



## **SOCIAL CARE, HEALTH AND HOUSING CABINET BOARD (SPECIAL)**

***Immediately Following the Joint Social Care Health and Housing and  
Children Young People and Education Scrutiny Committee on  
THURSDAY, 23 FEBRUARY 2017***

**COUNCIL CHAMBER - PORT TALBOT CIVIC CENTRE**

### **PART 1**

1. To agree the Chairperson for this Meeting.
2. To receive any declarations of interest from Members.

### **To receive the Report of Director of Social Services, Health and Housing**

3. Western Bay Population Assessment (*Pages 3 - 114*)

**S.Phillips  
Chief Executive**

**Civic Centre  
Port Talbot**

**Friday, 17 February 2017**

### **Cabinet Board Members:**

**Councillors:** J.Rogers and P.D.Richards

**Notes:**

- (1) *If any Cabinet Board Member is unable to attend, any other Cabinet Member may substitute as a voting Member on the Committee. Members are asked to make these arrangements direct and then to advise the committee Section.*
- (2) *The views of the earlier Scrutiny Committee are to be taken into account in arriving at decisions (pre decision scrutiny process).*

## SOCIAL CARE, HEALTH AND HOUSING CABINET BOARD

23 FEBRUARY 2017

### REPORT OF THE DIRECTOR OF SOCIAL SERVICES, HEALTH AND HOUSING – N. JARMAN

#### Matter for Decision

**Wards Affected:** All

#### WESTERN BAY POPULATION ASSESSMENT

##### 1. Purpose of Report

- a) To approve the Western Bay Population Assessment.
- b) To authorise the Director of Social Services, Health and Housing to publish a link to the Population Assessment on the Council's website.
- c) To authorise the City and County of Swansea to submit the Population Assessment to Welsh Ministers on behalf of the three local authorities and the health board in the Western Bay region.
- d) To commend the above to Council for approval

##### 2. Executive Summary

- The Social Services and Wellbeing (Wales) Act 2014 requires that local authorities and local health boards must jointly carry out an exercise known as a Population Assessment.
- The purpose of the Population Assessment is to create an evidence base that will support the delivery of the statutory functions on both organisations and also inform planning and operational decisions.
- There is detailed statutory guidance which governs how population assessments should be developed and the minimum content that each should contain.
- The Assessment must be published in the form of a regional report but within the report the situation for each local area must be set out.

- The first Assessment must be completed, approved and published by 31<sup>st</sup> March 2017.

The report for the Western Bay area consists of three layers of detail:

- A suite of web-pages designed to provide a high level summary of care and support needs, services and key issues for the Western Bay area;
- A suite of downloadable documents ('chapters') which provides a more detailed description of arrangements;
- A suite of technical reports which contain the evidence and analysis that the two other products are based upon.;
- The Population Assessment will be used to develop a Plan by the Regional Partnership Board for developing services across the Western Bay Region;
- The Population Assessment is also part of the evidence being collated by the Public Services Board in developing the Wellbeing Assessment which will be presented to Council on 15<sup>th</sup> March 2017.

### **3. Legislation**

Section 14 of the Social Service and Wellbeing (Wales) Act 2014 requires that local authorities and Local Health Boards must jointly carry out an assessment of the needs for care and support, and the support needs of carers in the Local Authority's area.

This assessment must also identify:

- a) the extent to which those needs are not being met
- b) the range and level of services required to meet those needs
- c) the range and level of services required to deliver the preventative services required in section 15 of the Act; and
- d) how these services will be delivered through the medium of Welsh

### **4. Purpose of the Population Assessment**

The purpose of the population assessment is to ensure that Local Authorities and Local Health Boards jointly produce a clear and specific evidence base in relation to care and support needs and carers' needs to underpin the delivery of their statutory functions and inform planning and operational decisions. This will ensure

services are planned and developed in an efficient and effective way by public sector partners to promote the well-being of people with care and support needs.

The population assessment will drive change, including by enabling both local authorities and Local Health Boards to focus on preventative approaches to care and support needs. It will provide the information required to support resource and budgetary decisions; ensuring services and outcomes are targeted, sustainable, effective and efficient. It will underpin the integration of services and particularly support the duties set out in Part 9 of the Act.

## **5. Links to other Strategic Planning Arrangements**

The Population Assessment must be taken into account by Public Services Boards when preparing the Wellbeing Assessments required by the Wellbeing of Future Generations (Wales) Act 2015.

The Population Assessment must inform and be informed by the Integrated Medium Term Financial Plans prepared by Health Boards as well as linking to other relevant key plans, such as housing and homelessness plans.

## **6. Approval and Publication Requirements**

A single regional report must be prepared for the Western Bay area and that report must be approved by the Board of the ABMU Health Board and the full Council meetings of each of the constituent Local Authorities.

Upon completion, assessment reports must be published on the websites of all Local Authorities and Local Health Boards involved in their production. A copy of the population assessment report must also be sent to Welsh Ministers at the time of publication. This function can be delegated to the lead co-ordinating body, who in this case is the City & County of Swansea.

The population assessment report should be drafted using accessible language so that it can be considered by members of the public. It is important the assessment report explains clearly how the local authorities and the Local Health Board have arrived at their decision in relation to the needs identified and the level of services required to meet those needs.

The report must be published by 31<sup>st</sup> March 2017.

## **7. Overview of arrangements established to prepare the Population Assessment**

A steering group, chaired by the Director of Public Health, Sara Hayes, was established to prepare the Population Assessment with members drawn from the three Local Authorities, the Health Board, Public Health Wales and the Councils for Voluntary Service.

- I. A detailed, technical level of data in the form of topic papers;
- II. Summaries of the topic papers available in downloadable format;
- III. A suite of web pages drawing out the headlines of the assessment.

In line with the statutory guidance produced by Welsh Government, each level of data has been structured in accordance with core themes:

- Learning disabilities/Autism
- Mental health
- Health/ Physical disability
- Sensory impairment
- Carers
- Violence against women, domestic abuse and sexual violence
- Secure Estate
- Older people
- Children and Young People
- Safeguarding

Additionally, there is an introductory section explaining the purpose of the Population Assessment and its limitations, together with resource sections which provide high level context for the delivery of health and social care, making reference particularly to financial and workforce arrangements.

## **8. Developing the Topic Papers ('technical reports')**

A Data Sub-Group developed the technical level of detail for the assessment in the form of topic papers. Data collection was structured to provide consistency across the core themes. Topic papers were developed for each local authority area and drew on a range of published statistical data as well as qualitative and quantitative data held by partner organisations. Where possible, service managers were involved in providing or confirming the data collection and the interpretation placed on the data collected.

At the conclusion of the data collection phase, 10 individual topic papers had been produced. It is not intended that these are "published" but they can be made available on demand as technical reports. Final formatting of the topic papers is currently taking place.

## **9. Incorporating the voice of service users and carers and wider stakeholders**

The statutory guidance emphasises the importance of ensuring citizens and wider stakeholders can contribute to the development of the Population Assessment.

An Engagement Sub-Group was formed to explore how this requirement could be accommodated within the timescale of the project. It was identified that work was being undertaken in parallel by the three Public Services Boards across the Western Bay region to engage with a wide range of stakeholders to explore their perceptions of wellbeing, as part of the requirements for the Wellbeing of Future

Generations (Wales) Act 2015. Arrangements were made to incorporate questions relating to the wellbeing of people who need care and support and their carers in that exercise. Additionally, the research contract – that was awarded to Miller Research Ltd., following a competitive bidding exercise – provided for all secondary research available across the Western Bay area which contained information about the wellbeing of people with care and support needs and carers to be analysed.

