Offering a rapid response to GP referrals, appointments can also be made directly with the Practitioners without the need to see the GP first. The Practitioners will also be able to refer directly to primary and secondary mental health services should they feel the patient is in need of more intensive and specialist mental health care and support. Funded initially via the Stay Well in Your Community Transformation Programme, ongoing funding will be secured through the Mental Health Transformation Fund and by shifting resources through anticipated released capacity in the LPMHSS/CMHT service.

In Bridgend, new mental health social work posts have been created that combine with existing NHS Local Primary Mental Health Support Services to provide a holistic approach to supporting citizens in Primary Mental Health Services. Previously specialist mental health Social Work support was only available in Secondary Care services but now this gap has been filled and an additional 182 citizens have received specialist mental health social work support since August 2018.

New Dementia Schemes Funded

Thanks to Welsh Government Dementia Integrated Care Funding, we have been able to fund some new schemes that are helping to improve the experience of people living with dementia, and their families. These schemes include:

Community Capacity Grant Scheme – supporting 10 third sector organisations to provide a range of activities and support networks for people living with dementia, their carers and families;

"I am 84 years old and I am currently living with dementia and diabetes. This group has allowed me to be me and has given me self-confidence and a new lease of life, where I laugh and meet new people".

"I feel like I achieve something at a time when my independence is difficult",

"I feel happy and confident and so rewarding helping other persons living with the same diagnosis".

Dementia Friendly Communities Co-ordinator – who has mapped what support services are available and, on identifying a gap, has set up a support group in Tonypandy;

Specialist Dementia Intervention Team (SDIT) – this team provides advice and support to care home staff on how to prevent and help manage behaviours that challenge. The team has now been expanded to provide support to families and carers looking after someone living with dementia in their own home.

Occupational Therapy Memory Assessment Team (OTMAS) – this team offers people pre and post diagnostic assessment of occupational and functional needs, and interventions via a Home Based Memory Rehabilitation programme. People receiving the service have reported increased independence, improved ability to carry out tasks at home and in the community, and increased use of apps that help with diary management and mental stimulation.

Dementia Care Matters – in Merthyr Tydfil in conjunction with Dementia Care Matters, a culture change project is underway to develop a model of care for day services that is truly person centred. People living with dementia, their carers, families and staff, have been involved in focus groups identifying what matters to them. This will also help to inform the redesign of the dementia day unit at Keir Hardie Health Park.

Integrated Day Services in Bridgend – specialist day services have been developed for people with complex needs who would be unable to access universal services within the community. They are supported to remain living at home by being offered meaningful daytime opportunities in a safe and supported environment, and timely multidisciplinary assessments to promote their well-being, support family choice and control and allow for pre-emptive intervention to maintain people and their well-being outcomes.

Dementia Link Service – in Bridgend the Dementia Link Service offers information, advice and support to people particularly in the early stages of dementia, including pre-diagnosis.

Dementia Action Plan Steering Group and Sub Groups

To oversee implementation of the Welsh Government's Dementia Action Plan across Cwm Taf Morgannwg, a multi-agency Steering Group and several sub groups have been established which also involve and ensure engagement with people living with dementia and their carers.

7 Service Improvement

Children Adolescent Mental Health Services, (CAMHS):
Has received significant investment to support service improvement. Partnership working with internal and external stakeholders will help support the implementation of expanding of the Crisis service – investment to allow the service to move from a 5 day model to 7 day working, which will have a significant benefit for patients presenting in crisis on weekends.

- Recruitment of workforce to support service demand.
- Support additional clinics.
- Introduction of a dedicated support line for professionals, to support individuals to been seen in the right services.
- ICF funding has been approved that will further enhance the liaison function of the Primary CAMHS team. The Local Authority are setting up a task and finish group to oversee implementation of this.

Mental Health Outpatients:
A key enabler for our redesign if community mental health services, is a redesign of our adult mental health outpatients service. This has involved a review of the role of consultant psychiatrists in care co-ordination, with a view to introducing a different skill mix thereby releasing consultant and senior psychiatrist capacity from outpatient clinics to enable them to instead provide expert support to Mental Health teams and other professions such as GPs. Improved partnerships with benefits agencies are also being explored to enable a clearer understanding and process for supporting patients to access benefits for which they are eligible, reducing reliance on outpatient services for such purposes

Early Intervention in Psychosis (EIP)
A working group has been established to develop services further within Cwm Taf Morgannwg. Working closely with clinical colleagues and other relevant partner agencies is ongoing. The aim is to develop a framework that takes existing patterns of service deliver and ensuring that clinical leadership and governance arrangements are in place. Whilst also taking into consideration national guidelines, assessment needs of our population and workforce requirements.

Psychological Therapies:
The Health Board has welcomed significant Welsh Government investment in mental health services this year via Psychological Therapies funding and the Mental Health Innovation and Transformation Fund. This funding is enabling us to improve the range of psychological therapies available, through appointment of additional therapists and developing a multidisciplinary psychologically informed and appropriately skilled workforce. The funding is also enabling improvements to the commissioning structure for mental health related Continuing Health Care, in order to ensure best use of this significant resource; develop local low secure and forensic services; advancing practice within adult inpatient care; enhancing community based support for people with dementia; and enhancing the local primary care Children and Adolescent Mental Health Service (CAMHS).

8 Future Directions

The revised All-Wales Together for Mental Health Delivery Plan for 2019-2022 is due to be published in late 2019 following the formal consultation process that took place over the summer. Once published the Board will arrange stakeholder workshop sessions to review and align priorities for the coming period, to inform future direction.

In the meantime partners within the Cwm Taf Morgannwg Together for Mental Health Partnership Board continue making progress addressing the local agreed priorities through multi-agency streams.

The CAMHS service is working towards closer integration of the Primary and Specialist CAMHS services to ensure seamless provision for young people. There is also significant investment in earlier intervention and liaison with professionals which is seen as key to ensure that mental health problems are responded to early in order to reduce the reliance on more specialist CAMHS services.

RHONDDA CYNON TAF COUNTY BOROUGH COUNCIL
MUNICIPAL YEAR 2019/20

HEALTH & WELLBEING SCRUTINY COMMITTEE

7TH JANUARY 2020

REPORT OF THE GROUP DIRECTOR, COMMUNITY & CHILDREN'S SERVICES

Agenda Item No: 4

DELAYED TRANSFERS OF CARE

Author: Neil Elliott, Director of Adult Services. Tel No. 01443 444603.

1. PURPOSE OF THE REPORT

1.1. This report has been prepared to update the Health and Wellbeing Scrutiny Committee on the performance of Delayed Transfers of Care (DTOC) in Rhondda Cynon Taf. This report also draws Scrutiny Committee's attention to the plans in place across health and social care for the winter pressures period to ensure continued focus on managing DTOC.

2. RECOMMENDATIONS

It is recommended that the Health and Wellbeing Scrutiny Committee:

2.1. scrutinise and comment on the information provided

2.2. consider whether there is any further information or matters contained in the report that the it wishes to receive and scrutinise in greater depth

3. REASONS FOR RECOMMENDATIONS

3.1. To provide the Health and Wellbeing Scrutiny Committee with an opportunity to examine the performance of DTOC and the plans in place to support the increased pressures placed on health and social care during the winter period.

4. BACKGROUND

4.1. As part of the Health and Wellbeing Scrutiny Committee work programme it is agreed that Committee receive regular updates on DTOC performance in Rhondda Cynon Taf.

4.2. A DTOC is defined as being experienced by an inpatient occupying a bed in an NHS hospital, who is ready to move on to their next stage of care usually in their own home or in a residential or nursing care in the community, but cannot be discharged from the hospital environment for one or more reasons. This can also be called bed blocking.

4.3. No-one wants to remain in hospital for any longer than they need to and after a stay in hospital, most patients need little or no onward care and are discharged timely. However, discharge planning for people often older people with complex support needs will, quite rightly, take longer and involves a multi-disciplinary response from both health and social care working alongside the person to achieve the ultimate goal for that person - going home. Therefore, tackling DTOC is an important task.

5. DTOC PERFORMANCE

5.1. The Social Services and Wellbeing (Wales) Act 2014 introduced a new performance measurement framework for local authorities in relation to their social services functions. As a result, new performance information requirements were introduced from 2016/17 and local authorities are required to collect a number of performance measures detailed in the Code of Practice in relation to social services performance issued under the Act, which includes "the rate of delayed transfers of care for social care reasons per 1,000 population aged 75 or over".

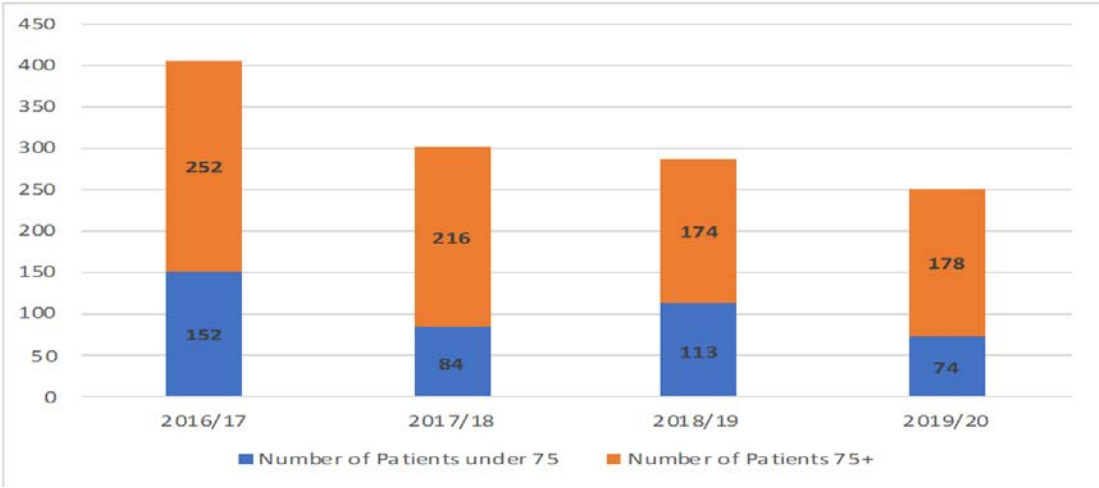
5.2. The table below shows Rhondda Cynon Taf and Wales average data for the national performance measure compared annually back to 2016/17.

	2016/17		2017/18		2018/19		2019/20 (Qtr 2)	
Performance Measure	**Wales**	**RCT**	**Wales**	**RCT**	**Wales**	**RCT**	**Wales**	**RCT**
The rate of delayed transfers of care for social care reasons per 1,000 population aged 75+	2.8	4.95	3.48	1.88	4.9	3.43	TBD	3.48

5.3. Whilst the rate of delayed transfers of care for social care reasons (per 1,000 population aged 75 or over) is increasing and mirroring the overall trend across Wales there has been an overall reduction in the number of delays since 2016/17 in Rhondda Cynon Taf.

5.4. Over the 3 years, from 2016/17 to 2018/19, Rhondda Cynon Taf has seen a steady decline in the number of people experiencing DTOC. The number of patients experiencing a delay has fluctuated, but overall there has been a 29% reduction. However, based on current performance, we are experiencing an increase in the number of delays in 2019/20, in line with the national trend, and in particular patients aged 75 and over.