The research report prepared by Miller Research Ltd., summarises the findings of both the primary research conducted by the company and the secondary research evidence made available by the partners who have participated in this exercise.

The Western Bay Regional Citizen's Panel has received updates about the Population Assessment, as it has been developed and the final report will be shared with the Regional Citizen's Panel as the principal engagement mechanism for receiving feedback on the report and its findings. The ABMU HB Stakeholder Reference Group has also been part of the engagement exercise. Any feedback from the Regional Citizen's Panel and the SRG will be collated and worked into future iterations of the Population Assessment and will inform the Area Plan.

## **10. Developing the Regional Report**

The regional report has been produced as a digital output, supported by other formats to meet the accessibility requirements in the guidance. Essentially, the top level of the report is a suite of webpages which attempts to convey a straightforward and accessible account of:

- a) the needs of people for care and support across the Western Bay region;
- b) the range of services in place to meet those needs; and
- c) the factors that will need to be planned for in the next period.

The webpages are structured according to the core themes, with the addition of the introductory and resource sections referenced earlier in this report.

Bridging the gap between the high level web pages and the more detailed technical topic papers are a set of downloadable summaries, or chapters. There is a chapter summary for each core theme which brings together the three detailed topic papers for each core theme, adopting an easy to read format.

Both the webpages and the downloadable summaries are available in Welsh and English and there will be audio book and other formats made available, where appropriate, to ensure adherence to the guidance regarding accessibility, which also takes into account policies partner organisations have in place for their public information.

The task of preparing both the webpages and the downloadable summaries was overseen by an Editorial Sub-Group. Essentially, the work involved drawing out the main themes from the technical documents produced by the Data Sub-Group and the findings of the Engagement Sub-Group. An external provider was engaged to create the web resources as there was no resource available from

within partner organisations to undertake this aspect of the work. Draft outputs were reviewed and signed off by the Editorial Group members.

The web pages can be accessed here:

<http://westernbay.dns-systems.net/index.php/en/home/>

## 11. Emerging Themes

The Social Services and Wellbeing (Wales) Act 2014 provides a statutory framework for local authorities to exercise their social services functions with their partners and it is therefore the new law for improving the well-being of people requiring care and support, including both service users and carers.

It is worth reflecting that the fundamental principles of the SSWB Act are to promote:

- **Voice and control** – putting the individual and their needs, at the centre of their care, and giving them a voice in, and control over, reaching the outcomes that help them achieve well-being;
- **Prevention and early intervention** – increasing preventative services within the community to minimise the escalation of critical need;
- **Well-being** – supporting people to achieve their own well-being and measuring the success of care and support;
- **Co-production** – encouraging individuals to become more involved in the design and delivery of services.

An initial mapping of the themes emerging from the Population Assessment suggests the following :

<b>Mapping of themes from Western Bay Population Assessment (January 2017)</b>		
<b>Needs relating to Regional demographics</b>	<b>Demand which is increasing</b>	<b>New Population demand</b>
Chronic Conditions long term	Safeguarding Adults	Older people with LD with long term/ sensory conditions
Childhood -obesity	Safeguarding children	Children and Young people with complex conditions e.g. autism and complex behaviour/ emotions
Childhood -smoking	Mental Health support	Physical Disability / Health / Brain Injury
Early death -males	Mental Health- substance misuse	Refugee/ Asylum seekers



Mental Health - Adults	Violence Against Women	Resettlement – prisoners
Mental Health - Children	Carers – support for well-being	
Links to poverty and deprivation/ homelessness	Prisoners within Secure Estate	
People experiencing Social Isolation	People requesting Direct Payments	
People who depend on public transport	Transitions	
Dementia/ Early onset	Respite care	
Vulnerable people living in rural areas	Telecare/ Assistive	
Available accommodation/ tenancy- with support	Substance misuse	
	Risks associated with vulnerability- CYP, LD, MH, SE	

Some early key messages emerging from above analysis:

**Safeguarding:** balancing efforts to focus on prevention with the need to respond to an increasing number of safeguarding concerns

**Meeting needs:** early intervention and effective assessments promoting strengths and positive solutions can help to meet outcomes as well as reduce future demand.

**Violence against women:** The need to ensure effective links between social services and health and the new Violence Against Women, Domestic Abuse and Sexual Violence Partnerships.

**Mental Health:** gap in Child and Adolescent Mental Health Service availability/ accessibility.

**Learning Disability:** data suggests an ageing population who are outliving carers, and may suffer long term conditions such as dementia, sensory loss and chronic conditions.

**Transport:** the importance of public transport, especially for older people, children and young people

**Place:** the importance of good facilities and the physical environment for wellbeing – especially in terms of children, young people and older people and their perceptions of crime and safety.

**Remodelling services and upskilling workforce:** in order to promote independence and improved outcomes through targeted interventions, and to help manage demand (**outcomes- based commissioning**)

**IAA:** Promoting access to up to date information and advice as well as improved management of expert knowledge held by professionals and within third sector, and wider communication of what is available via web and other public channels.

**Collaboration:** as way of managing resources and addressing demand, needs from new populations and meeting financial challenges

## 12. Next Steps

Once the Population Assessment has been approved by the three Local Authorities and the Health Board, arrangements will need to be established to prepare the Area Plan, setting out the future pattern of services for the Region.

As far as the Population Assessment is concerned, the webpages will be hosted by the City and County of Swansea on behalf of the Western Bay partnership (with links to/from partner websites as required in the Act). As part of the contract for creating the web resource, training is available to ensure the information asset created can be maintained and built upon.

The Steering Group and its sub-group members also intend to carry out a “lessons learned” exercise. The exercise will seek to identify learning to inform:

The Western Bay partnership – in relation to future work connected with the assessment. In particular, to address limitations in the data and the analysis, as well as improvements that the participants identify could be made to the process of creating and publishing future assessments;

Welsh Government - it was evident in completing this exercise that there was difficulty in meeting all of the statutory requirements set out in guidance as other aspects of the Act had not been fully embedded. It was also evident that there is significant overlap with other legislative requirements – in particular the Wellbeing of Future Generations (Wales) Act 2015 and the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2016. It will be important to draw these issues out clearly so that Welsh Government officials can reflect on whether changes to the policy framework might be made.

The Population Assessment has demonstrated that there is a commonality across the four statutory organisations in what we are trying to achieve in delivering health and social care services. It is going to provide the opportunity to focus on high level regional working priorities going forward which add value. The next steps include a workshop for the Regional Partnership Board to review the Population Assessment and what it is telling us. The Population Assessment is a ‘live’ tool and therefore will be adapted and updated.

## 13. Role of the Regional Partnership Board

The Regional Partnership Board is required to ensure that partners work effectively together to respond to the Population Assessment. The Board is not required to approve the Population Assessment. Approval of the Population Assessment is the responsibility of the Health Board and the full councils of the three local authorities.

The Regional Partnership Board does however, have a critical role to play in identifying the main priorities emerging from the Population Assessment and to consider the implications for the Board in preparing the Western Bay Area Plan.

#### **14. Financial Impact**

A budget was established by the Regional Partnership Board to complete the Population Assessment. The cost to Neath Port Talbot County Borough Council (officer time) has been reimbursed to the Council from this budget.

#### **15. Workforce Impact**

The Population Assessment exercise itself has no significant workforce impacts.

#### **16. Equality Impact**

An equality impact assessment has been developed to support this exercise and it identifies that there is greater insight into the care and support needs of some people with protected characteristics than others. Gaps in the data have been identified and included in the equality impact assessment and should be used to inform future research and data development considerations.