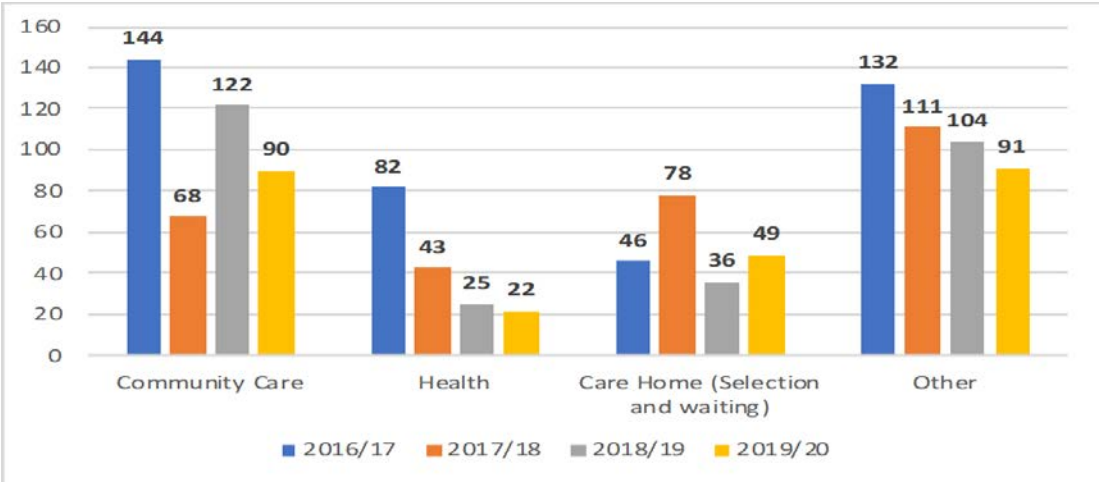
5.5. The graph below shows the total number of patients delayed between 2016/17 and 2019/20 (up to November 2019).



5.6. The reasons for a patient being a DTOC are varied and complex with over 120 different codes to classify them, although they can be summarised under the following broad headings:

- Community Care - which relates to social care assessment and care arrangements including housing, adaptations and equipment, and domiciliary care
- Health - like community care these would include reasons relating to assessment and care arrangements, including mental health
- Care Home - which includes care home placement choice and selection availability
- Other - which includes for example adult protection, mental capacity, disagreements, legal and financial related issues.

5.7. The graph below shows that the reduction over the 3 years from 2016/17 to 2018/19 was across all delay categories. However, as previously mentioned we are experiencing an increase in the number of delays in 2019/20 for health reasons and in relation to the selection of and waiting for a care home.



5.8. The causes of a DTOC are complex and many. However, we know from our analysis that patients have become more frail and require greater support on

discharge. The main reasons for the delays, in particular those being experienced in 2019/20, are summarised below:

- There continues to be high demand for home care as we successfully support people with more complex care packages to live at home rather than in a care home. This continues to put pressure on supply and capacity in some areas of the County Borough at “peak call” times. Providers continue to recruit staff in these areas, although this is being managed across care providers, through the Brokerage Team, to minimise impact on delays awaiting commencement of care packages. We continue to actively support and work with care providers to build capacity and resilience of the domiciliary care market. Support is provided by the local authority in-house Support @Home Service as a short term measure where there is a lack of capacity in the independent sector.

- There is reducing capacity across dementia care homes, in particular nursing care capacity i.e. those people with the most complex needs, which is adding pressure onto residential placements which require transfer to nursing. To reduce this risk, we have developed in partnership with Health the Specialist Dementia Team to support people with dementia and behaviours that challenge, and it provides training and support plans for staff. Capacity of the Team has been increased to meet an increase in demand for the services provided.

- Demand for assessment remains high. We continue to prioritise hospital discharges and we have used additional funding to increase social work support to both reduce the number of admissions to hospital and create some additional capacity to respond to hospital patients and reduce length of stay in hospitals and minimise delays in a person’s discharge from hospital.

- There is a growing number of cases that require referral to the Court of Protection (COP) to confirm ongoing care arrangements, in particular placement into a care home when the person is firmly stating they want to return home. Legal advice regarding our practice for referrals to the COP, confirms our actions are according to the Law; although this is causing delays for some patients.

- There is also an increase in demand for housing and housing related support, with a particular increase in demand for specialist and adapted housing. Work is being done to improve the supply of adapted housing with Housing Strategy and Housing Providers and ensure early identification of complex needs to ensure bespoke adaptations can be prioritised as early as possible to prevent delayed discharge. In addition, some people who are admitted to hospital when of no fixed abode are appropriately prioritised in the highest band but encountering delays when bidding via the choice based letting system as they wish to live in very high demand areas. We are working with Housing Strategy to review the process for these people to improve timely access to housing via the general needs register.

6. WINTER PRESSURES

Annual Winter Pressures and Preparedness Plan

6.1. Cwm Taf Morgannwg University Health Board (CTMUHB) is required to prepare and publish an annual Winter Pressures and Preparedness Plan in partnership with its local authority partners and the Welsh Ambulance Service Trust.

6.2. The plan predominantly focuses on the contingency plans that CTMUHB have in place to deal with periods of increased demand and inclement weather to ensure that they continue to deliver services during these periods. Locally the winter plan will be monitored via monthly planned joint Winter Pressures Meetings. However, during periods of increased demand the frequency of these meetings will increase.

6.3. Rhondda Cynon Taf's contribution to the plan focuses on the existing arrangements that support the hospital discharge process; primarily Stay Well @Home (SW@H).

6.4. As the Scrutiny Committee will be aware, Rhondda Cynon Taf, in partnership with Merthyr Tydfil and CTMUHB, have developed a multi-disciplinary team, SW@H based on the two acute hospital sites of Royal Glamorgan and Prince Charles. SW@H are primarily based at A&E but also support discharges from the Acute Medical Unit and Clinical Decision Unit, additionally supporting all wards as capacity dictates.

6.5. SW@H complements the existing discharge services already in place (e.g. the Health and Social Care Discharge Coordinators, the Psychiatric Liaison Service and Discharge Liaison Service and services provided by the Third Sector including Age Connects Morgannwg and Cwm Taf Care and Repair).