#### **17. Legal Impact**

The Population Assessment has been prepared to comply with Section 14 of the Social Service and Wellbeing (Wales) Act 2014 and associated Statutory Guidance.

#### **18. Risk Management**

This is the first Population Assessment conducted under the Social Services and Wellbeing (Wales) Act 2014. There are a number of issues that have arisen in the course of completing the exercise which should be documented to inform further exercises. It is planned that a lessons learned exercise will be completed to identify the salient issues. This will reduce the risks that resources are not used efficiently in completing future exercises; and the conflicts between this legislation and provisions contained within the Wellbeing of Future Generations (Wales) Act 2015 and the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2016 would otherwise continue.

## **19. Recommendations**

- a) To approve the Western Bay Population Assessment.
- b) To authorise the Director of Social Services, Health and Housing to publish a link to the Population Assessment on the Council's website.
- c) To authorise the City and County of Swansea to submit the Population Assessment to Welsh Ministers on behalf of the three local authorities and the health board in the Western Bay region.
- d) To commend the above to Council for approval

## **20. Reason for Proposed Decision**

To discharge the duty placed upon the three local authorities and the ABMU Health Board operating as a Western Bay region to produce a regional population assessment report and to authorise the relevant officers to publish the assessment and submit the regional report to Welsh Ministers.

## **21. Implementation of Decision**

The decision is for immediate implementation.

## **22. List of Background Papers**

Social Services and Wellbeing (Wales) Act 2014

Part 2 Code of Practice (General Functions)

## **23. Appendices**

Sample downloadable document ('chapter')

Sample technical report ('topic paper')

## **24. Officer Contacts:**

Mr N Jarman, Director of Social Services, Health and Housing, Tel: 01639 763279  
or e-mail: [n.jarman@npt.gov.uk](mailto:n.jarman@npt.gov.uk)



**Caring Together  
Western Bay**  
*Health and Social Care Programme*  
**Gofalu Gyda'n Gilydd  
Bae'r Gorllewin**  
*Rhaglen Iechyd a Gofal Cymdeithasol*

# Social Services and Well-being (Wales) Act 2014

## Population Assessment

### Equality Impact Assessment Report

This form should be completed for each Equality Impact Assessment on a new or existing function, a reduction or closure of service, any policy, procedure, strategy, plan or project which has been screened and found relevant to equality.

**(a) This EIA is being completed for a...**

Service/ Function	Policy/ Procedure	Project	Strategy	Plan	Proposal
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**(b) Please name and describe below...**

The Social Services and Wellbeing (Wales) Act 2014 came into force on 6 April 2016. Its aim is to provide a framework for local authorities and health, to engage with and empower citizens, to help them achieve independence and well-being, and where necessary, to obtain the support they need.

The Act establishes a Regional Partnership Board (RPB) for each of the 7 regions in Wales, mirroring Health Board footprints. Each RPB is required to respond to a combined population assessment report. Working in partnership, local authorities and the local health board must produce a combined population assessment of the whole local health board area (Western Bay region). The report must include an assessment of the range and level of services required to meet the identified need, including the range and level of preventative services.

The population assessment focuses specifically on identifying and meeting care and support needs, including the needs of carers and of the population in the Western Bay region. The findings of this exercise will inform the broader assessment of well-being as required under the Well-being of Future Generations (Wales) Act.

This EIA focuses on our process for the required assessment to ensure that it is executed fairly and with due regard to our equality duties.

**(c) It was initially screened for relevance to Equality and Diversity on...04.08.16**

**(d) It was found to be relevant to...**

Children/young people (0-18).....	<input checked="" type="checkbox"/>	Religion or (non-)belief .....	<input checked="" type="checkbox"/>
Any other age group (18+) .....	<input checked="" type="checkbox"/>	Sex .....	<input checked="" type="checkbox"/>
Disability .....	<input checked="" type="checkbox"/>	Sexual orientation .....	<input checked="" type="checkbox"/>
Gender reassignment .....	<input checked="" type="checkbox"/>	Welsh language .....	<input checked="" type="checkbox"/>
Marriage & civil partnership.....	<input checked="" type="checkbox"/>	Poverty/social exclusion .....	<input checked="" type="checkbox"/>
Pregnancy and maternity .....	<input checked="" type="checkbox"/>	Carers (inc. young carers) .....	<input checked="" type="checkbox"/>
Race .....	<input checked="" type="checkbox"/>	Community cohesion .....	<input checked="" type="checkbox"/>

## Section 1 – Aims:

**Briefly describe the aims of the initiative:**

### What are the aims?

To ensure compliance with the requirements of the SSWB Act's requirements by:

- ascertaining the current level of health and social care provision in the Western Bay region
- undertaking a thorough analysis of available data
- undertaking meaningful and inclusive engagement activities to obtain qualitative information
- including findings in a final assessment report and identify further required actions.

### Who has responsibility?

- Western Bay Leadership Group
- Western Bay Programme Team
- Western Bay Population Assessment Steering Group membership
- Data Analysis Sub Group membership
- Communications and Engagement Sub Group membership
- Editorial Group membership

### Who are the stakeholders?

The overall population of the Western Bay region (both users and non-users of health and social care services).

## Section 2 - Stakeholder information:

**Please tick what information you know about your service users and provide details/ evidence of how this information is collected.**

Children/young people (0-18).....	<input checked="" type="checkbox"/>	Carers (inc. young carers) .....	<input checked="" type="checkbox"/>
Any other age group (18+) .....	<input checked="" type="checkbox"/>	Race .....	<input checked="" type="checkbox"/>
Disability .....	<input checked="" type="checkbox"/>	Religion or (non-)belief .....	<input checked="" type="checkbox"/>
Gender reassignment .....	<input checked="" type="checkbox"/>	Sex .....	<input checked="" type="checkbox"/>
Marriage & civil partnership.....	<input checked="" type="checkbox"/>	Sexual orientation.....	<input checked="" type="checkbox"/>
Pregnancy and maternity .....	<input checked="" type="checkbox"/>	Welsh language.....	<input checked="" type="checkbox"/>

### What information do you know about your service users and how is this information collected?

The population assessment bears relevance to all protected characteristic groups as all citizens are included within the scope of the exercise.

Information on the above named groups is gathered and presented by the Western Bay Programme's constituent partners within their respective Strategic Equality Plans and annual equality reports:

- <http://www1.bridgend.gov.uk/services/equalities/strategic-equality-plan.aspx>
- <https://www.npt.gov.uk/default.aspx?page=7628>
- <http://www.swansea.gov.uk/sep>
- <http://www.wales.nhs.uk/sitesplus/863/page/59057>
- [www.swansea.gov.uk/statistics](http://www.swansea.gov.uk/statistics)
- <http://www.bridgend.gov.uk/lgnl-level-2/statistics-and-census-information.aspx>
- <https://www.npt.gov.uk/default.aspx?page=626>

The Equality and Human Rights Commission's [Page 14](#) [How fair is Wales?](#) and [Is Wales Fairer?](#) reports also set out the national perspective in terms of entrenched inequalities, offering a useful insight

into the challenges faced by particular groups and individuals.

In addition to the protected characteristic groups, the population assessment must be structured around a series of nine core themes identified by Welsh Government.

These are:

- Children and young people
- Older people
- Health/physical disabilities
- Learning disability/autism
- Mental health
- Sensory impairment
- Carers who need support
- Violence against women, domestic abuse and sexual violence
- Secure estate

### **The approaches to evidence gathering used:**

The Western Bay Programme devised a two pronged approach to evidence gathering:

**Data Analysis Subgroup** – The Terms of Reference are attached to this EIA as **Appendix 1**. The Data Analysis Subgroup reviewed statistical outputs listed by the Local Government Data Unit and select output for inclusion in relation to the nine core themes. The main aim was to produce three standardised sets of nine quantitative topic reports for each of the three local authority areas which include social services and wellbeing data for the editorial group to synthesise into a regional report.

**Communications and Engagement Subgroup** – The Terms of Reference are attached to this EIA as **Appendix 2**.

A key aspect of this group's remit is a scoping exercise to obtain findings of previous engagement (involving Third Sector partners) since October 2014. Information gathered will be collated to form an initial qualitative evidence base which will grow and evolve as data continues to emerge and further engagement is undertaken to address identified gaps.

Significant primary engagement on behalf of Western Bay has been undertaken by an externally commissioned company. This has been in the form of targeted focus groups relating to the nine core themes; drop in sessions in communities attended by a wide range of stakeholders including members of the public and a public online survey. Protected characteristics were requested as part of all primary engagement, albeit voluntarily.

The key findings from the primary engagement have identified the below themes as important to people living in our communities.

- Information and communication
- Social networks
- Feeling safe and secure in community
- Transport
- Short term respite
- Access to healthcare, especially NHS services
- Housing
- Environmental cleanliness, safety
- Welfare and financial information

### Any Actions Required?

- Identify gaps within qualitative and quantitative evidence base following scoping exercise.
- Take steps to address gaps (within 2016/17 timeframe, if possible, or to be included within Draft Population Assessment Engagement Plan and final report for action in 2017/18).

### Section 3 - Impact on Protected Characteristics (See guidance):

Please consider the possible impact on the different protected characteristics. This could be based on service user information, data, consultation and research or professional experience (e.g. comments and complaints).

	Positive	Negative	Neutral	Needs further investigation
Children/young people (0-18)	➡ <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Any other age group (18+)	➡ <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Disability	➡ <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Gender reassignment	➡ <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Marriage & civil partnership	➡ <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Pregnancy and maternity	➡ <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Race	➡ <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Religion or (non-)belief	➡ <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Sex	➡ <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Sexual orientation	➡ <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Welsh language	➡ <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Carers (inc. young carers)	➡ <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>



**Thinking about your answers above, please explain in detail why this is the case.**

The Population Assessment will give us an overview of the current care and support needs of the people living in the Western Bay area as well as an indication of where further work needs to be undertaken to meet the needs of our population in the future. Following the assessment which will serve as a robust tool to highlight the gaps in care and support services, the regional area plan will be developed (and is required by Welsh Government by April 2018) to address developments in current and new services that are required. During the development of the regional plan, the impact on the protected characteristics will be clearer and can be populated fully. At the time of the assessment, further investigation was required to ascertain whether the outcomes would have an impact on the protected characteristics.

**What consultation and engagement has been undertaken (e.g. with the public and/or members of protected groups) to support your view? Please provide details below.**

As part of the assessment, targeted focus groups relating to the nine core themes were undertaken; drop in sessions in communities attended by a wide range of stakeholders including members of the public and a public online survey was available to all members of the population including those receiving care and support. There was a range of questions asked of the respondents ranging from general opinions on wellbeing and more specific questions on their experiences of care and support services. A breakdown of the respondents via these engagement activities can be found as **Appendix 3** to this Equality Impact Assessment. The key messages from the engagement activities detailed above and in **Appendix 3** will be summarised and included in each chapter of the final Population Assessment Report and will be used to support the recommendations of the report. The complete engagement report will also be available on request as a technical report supporting the Population Assessment's findings.

The content of the draft Population Assessment will be tested before being finalised using three key existing groups, engaging a wide range of stakeholders. These are:

- ABMU's Stakeholder Reference Group – 5<sup>th</sup> January 2017
- Third Sector Network – 25<sup>th</sup> January 2017
- Western Bay Regional Citizen's Panel – 17<sup>th</sup> February 2017

**Any actions required (to mitigate adverse impact or to address identified gaps in knowledge).**

- Review impact on protected characteristics of the population assessment and subsequent regional area plan when the plan is written throughout 17/18.

## **Section 4 - United Nations Convention on the Rights of the Child (UNCRC):**

**In this section, we need to consider whether the initiative has any direct or indirect impact on children. Many initiatives have an indirect impact on children and you will need to consider whether the impact is positive or negative in relation to both children's rights and their best interests**

Swansea's 'Super Survey' and Bridgend's 'Big Youth Voice' will be a valuable resource in establishing the current position from a CYP perspective. **Other similar activities undertaken NPTCBC?**

**Actions (to mitigate adverse impact or to address identified gaps in knowledge).**

- 

## **Section 5 - Monitoring arrangements:**

**Please explain the arrangements in place (or those which will be put in place) to monitor this initiative:**

**Monitoring arrangements:** Editorial group responsibility

**Actions:** Review Equality Impact Assessment throughout development of regional area plan.

## **Section 6 – Outcomes:**

Having completed sections 1-5, please indicate which of the outcomes listed below applies to your initiative (refer to the guidance for further information on this section).

Outcome 1: Continue the initiative – no concern

Outcome 2: Adjust the initiative – low level of concern

Outcome 3: Justify the initiative – moderate level of concern

Outcome 4: Stop and refer the initiative – high level of concern.

**For outcome 3**, please provide the justification below:

## Action Plan:

Objective - What are we going to do and why?	Who will be responsible for seeing it is done?	When will it be done by?	Outcome - How will we know we have achieved our objective?	Progress
Identify gaps within qualitative evidence base following scoping exercise.				
Take steps to address gaps (within 2016/17 timeframe, if possible, or to be included within Draft Population Assessment Engagement Plan and final report for action in 2017/18).				
Review impact on protected characteristics of the population assessment and subsequent regional area plan when the plan is drafted throughout 17/18.				

## Appendix 1 -

### TERMS OF REFERENCE

NAME OF GROUP	<b><u>POPULATION ASSESSMENT – DATA ANALYSIS SUBGROUP</u></b>
<b>KEY DELIVERABLES</b>	1. To produce three standardised sets of nine quantitative topic reports for each of the three local authority areas which includes social services and wellbeing data for the editorial group to synthesise into a regional report.
<b>MAIN TASKS</b>	<ol style="list-style-type: none"> <li>1. Review statistical output listed by the Local Government Data Unit and select output for inclusion in the relevant topic paper.</li> <li>2. Review other statistical data and select data for inclusion in the relevant topic paper.</li> <li>3. Review other data/ research and select content for inclusion in the relevant topic paper.</li> <li>4. Provide commentary for each topic, making local authority, regional and national comparisons where appropriate identifying how the Western Bay region compares with other regions across Wales.</li> <li>5. Produce the topic paper outputs in a format that enables content to be edited.</li> <li>6. Consult with social services/ other professional groups (e.g. housing) and third sector representatives to provide commentary on relevant topic papers.</li> </ol>
<b>TIMETABLE</b>	<p>Topic papers to be generated sequentially over the milestone period to avoid bottlenecks arising at the end of the milestone period. Topic papers to be produced below, note <b>the timetable and the order of them is to be agreed.</b></p> <ol style="list-style-type: none"> <li>1. <i>Learning disabilities/Autism</i></li> <li>2. <i>Mental health</i></li> <li>3. <i>Health/ Physical disability</i></li> <li>4. <i>Sensory impairment</i></li> <li>5. <i>Older people</i></li> <li>6. <i>Children and young people</i></li> <li>7. <i>Carers</i></li> <li>8. <i>Gender based violence, domestic abuse and sexual violence</i></li> <li>9. <i>Secure Estate</i></li> </ol> <p>Completion of topic papers to be achieved by <b>Friday 30<sup>th</sup> September 2016.</b></p>
<b>MEMBERSHIP:</b>	<p>Chair – Judith Brooks, BCBC NPT – Fiona Clay-Poole CCoS – John Grenfell &amp; Owen Davies</p>