6.6. SW@H undertake a proportionate assessment and commission appropriate community services to support discharge home with the aim of supporting the individual at A&E to safely return home and avoid any unnecessary hospital admissions. They can commission a range of community responses such as Nursing @Home including the IV service and social care community package of support within 4 hours, 7 days a week. To support these arrangements the capacity of community services have been enhanced and access arrangements and eligibility criteria have been revised.

6.7. Rhondda Cynon Taf's domiciliary care Support @Home Service also supports discharge and hospital avoidance through:

- Providing a 4 hour response to referrals from the SW@H hospital based team and community professionals 7 days a week
- Providing Intermediate Care and Reablement Services including a duty Occupational Therapist response
- Community equipment out of hours
- Additional community based social workers

6.8. Health and Social Care Discharge Coordinators based at both the acute and community hospital sites support more complex discharges - supported by additional social worker capacity at the two community hospitals. The social workers attend multidisciplinary meetings, patient flow meetings and support timely discharges home.

6.9. SW@H continues to demonstrate measurable improvement on individual outcomes through enhanced communication and integration of health and social care services at the critical interface that occurs during presentation at A&E and hospital admission through to discharge. A copy of the SW@H evaluation highlight report for 2018/19 is attached as Appendix 1 for members perusal.

6.10. Further development of SW@H is planned for later in 2019/20 with the planned role out of phase 2 from January 2020, as part of the Welsh Government's Transformation Fund announced in the Summer.

6.11. SW@H phase 2 aims to further support hospital avoidance - Rhondda Cynon Taf (and Merthyr Tydfil) will extend the Single Point of Access opening hours from 8.30am to 5.00pm (5 days a week) to 8.30am to 8.00pm (7days per week), including bank holidays.

6.12. Access to services such as CTMUHB @home nursing, local authority commissioned enabling services and community equipment, will be provided to community professionals such as GP, GP out of hours, Welsh Ambulance Service Trust, District Nurses and Social Care Emergency Duty Teams to provide services as an alternative to avoid conveyance to hospital.

6.13. The Transformation Fund is also supporting Rhondda Cynon Taf to develop a new model for Assistive Technology to be implemented from January 2020, which will include:

- a 24 hour mobile response service to support people in their own homes by responding to non-medical emergencies such as falls, supporting hospital avoidance and reducing conveyances to hospital

- as proof of concept a proactive outbound calling system to support those at risk in the community and to prevent crisis response.

Additional Winter Pressures Funding

6.14. In September 2019, in recognition of the ongoing challenges across the health and social care system, the Minister for Health and Social Services agreed a package of £30 million to support delivery of health and social care services over the remainder of 2019/20, with a particular focus on winter. Of which,

- £17 million has been allocated to Regional Partnership Boards (RPB) to administer and should promote integrated, regional planning across health and social care services, through joint decision making and formal agreement via RPBs.

For Cwm Taf Morgannwg RPB, the allocation amounts to £2.7 millon, allocated per organisation to focus on community based solutions as follows:

Bridgend	£850,000
Merthyr Tydfil	£330,500
Rhondda Cynon Taf	£1,300,000
CTMUHB (community wide)	£270,000

- £10 million has been made directly available to local health boards to support immediate action and support delivery of integrated winter delivery plans, alongside the ambulance service, local authority and third sector partners.

  For CTMUMB, the allocation amounts to £1.6 million.

- £3 million has been retained centrally by Welsh Government to target funding for nationally agreed priorities.

6.15. This funding is being made available earlier than ever before and reflects the unrelenting pressure being experienced by services across the whole system. Welsh Government have been clear that this funding must be used to target action against the following key themes identified for winter, or related action to support improved flow through the health and social care system that will optimise patient experience and outcomes:

- Optimising cross organisational and sector working
- Urgent primary care out of hours resilience
- Preventing unnecessary conveyance and admission to hospital
- Discharge to assess/ recover (D2AR)
- Community step down capacity
- An enhanced focus on the respiratory pathway
- An enhanced focus on frailty pathway

6.16. These themes are focused on enabling at-risk and vulnerable populations to remain at home or in their community through integrated action and promoting flow through the system to enable people to leave hospital when they are ready to do so, with any ongoing care or support they require in place. Delivery of these actions should strengthen resilience for the winter period.

6.17. In terms of Rhondda Cynon Taf, it has been agreed that the additional £1,300,000 funding allocated through the RPB be used to facilitate hospital discharge and prevent admission and provide additional:

- interim placements
- intermediate care and reablement capacity
- domiciliary care capacity

- social work assessment capacity at the hospital interface
- community occupational therapist capacity

6.18. The CTMUHB will also provide additional district nurse, GP out of hours and mental health practitioner capacity from its RPB allocation.