	BCBC – Cheryl Thomas ABMU HB/ PHW – Thom Waite/ Jo McCarthy/Kirsty Little (will link with Navjot Kalra)
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## Appendix 2 -

### TERMS OF REFERENCE

NAME OF GROUP	<u>POPULATION ASSESSMENT – COMMUNICATIONS &amp; ENGAGEMENT SUBGROUP</u>
<b>KEY DELIVERABLES</b>	<ol style="list-style-type: none"> <li>1. To produce an engagement report for the Western Bay region for the purpose of informing the population assessment</li> <li>2. To undertake stakeholder engagement and gather feedback on the content of the draft population assessment report (to be delivered in two phases)</li> <li>3. To undertake an Equality Impact Assessment in respect of the Western Bay approach to carrying out the population assessment.</li> </ol>
<b>MAIN TASKS</b>	<ol style="list-style-type: none"> <li>1. Identify the stakeholders for each of the core themes, and additionally those stakeholders who have an interest across more than one core theme</li> <li>2. Map current engagement mechanisms for each of the stakeholder groups and identify gaps</li> <li>3. Map existing knowledge of stakeholders' views of their well-being and current health and social care service provision</li> <li>4. Identify where additional engagement activity is required to inform the population assessment</li> <li>5. Coordinate engagement activity, in partnership with successful tender applicant following selection process</li> <li>6. Collate stakeholder feedback, in partnership with the above</li> <li>7. Prepare a standardised report of findings by theme and submit to the Editorial Sub Group</li> <li>8. Secure stakeholder feedback on the draft regional population assessment report (i.e. the second phase of engagement).</li> </ol>
<b>MEMBERSHIP</b>	<p>Chair – Kirsty Roderick (Western Bay)            Western Bay – Sara Harvey            BCBC – Andrew Harris            NPTCBC – Anita James, Liam Hedges            CCoS – Simon Jones, Helen Barney            ABMU - Joanne Davies, Jane Williams            PHW – Joanne McCarthy, Kirsty Little            CVCs – Helen Evans, Kay Harries, Tina Williams, Amy Meredith-Davies            Liaison with Equalities Officers from each local authority area (for input to EIA).</p>
<b>MEETING FREQUENCY</b>	Fortnightly in principle, varying dependent upon timetabled activities.

### Appendix 3 – Breakdown of respondents to engagement activities

Attendance	Drop-ins /Focus Groups in schools	Online Survey	Pre-existing groups
Learning Disability & Autism	24	0	23
Sensory Impairment	1	10	34
Secure Estate	0	0	0
Carers Who Need Support	2	26	16
Health and Physical Disability	13	28	6
Violence against women, Domestic Abuse and Sexual Violence	3	0	2
Mental Health	10	8	14
Older People (65+)	34	27	44
Children and Young People (under 18)	56	0	13
<b>Total</b>	<b>143</b>	<b>65</b>	<b>152</b>

Table 1 Attendance of citizen groups in Bridgend area

Attendance	Drop-ins /Focus Groups in schools* <sup>1</sup>	Online Survey* <sup>2</sup> , ** <sup>2</sup>	Pre-existing groups
Learning Disability & Autism	3	0	10
Sensory Impairment	0	1	15
Secure Estate	0	0	0
Carers Who Need Support	0	15	8
Health and Physical Disability	8	3	6
Violence against women, Domestic Abuse and Sexual Violence	0	0	0

<sup>1</sup> \* Numbers referred to people who identified as

<sup>2</sup> \*\* the Survey was removed from the Bridgend County Council website after a few days <sup>3</sup> \*\* The online survey was removed from the City and County of Swansea website after 2 days<sup>4</sup> As defined in the Practitioners' Manual for public engagement

<b>Mental Health</b>	1	0	8
<b>Older People (65+)</b>	3	1	21
<b>Children and Young People (under 25)</b>	13	0	0
<b>Total</b>	28	20	68

Table 2 Attendance of citizen groups in Neath Port-Talbot area

<b>Attendance</b>	<b>Drop-ins /Focus Groups in schools *</b>	<b>Online Survey*</b>	<b>Pre-existing groups</b>
<b>Learning Disability &amp; Autism</b>	2	0	5
<b>Sensory Impairment</b>	0	3	0
<b>Secure Estate</b>	0	0	0
<b>Carers Who Need Support</b>	0	26	10
<b>Health and Physical Disability</b>	3	8	0
<b>Violence against women, Domestic Abuse and Sexual Violence</b>	0	0	7
<b>Mental Health</b>	3	5	0
<b>Older People (65+)</b>	2	10	23
<b>Children and Young People (under 25)</b>	21 (incl. ALN)	0	0
<b>Total</b>	31	52	50

Table 3 Attendance of citizen groups in Swansea area

<b>Attendance</b>	<b>Drop-ins /Focus Groups in schools *</b>	<b>Online Survey*, **3</b>	<b>Pre-existing groups</b>
<b>Learning Disability &amp; Autism</b>	1	0	8
<b>Sensory Impairment</b>	1	3	19
<b>Secure Estate</b>	0	0	0
<b>Carers Who Need Support</b>	1	33	6

<sup>3</sup> \*\* The online survey was removed from the City and County of Swansea website after 2 days<sup>4</sup> As defined in the Practitioners' Manual for public engagement



<b>Health and Physical Disability</b>	2	15	2 (from RNIB)
<b>Violence against women, Domestic Abuse and Sexual Violence</b>	2	0	0
<b>Mental Health</b>	0	3	5
<b>Older People (65+)</b>	4	16	0
<b>Children and Young People (under 25)</b>	12	0	7
<b>Total</b>	23	70	47

## Locations and names of targeted groups attended

### Bridgend:

- Bridgend Deaf Club
- Bridgend carers centre
- Age Connect
- Stroke Association
- Mental health Matters
- Interviews:
  - Lisette Saunders - HM Prison Parc
  - Sue Richard - Cruse Bereavement
  - Kay Harries - ex Age Connect

### Neath Port Talbot:

- Young at Heart group (Deaf group with non-verbal members)
- Age Concern
- NPT Carers Services
- Interviews:
  - Mark Lazarus - Hillside Secure Home
  - Karyl Carter - Stroke association

### Swansea

- Gofal
- People First
- RNIB
- Young Single Homeless project

- Swansea Young Adult carers
- Swansea Women's Aid
- Interviews
  - Lynne Sanders – Swansea Women's Aid
  - Nicola Russell-Brooks - Age Cymru

Table 4: Dates and locations of the drop-in workshop and focus groups in Bridgend

Venue	Date and time	Number of attendees
Ogmore Valley Life Centre	Monday 26/09, 2pm – 7pm	1
Porthcawl Pavilion	Tuesday 27/09, 9am - 1pm	7
Blaengarw Workmen’s Hall	Tuesday 27/09, 3pm – 7pm	0
St Michael’s Crypt, Maesteg	Friday 30/09 , 9am – 1pm	3
Bridgend Life Centre+	Friday 30/09, 3pm – 7pm	13
Pencoed Miners Welfare Hall	Saturday 1/10, 9am – 1pm	2

Engagement with children and young people:

1 ALN school: 7 students

1 welsh secondary school: 6 students

Table 5: Dates and locations of the drop-in workshop and focus groups in Neath Port Talbot