7. EQUALITY AND DIVERSITY IMPLICATIONS

7.1. This is an information report - there are no equality and diversity implications associated with this report.

8. CONSULTATION

8.1. This is an information report - there is no consultation required for this report.

9. FINANCIAL IMPLICATION(S)

9.1. This is an information report - there are no financial implications aligned to this report.

10. LEGAL IMPLICATIONS OR LEGISLATION CONSIDERED

10.1. This is an information report – none at present

11. LINKS TO THE CORPORATE AND NATIONAL PRIORITIES AND THE WELLBEING OF FUTURE GENERATIONS ACT

11.1. This report supports two of the Council's corporate priorities, namely:

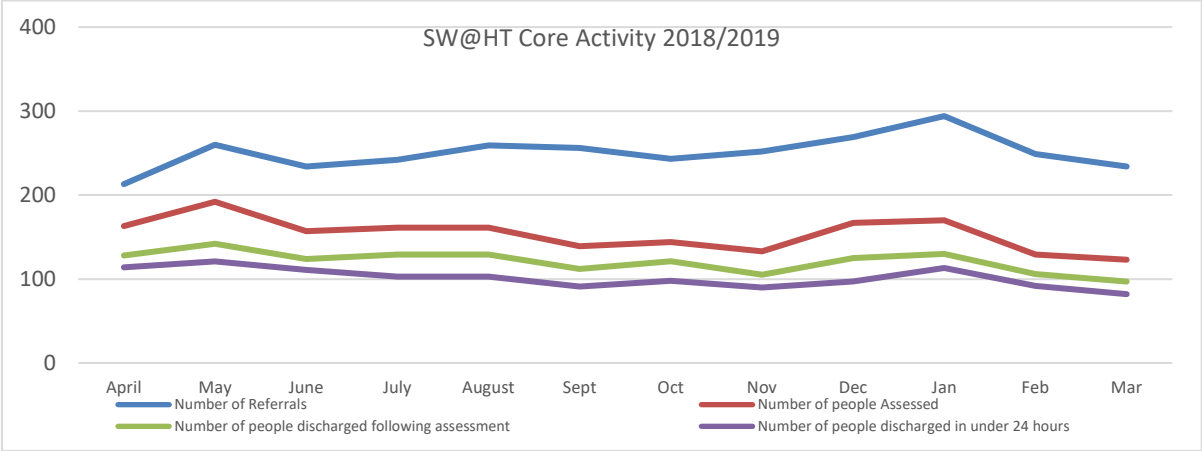
- People - promoting independence and positive lives for everyone
- Living within our means - where services are delivered efficiently to achieve value for money for the taxpayer

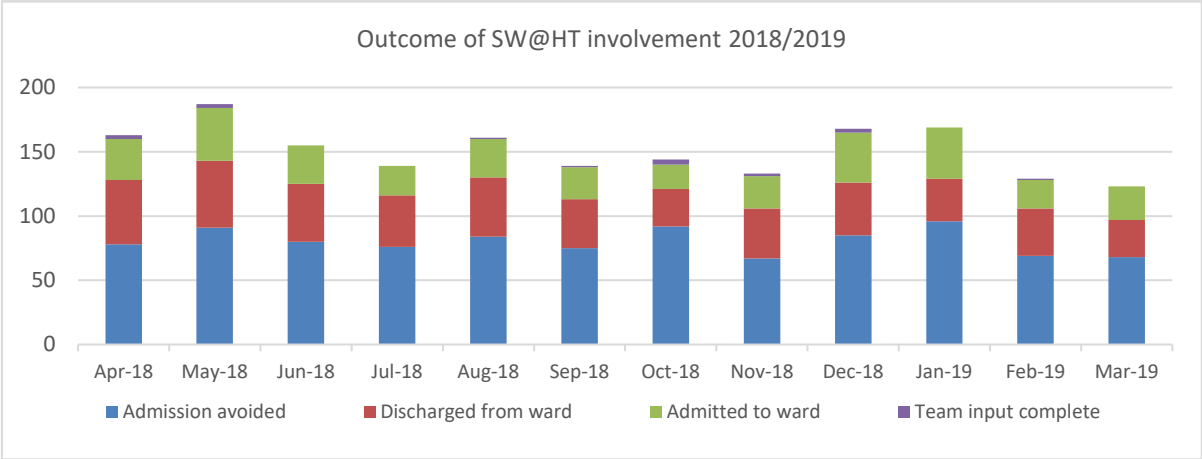
12. CONCLUSION

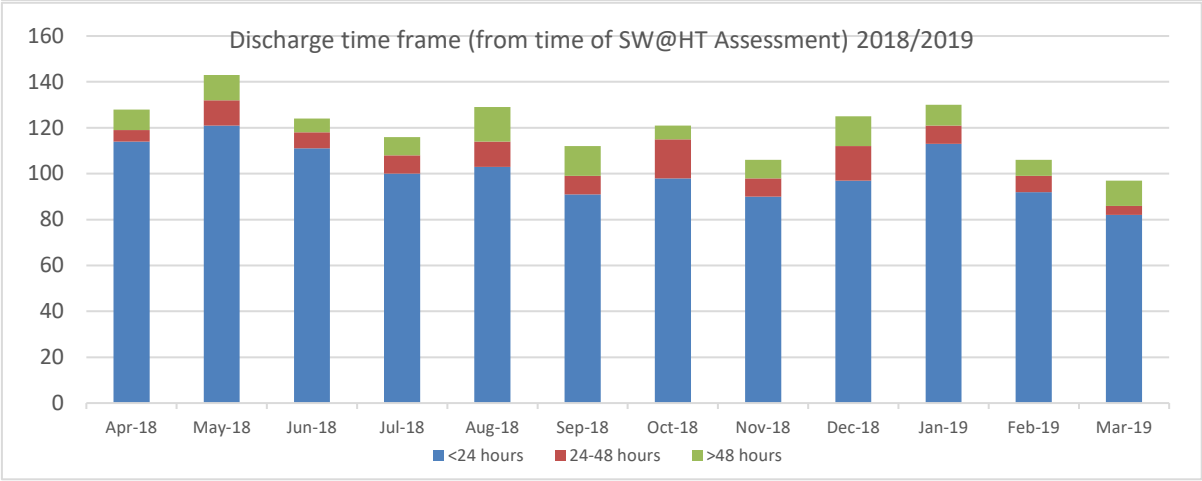
12.1. This report aims to update Scrutiny Committee on DTOC performance and the plans in place to support the increased pressures placed on health and social care during the winter period.

Stay Well @ Home Team - Highlight RBA report: 2018/2019

	2018/2019	Compared to 2017/2018
Total Number of referrals	3005	13% ↓
Total number of assessments completed	1870 (62%)	8% ↓
Number of referrals responded to in less than 1 hour	1532 (82%)	3% ↑
Number of those discharged home	1435 (77%)	6% ↑
Number of those discharged home in less than 24 hours following assessment by SW@HT	1212 84%	5% ↑
Number of social care packages of support	738 (51%)	8% ↑
Support@ Home	664 (46%)	7% ↑
Initial Response	74 (5%)	1% ↑
Number of referrals to Nursing @ Home (4Hr response)	12 (1%)	↔
Number of @Home referrals	132 (9%)	119 ↑
Number of referrals to YMS@H	51 (4%)	No comparable 12 month data
Total Number of community based services commissioned to support discharge	2610	2501 ↑
Number of unmet needs captured	311	352 ↓
Service User experience - (Voting Button & Survey comments)	98% ☺	No comparable 12 month data







RHONDDA CYNON TAF COUNTY BOROUGH COUNCIL
MUNICIPAL YEAR 2019/20

HEALTH & WELLBEING SCRUTINY COMMITTEE **7TH JANUARY 2020** **REPORT OF THE GROUP DIRECTOR, COMMUNITY & CHILDREN'S SERVICES**	**Agenda Item No: 5** **MOTOR NEURONE DISEASE (MND) CHARTER**

Author: Neil Elliott, Director of Adult Services. Tel No. 01443 444603.

1. PURPOSE OF THE REPORT

1.1. This report has been prepared at the request of the Health and Wellbeing Scrutiny Committee to provide Members with an overview of the Motor Neurone Disease (MND) Charter in order to consider the most practical way to adopt the aims of the Charter across the Rhondda Cynon Taf.

2. RECOMMENDATIONS

It is recommended that the Health and Wellbeing Scrutiny Committee:

2.1. scrutinise and comment on the information provided

2.2. consider whether there is any further information or matters contained in the report that it wishes to receive and scrutinise in greater depth

2.3. consider whether there are recommendations that it wishes to make to improve what the Council and its partners can do to support those living with autism in Rhondda Cynon Taf

3. REASONS FOR RECOMMENDATIONS

3.1. At its meeting on 9th July 2019, the Health and Wellbeing Scrutiny Committee requested an overview of an overview of the MND Charter in order to adopt the aims of the Charter across the Rhondda Cynon Taf, following adoption of a notice of motion at the Council meeting on 6th March 2019.

4. MOTOR NEURONE DISEASE (MND)

4.1. MND is a rare and progressive illness that affects a set of nerves in the brain and spinal cord called Motor Neurones.

4.2. 'Motor Neurones' control important muscle activity such as gripping, walking, speaking, swallowing and breathing. When a person has MND, the motor

neurones controlling these actions stop working properly leading to muscle weakness and wasting which can consequently affect the way a person walks, talks, eats, drinks and breathes.

4.3. There are many symptoms of MND. Not everyone with MND will experience every symptom listed, and there is no set order in which the symptoms may appear:

- Weakness and loss of movement in limbs
- Twitching sensation in muscles (fasciculations)
- Fatigue
- Difficulties with speech
- Swallowing difficulties
- Occasionally, people with MND may experience mild cognitive changes (in thinking, behaviour, etc.)
- Occasionally, people may experience emotional lability - involuntary or disproportionate emotional displays

4.4. MND affects people from all communities and in a person's lifetime the risk of developing MND is 1 in 300 people. It affects up to 5,000 adults in the UK at any one time and on average 6 people are diagnosed every day with the same number losing their lives each and every day. There is currently no cure. MND kills a third of people within a year and more than half within two years of diagnosis.

4.5. The cause of MND is currently unknown. MND usually occurs in people with no family history of the disease, though a small percentage of cases may be inherited. In most cases it is thought that a mix of genetic and environmental triggers are involved although genes may play the smaller role. MND affects adults, but is a rare condition. It usually affects people between the ages of 50-70, though some older and some younger adults are sometimes diagnosed. Men are twice as likely to have MND as women, though this evens out with age.

5. MOTOR NEURONE DISEASE (MND) CHARTER

5.1. The Motor Neurone Disease Association (MNDA) is the only national charity in England and Wales and Northern Ireland focused on MND care, research and campaigning.

5.2. The MNDA have developed an MND charter setting out how everyone with a connection to MND, either personally or professionally, should recognise and respect the rights of people with MND and work towards the Charter's vision of the right care. The charter can be found at Appendix 1.

5.3. The MND charter has identified 5 key areas:

- The right to an early diagnosis and information
- The right to access quality care and treatments
- The right to be treated as individuals and with dignity and respect

- The right to maximise their quality of life
- Carers of people with MND have the right to be valued, respected, listened to and well supported

5.4. The detail under the five points illustrate what good care looks like for people with MND and their carers. These details can be found in the Charter document attached at Appendix 1.

5.5. The Charter was created to help raise awareness and campaign to improve services for people with MND and their carers at the local level. To make sure everyone understands and respects the rights of people with MND and their carers so they are given the very best opportunity to access the care they need to live the highest quality of life possible, and achieve dignity in death. Ultimately, it aims to support work towards achieving the vision of the right care, in the right place, at the right time for people with MND and their carers.

5.6. The Charter has helped raise awareness of MND and 33,630 individuals and organisations have signed up to the Charter. It has led to work with health and social care professionals, national and local politicians and organisations, including councils, to improve services for people with MND and their carers.

6. SOUTH WALES MOTOR NEURONE DISEASE CARE NETWORK

6.1. There is no cure for MND, although proactive care and support can improve quality of life. Many people living with MND and their families are fearful of what will happen as their illness progresses.

6.2. Specialised services for people living with MND and their families were limited prior to 2012. The previous model of a Care Centre with two specialist nurses in Cardiff resulted in areas of good care, but also areas of patchy and poorly coordinated care across South Wales. Many people living with MND had no access to specialist input and their needs were not met in a coordinated or timely fashion, resulting in reduced quality of life.