Venue	Date and time	Number of attendees
Croeserw Community Enterprise Centre, Cymmer	Monday 28/09, 9am – 1pm	2
Gwyn Hall, Neath	Saturday 1/10, 2-6pm	12
Cymllynfell Welfare Hall	Monday 3/10, 9am -1pm	0
Dove Workshop, Neath	Monday 3/10, 2pm- 6pm	1
Pontardawe Arts Centre, Pontardawe	Wednesday 5/10, 9am – 1pm	5
St Paul Centre, Port Talbot	Wednesday 5/10, 3pm- 7pm	5

Engagement with children and young people:

1 ALN school: 10 students

1 primary school: 6 students

1 Welsh secondary school: 5 students

Table 6: Dates and locations of the drop-in workshop and focus groups in Swansea

Venue	Date and time	Number of attendees
Townhill Community Centre	Wednesday 28/09, 9am–1pm	11
Canolfan Gorseinon Centre	Wednesday 28/09, 3 – 7pm	2
Pennard Parish Hall	Thursday 29/09, 3 – 7pm	4
St Phillips Community Centre	Friday 30/09, 2pm – 6pm	7
Sketty Park	Tuesday 4/10, 9am – 1pm	3
Morrison Community Centre	Friday 7/10, 2pm – 6pm	2

Engagement with children and young people:

- 1 Welsh secondary school: 8 students
- 2 secondary schools: 6 and 8 students

### One-to-one interviews

The individual depth interviews were planned as an essential part of the methodology to ensure we obtained the views of ‘harder to reach’ or ‘seldom heard’<sup>4</sup> citizens. These were people who may be difficult to identify in the first instance, challenging to engage with<sup>5</sup>, and who may struggle with the structure of a focus group or workshop because of their particular vulnerabilities.

As the project progressed, the need for the one-to-one interviews diminished. Two were still carried out for very particular reasons, but generally the individuals who we had thought would prefer an individual depth interview were happy to attend workshops with others. Depending on the number of others present, we sometimes then allocated them one of the two moderators present so that their conversation could remain confidential. However when we were not able to engage with a group we tried to undertake interviews with stakeholders. They gave us a more general overview of the relationship, satisfaction service users have with social services as well as the barriers and the issues they face dealing with social services.

### Development and dissemination of bilingual online consultation survey

We designed an online survey in order to extend the scope of the consultation further. Whilst traditionally used as a quantitative method of information gathering, we developed more open-ended questions relating to the main thematic areas of well-being and some specific questions in relation to social care for the purpose of obtaining additional qualitative feedback.

<sup>4</sup> As defined in the Practitioners’ Manual for public engagement

<sup>5</sup> Secure estate, children and young people facing bereavement

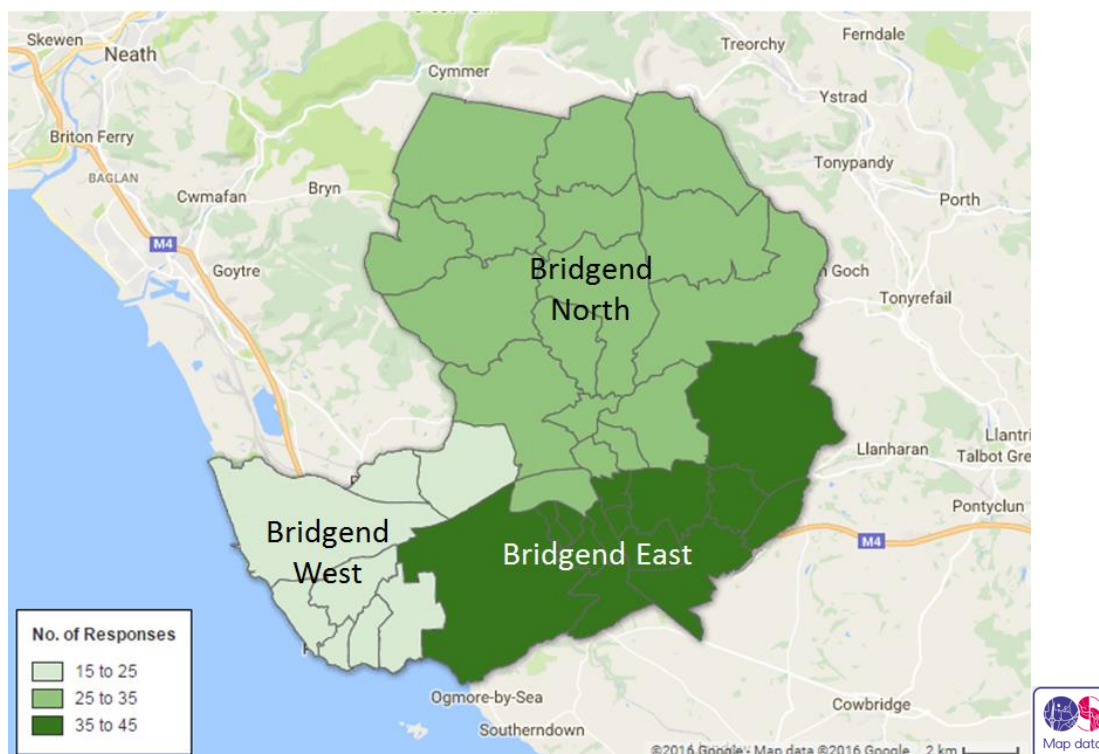
The survey was posted on-line for the period 9<sup>th</sup> September 2016 until 14<sup>th</sup> October 2016, in the medium of Welsh and English. A total of 637 responses were obtained in English, and 3 in Welsh.

The map below illustrates the number (total of 76) and geographical area of responses received from all those giving a Bridgend postcode.

Among the participants who gave us their postcode we identified 23 from Bridgend North, 34 from Bridgend East and 19 from Bridgend West (

Figure 1).

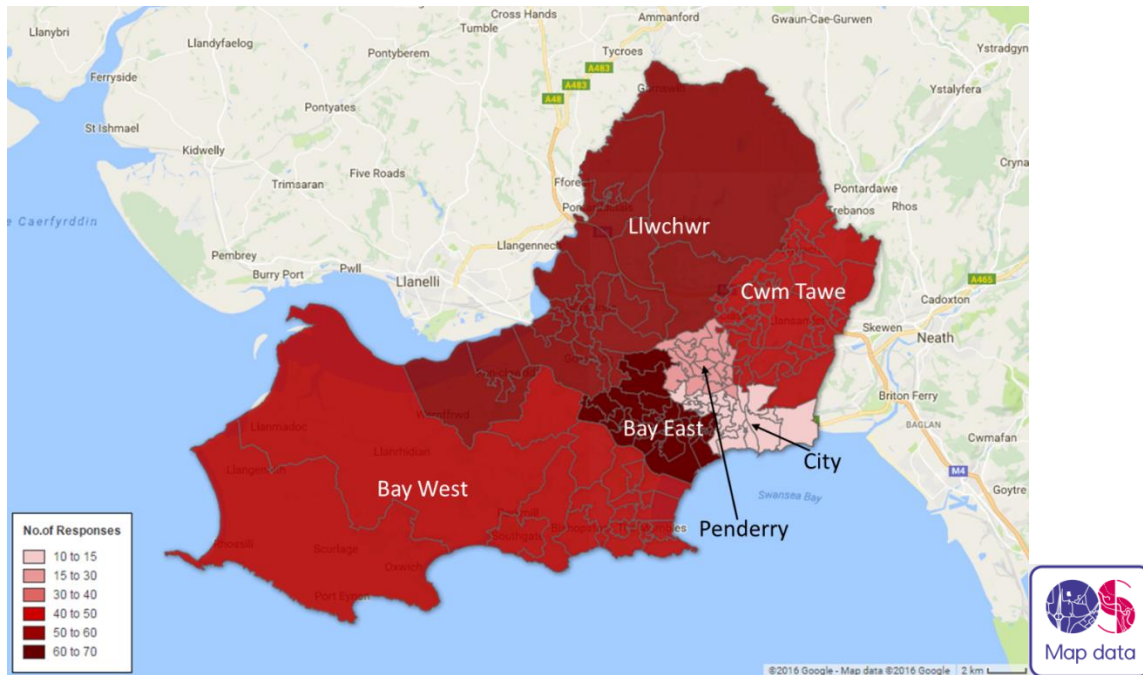
Figure 1: Number of survey respondents per community area



Source Google map ©Crown Copyright and database right 2016. Ordnance Survey 100023405

Among the participants who gave us their postcode we identified 57 from Bay East, 43 from Bay West, 14 from City, 46 from Cwm Tawe, 49 from Lwchwr and 16 from Penderry community area (Figure 2).