6.3. A network model of care has been developed and implemented with support from the MNDA. The new model involves building on established links between key professionals from relevant specialties and professions, and forging new links across primary, secondary and tertiary care, across statutory and voluntary sectors, across health and social care, and across community and hospital settings. Twelve multi-disciplinary clinics have been established across South Wales since 2013. These clinics effectively provide a 'one stop shop' for people living with MND, reducing the amount of time spent at appointments, reducing medicalisation of their disease and giving people living with MND more time to 'live with MND' rather than 'die from MND'.

6.4. A service is now offered to all people living with MND in South Wales, including initial assessment by a care coordinator at home, providing information and support following diagnosis, and 3 monthly appointments at one of the 12 MDT clinics held across South Wales.

6.5. The Cwm Taf area Clinic takes place Every third Monday of the month (by appointment) at Ysbyty Cwm Cynon, Mountain Ash.

7. THE APPROACH OF SCRUTINY - GATHERING EVIDENCE

7.1. To support the Committee to develop its understanding of the challenges and experiences of people living with MND and their families in Rhondda Cynon Taf, Members are asked to consider what evidence they may wish to consider receiving as part of this matter. This might include hearing from service delivery leads from a health and MND Care Network.

7.2. Members are also asked to consider if there would be value in hearing the views and direct experiences of people living with MND and their families, either from individuals or through support groups or organisations with represent them.

7.3. Members may wish to utilise a varied of methods to gather this evidence, including a public 'call to action' to secure this information to support the future work of the committee in respect of this matter.

7.4. In taking this approach, members are asked to consider:

- What do we want to achieve?
- What do we know/need to know?
- What are we going to ask about?

8. EQUALITY AND DIVERSITY IMPLICATIONS

8.1 This is an information report - there are no equality and diversity implications associated with this report.

9. CONSULTATION

9.1 This is an information report - there is no consultation required for this report.

10. FINANCIAL IMPLICATION(S)

10.1 This is an information report - there are no financial implications aligned to this report.

11. LEGAL IMPLICATIONS OR LEGISLATION CONSIDERED

11.1 This is an information report – none at present

12. LINKS TO THE CORPORATE AND NATIONAL PRIORITIES AND THE WELL-BEING OF FUTURE GENERATIONS ACT

12.1 The Scrutiny Working Group report links to the Council's Corporate Plan Priority People – 'Promoting independence and positive lives for everyone'.

13. CONCLUSION

13.1 This paper seeks to give Scrutiny Committee an overview of the Motor Neurone Disease Charter in order for it to consider the most practical way to adopt the aims of the Charter across the Rhondda Cynon Taf.

mnda
motor neurone disease
association

CHAMPION THE CHARTER ON YOUR DOORSTEP

themndcharter

Achieving quality of life, dignity and respect for people with MND and their carers

The MND Charter is a statement of the respect, care and support that people living with motor neurone disease (MND) and their carers deserve, and should expect.

We believe that everyone with a connection to MND, either personally or professionally, should recognise and respect the rights of people with MND as set out in the Charter, and work towards the Charter's vision of the right care, in the right place at the right time.

About MND:

- MND is a fatal, rapidly progressing disease that affects the brain and spinal cord.
- It can leave people locked in a failing body, unable to move, talk and eventually breathe.
- A person's lifetime risk of developing MND is up to one in 300.
- It kills around 30% of people within 12 months of diagnosis, more than 50% within two years.
- It affects people from all communities.
- It has no cure.

Therefore, what matters most is that people with MND receive a rapid response to their needs and good quality care and support, ensuring the highest quality of life as possible and the ability to die with dignity. The MND Charter serves as a tool to help make this happen.

MND is a devastating, complex disease and particularly difficult to manage. We believe that if we get care right for MND we can get it right for other neurological conditions, and save public services money in the long run. But more importantly, we can make a positive difference to the lives of people with MND, their carers and their loved ones.

1 People with MND have the right to an early diagnosis and information

THIS MEANS:

- An early referral to a neurologist.
- An accurate and early diagnosis, given sensitively.
- Timely and appropriate access to information at all stages of their condition.

There is no diagnostic test for MND – it can only be diagnosed by ruling out other neurological conditions. People with MND can be halfway through their illness before they receive a firm diagnosis.

GPs need to be able to identify the symptoms and signs of a neurological problem and refer directly to a neurologist in order to speed up diagnosis times for MND.

Appropriate tests must be carried out as soon as possible to confirm MND. The diagnosis should be given by a consultant neurologist with knowledge and experience of treating people with MND[1]. The diagnosis should be given sensitively, in private, with the person with MND accompanied by a family member/friend and with time to ask questions. A follow-up appointment with the neurologist should be arranged soon after diagnosis.

At diagnosis people with MND should be offered access to appropriate information and should be informed about the MND Association. Appropriate information should be available at all stages of the person's condition in a language of their choice.

2 People with MND have the right to high quality care and treatments

THIS MEANS:

- Access to co-ordinated multidisciplinary care managed by a specialist key worker with experience of MND.
- Early access to specialist palliative care in a setting of their choice, including equitable access to hospices.
- Access to appropriate respiratory and nutritional management and support, as close to home as possible.
- Access to the drug riluzole.
- Timely access to NHS continuing healthcare when needed.
- Early referral to social care services.
- Referral for cognitive assessment, where appropriate.

People with MND may need care provided by health and social care professionals from up to 20 disciplines. This clearly needs co-ordination to work effectively. Co-ordinated care can improve the quality of life of people with MND and provide value for money for the NHS by preventing crises and emergency hospital admissions. The care should be co-ordinated by a specialist key worker with experience of MND who can anticipate needs and ensure they are met on time. Ongoing education for health and social care professionals is important to reflect advances in healthcare techniques and changes in best practice.

A third of people with MND die within 12 months of diagnosis. Early access to specialist palliative care[2] soon after diagnosis is therefore vital and should be available in a setting of the person's choice. Some hospices give preferential access to people with a cancer diagnosis. It is important that access is based on need, not diagnosis, so that people with MND have equitable access to hospice care. Hospices can

provide high-quality respite care, which can benefit both the person with MND and their carer.