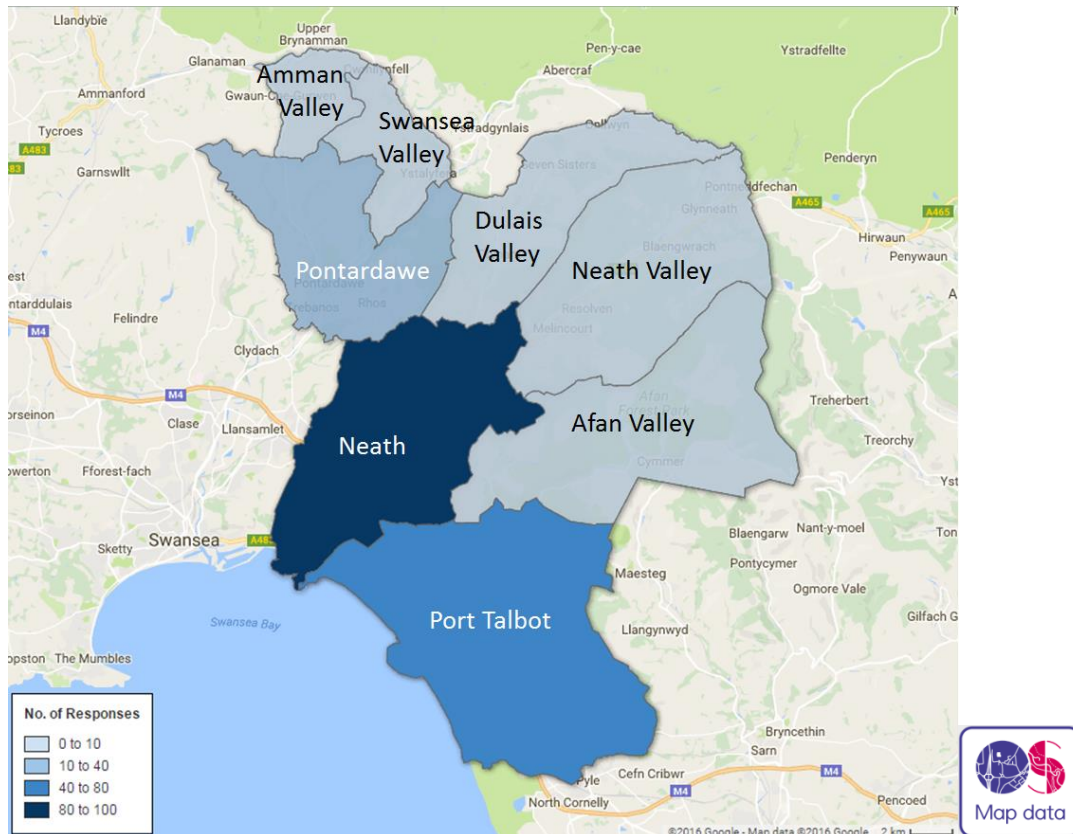
Figure 2: Number of survey respondents per community area



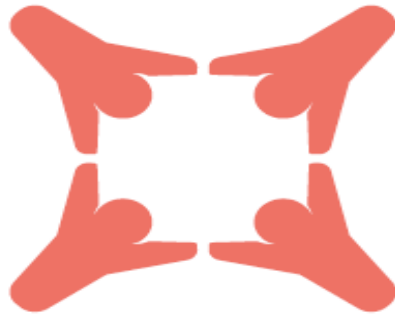
Source: Google map - Contains OS 1:25 000 Scale Colour Raster data - Swansea Ordnance Survey licence number 100023509.

The map below illustrates the number (total of 193) and community areas of responses received from all those giving a valid Neath Port Talbot postcode. Among the participants who gave us their postcode we identified 5 from Afan Valley, 2 from Amman Valley, 9 from Dulais Valley, 84 from Neath, 3 from Neath Valley, 23 from Pontardawe, 59 from Port Talbot, and 8 from Swansea Valley community area (Figure 3).

Figure 3: Number of survey respondents per community area



Source: Google map - Contains OS 1:25 000 scale colour Raster data



# **WESTERN BAY**

**POPULATION ASSESSMENT REPORT**

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# MENTAL HEALTH



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+ WHAT DO WE MEAN BY MENTAL HEALTH?	<u>01</u>
+ WHO IS AFFECTED AND HOW?	<u>02</u> – <u>05</u>
+ WHO IS RECEIVING HELP AND WHAT SUPPORT IS AVAILABLE?	<u>06</u> – <u>08</u>
+ THINGS PEOPLE TOLD US THAT MATTER TO THEM	<u>09</u>
+ WHAT CHANGES DO WE NEED TO PLAN FOR?	<u>10</u> – <u>13</u>

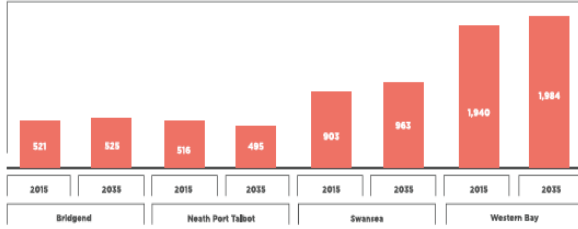
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— COMMON MENTAL DISORDERS

The following chart shows the projected numbers of people with probable psychotic disorder across Western Bay to between 2015 and 2035.

▼ Projected number of people with a probable psychotic disorder Wales (PMS 2000)



— EARLY ONSET DEMENTIA

Numbers in this population group are projected to remain stable, however improvements in diagnosis may increase these figures.

▼ Projected number of people with a probable psychotic disorder Wales (PMS 2000)

	2015	2020	2025	2030	2035
<b>+</b>					
Bridgend	38	40	42	40	38
Neath Port Talbot	39	39	39	37	35
Swansea	60	62	63	61	60
Western Bay	137	141	144	138	133

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**+** WHO IS RECEIVING HELP AND WHAT SUPPORT IS AVAILABLE ?

**+** According to the 2000 Psychiatric Morbidity Survey the treatment used most often for CMDs and people with probable psychosis is medication, with 99% of those with probable psychosis receiving medication as part of their treatment, and 83% of those with CMDs receiving medication as part of their treatment. Of those with probable psychosis 48% receive some form of therapy / counselling, while just 38% of those with CMDs receive this form of therapy. Of those with CMDs 62% receive only medication as treatment.

**+** Looking at the whole of Western Bay using the projection for having seen GP within last 2 weeks for 2015, approximately 4,700 GP consultations in a fortnight were carried out with people with CMDs or a probable psychotic disorder. Over a 52-week period, this is over 122,000 consultations (125,000 by 2035).