As MND progresses, the respiratory muscles and muscles of the mouth and throat may be affected. People with MND may therefore need respiratory and nutritional support. It is important that these services are available as close to the person's home as possible so that travelling is minimised and support is available quickly.

In 2001 the National Institute for Health and Care Excellence (NICE) recommended riluzole as a cost-effective drug for people with MND. GPs can be reluctant to prescribe riluzole on cost grounds, despite its NICE-approved status, or to monitor for side effects during its use. However, it is vital that people with MND have ongoing access to this important treatment.

As the disease progresses, people with MND may need more intensive health care. It is important that people with MND have timely access to NHS continuing healthcare when they need it.

People with MND are likely to need help with getting up, washing, dressing and preparing food as the disease progresses. Access to social care services is therefore important to maintain quality of life. People with MND may also need access to cognitive assessment, as up to half of people with the disease experience changes in cognition.

3 People with MND have the right to be treated as individuals and with dignity and respect

THIS MEANS:

- Being offered a personal care plan to specify what care and support they need.
- Being offered the opportunity to develop an Advance Care Plan to ensure their wishes are met, and appropriate end-of-life care is provided in their chosen setting.
- Getting support to help them make the right choices to meet their needs when using personalised care options.
- Prompt access to appropriate communication support and aids.
- Opportunities to be involved in research if they so wish.

Everyone with MND should be offered a personal care plan[3] to specify what care and support they need. The plan should be regularly reviewed as the disease progresses and the person's needs change.

People with MND should be offered the opportunity to develop an Advance Care Plan[4] to make clear their wishes for future care and support, including any care they do not wish to receive. The plan should be developed with support from a professional with specialist experience and may include preferences for end-of-life care.

Some people with MND will need support to help them make the right choices to meet their needs when using personalised care options, such as personal budgets.

As the disease progresses, some people with MND will experience difficulty speaking. It is important that people with MND can access speech and language therapy to help them maintain their voice for as long as possible. However, as the disease progresses, people with MND may need access to communication aids including augmentative and alternative communication (AAC)[5]. The ability to communicate is a basic human right. For people with MND, communication support and equipment are vital in order to remain socially active and to communicate their wishes about their care, especially during hospital stays and other medical environments.

Many people with MND value the opportunity to be involved in research as it provides hope that one day an effective treatment will be developed. Everyone with MND who wishes to should be able to participate in research as far as is practicable.

4 People with MND have the right to maximise their quality of life

THIS MEANS:

- Timely and appropriate access to equipment, home adaptations, environmental controls, wheelchairs, orthotics and suitable housing.
- Timely and appropriate access to disability benefits.

People with MND may find their needs change quickly and in order to maximise their quality of life, they may need rapid access to equipment, home adaptations, wheelchairs and suitable housing. These needs should be anticipated so that they are met in a timely way. This is particularly true of wheelchairs which are important for maximising independence and quality of life.

People with MND need timely and appropriate access to disability benefits to help meet the extra costs of living with a disability. Information on appropriate benefits needs to be readily accessible in one place and easily understandable.

5 Carers of people with MND have the right to be valued, respected, listened to and well supported

THIS MEANS:

- Timely and appropriate access to respite care, information, counselling and bereavement services.
- Advising carers that they have a legal right to a Carer's Assessment of their needs[1], ensuring their health and emotional well being is recognised and appropriate support is provided.
- Timely and appropriate access to benefits and entitlements for carers.

Caring for someone with MND is physically and emotionally demanding. Carers need to be supported in order to maintain their caring role. Every carer should have their needs assessed and given timely and appropriate access to respite care, information, counselling and bereavement services. It is important to support the emotional and physical needs of the carer in a timely way so that they can continue their caring role.

Carers should also have timely and appropriate access to benefits and entitlements to help manage the financial impact of their caring role.

[1] Recomendation in the NICE guideline on MND.

[2] Specialist palliative care – palliative care is the active holistic care of patients with progressive illness, including the provision of psychological, social and spiritual support. The aim is to provide the highest quality of life possible for patients and their families. Specialist palliative care is care provided by a specialist multidisciplinary palliative care team.

[3] Personal care plan – a plan which sets out the care and treatment necessary to meet a person's needs, preferences and goals of care.

[4] Advance care plan – a plan which anticipates how a person's condition may affect them in the future and, if they wish, set on record choices about their care and treatment and/or an advance decision to refuse a treatment in specific circumstances so that these can be referred to by those responsible for their care or treatment (whether professional staff or family carers) in the event that they lose capacity to decide or communicate their decision when their condition progresses.

[5] Augmentative and Alternative Communication (AAC) – is used to describe the different methods that can be used to help people with speech difficulties communicate with others. These methods can be used as an alternative to speech or to supplement it. AAC may include unaided systems such as signing and gesture as well as aided systems such as low tech picture or letter charts through to complex computer technology.

"Many people with MND die without having the right care, not having a suitable wheelchair, not having the support to communicate.

We have got to set a standard so that people like us are listened to and treated with the respect and dignity we deserve.

We have got to stop the ignorance surrounding this disease and have to make sure that when a patient is first diagnosed with MND, they must have access to good, co-ordinated care and services.

One week waiting for an assessment or a piece of equipment is like a year in most people's lives, because they are an everyday essential to help us live as normal a life as possible and die with dignity"

Liam Dwyer, who is living with MND

For more information:

www.mndassociation.org/mndcharter

Email: campaigns@mndassociation.org

Telephone: 020 7250 8447

We are proud to have the following organisations supporting the MND Charter:

Royal College of General Practitioners

Association of British Neurologists

Royal College of Nursing

Chartered Society of Physiotherapy

College of Occupational Therapists

Royal College of Speech & Language Therapists

British Dietetic Association

MND Association
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www.mndassociation.org

Registered charity no 294354

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