**+** For the whole of 2015, approximately 30,100 patients with CMD / probable psychosis will have spoken to their GP about a mental or emotional problem. Compared to the 122,000 consultations undertaken, it could be suggested that each CMD / probable psychosis patient, on average, will speak to their GP about a mental or emotional problem roughly 4 times in a year.

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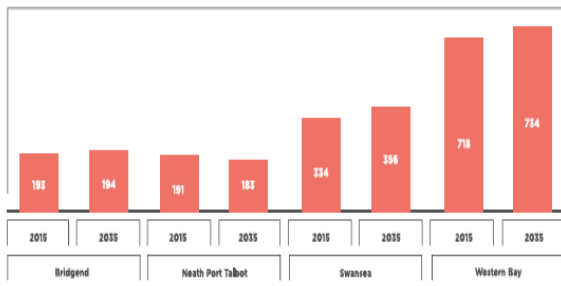
GPs treat the highest proportions and numbers of people with mental disorders. The majority of people with mental health issues either live in the local community with minimal support from Adult Social Care (ASC) or from specialist mental health services, they either self-manage, have family/community support or access primary health care. There are also a significant number of people with serious mental health problems who are supported to live in the community by specialist community services, such as:

- ▶ Psychiatrists
- ▶ Psychologists
- ▶ Community psychiatric nurses
- ▶ Community learning difficulty nurses
- ▶ Other nursing services
- ▶ Social workers
- ▶ Self-help/support groups
- ▶ Home help/home care workers
- ▶ Outreach workers

18% of people with a CMD are anticipated to use community care services within a year, while 51% of those with a probable psychosis are also anticipated to use community care services.

Day service is another aspect of community provision and is usually most focussed on those with the most serious disorders, particularly psychotic disorders. Only 3% of people with CMDs use day services compared to 37% of people with a probable psychosis.

▼ **Projected number with a probable psychotic disorder receiving day service during the previous year (PMS 2000)**



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Across Western Bay services for those aged 65 and over with mental health problems are provided in hospitals and in community settings. Inpatient services are provided from both General and Community Hospitals across Bridgend, Neath Port Talbot and Swansea and include:

- + Assessment and admission: provided at Cefn Coed Hospital, Neath Port Talbot Hospital, Tonna Hospital, Ystradgynlais Community Hospital and Princess of Wales Hospital
- + Continuing care and respite: provided at Cefn Coed Hospital, Garbgoch Hospital, Neath Port Talbot Hospital, Tonna Hospital, Glanrhyd Hospital and the Croeso Centre and Maesteg Community Hospital.

The rate of adults aged 65 and over receiving mental health services in Neath Port Talbot has increased gradually but in comparison to other local authorities in Wales is still very low and is well below the Wales average.

▼ **There are a range of community based mental health services and teams across Western Bay.**

- + Complex Needs Services for Women – Dechrau Newydd: Community Dialectical Behaviour Therapy service for women with mental health complex needs (primarily borderline personality disorder). This service works with patients in secondary care in close partnership with Community Mental Health Teams and in-patient services.
- + Crisis Resolution Home Treatment Teams (CRHTT): offer support and care for those people who without it would be admitted to hospital. They act as the gatekeeper to inpatient beds in order to ensure that all alternatives to inpatient care have been explored. Also support the early discharge of those people who have required inpatient care. Provide advice and signposting to people referred to them, but who they assess as not requiring their services.
- + Crisis Recovery Units (CRU): A day hospital type environment for people who require more support than can be delivered in their own home but do not require hospital admission.
- + Prison In-Reach Team (PIR): Community Mental Health Team based within both HMP Parc and HMP Swansea. The service provides assessment, management and Care Co-ordination of prisoners who are presenting with serious mental illness. Close liaison with probation (MAPP) and wider third sector services to manage presenting risks.

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**THINGS PEOPLE TOLD US MATTER TO THEM**

- + Support people to feel safe and involved in communities with sufficient amenities and services.
- + Help local support groups to provide practical support.
- + Improve access to information including support around financial management e.g. debt, welfare benefits
- + Help people to 'have a voice' and make informed choices and decisions
- + Access to GP appointments and social services
- + Improve public transport to help people to independently access services to carry out day to day activities.

**WHAT CHANGES DO WE NEED TO PLAN FOR ?**

An effective mental health care pathway will ensure:

- + People experiencing an acute mental health episode are kept safe and provided with a therapeutic environment to begin to recover. Often these settings need to be secure,
- + Access to recovery and rehabilitation services when the initial crisis has passed and the person is ready to continue their recovery,
- + Resettlement/step down services to help people make the move back to the community when they no longer need more intensive support, and
- + Medium to long term on-going community based support so people with mental health needs are supported to live where they choose e.g. in supported living, in their own tenancies, with host families etc.

The current pattern of mental health support is not yet in line with this model, individual service user outcomes and levels of independence could be better supported.

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## Topic 5

### Mental Health

**Bridgend County Borough Council**

**Lead: Mark Wilkinson**

#### 1. Overview of Current and Forecasted needs

The estimated prevalence of adult mental health problems has been surveyed within the UK every seven years since 1993, with the survey in 2000 the last year for which data has been published which included estimates to Wales, as well for England and Scotland. The 2000 survey and subsequent surveys at those aged 16-74.

It was published as Psychiatric morbidity among adults living in private households, 2000, and described as “the report of a survey carried out by Social Survey Division of the Office for National Statistics on behalf of the Department of Health, the Scottish Executive and the National Assembly for Wales”.

The 2007 survey was England-only Results of the 2014 survey have yet to be published.

The term “survey” understates the range of methodologies involved in the periodic assessment of the prevalence of mental health problems: a range of screening instruments are used and face-to-face interviews are also involved, including both lay and clinical researchers.

The estimates of prevalence and service use in this section are derived from the Psychiatric Morbidity for 2000, unless otherwise specified. Furthermore, the headline figures from the 2000 survey that reported Wales-specified estimates for Common Mental Disorders (CMD) and probable psychosis have been used throughout. The graphs showing “Wales (PMS2000)” in the titles are calculated from prevalence rates for Wales in 2000. GB (PMS2000) denotes whole survey results for 2000. Projections marked as “(PMS2007)” denote derivation from the England/Scotland 2007 survey.

#### **Defining Mental Illnesses**

The term used in this document relate to the terms used within the survey of psychiatric morbidity.

The common term **Common Mental Disorders (CMD)** refers to a specific range of six of the most common mental illnesses –

- Mixed anxiety and depressive disorder
- Generalised anxiety disorder
- Depressive episode
- Phobias
- Obsessive compulsive disorder
- Panic disorder

In the 2000 survey, CMDs were referred to as “neurotic disorders” which is terminology no longer used.

The term **probable psychosis** is used in the 2000 survey to describe mental illnesses that is more severe than the CMDs and mostly relates to schizophrenia and schizotypal illnesses, as well as more serious affective illness (mood disorders), such as bipolar affective disorder. Given the nature of the survey methodology, an accurate diagnosis of psychosis is not possible and is therefore described as “probable”. The 2007 survey found that methods used to assess “probable psychosis” resulted in a slightly higher proportion of people (0.5%) identified than survey instruments that more accurately assessed a diagnosis of psychosis (0.4%).

The term personality disorder relates to the following categories:-

- Avoidant
- Dependant
- Obsessive compulsive
- Paranoid
- Schizotypal
- Schizoid
- Histrionic
- Narcissistic
- Borderline
- Antisocial
- Passive-aggressive
- Depressive

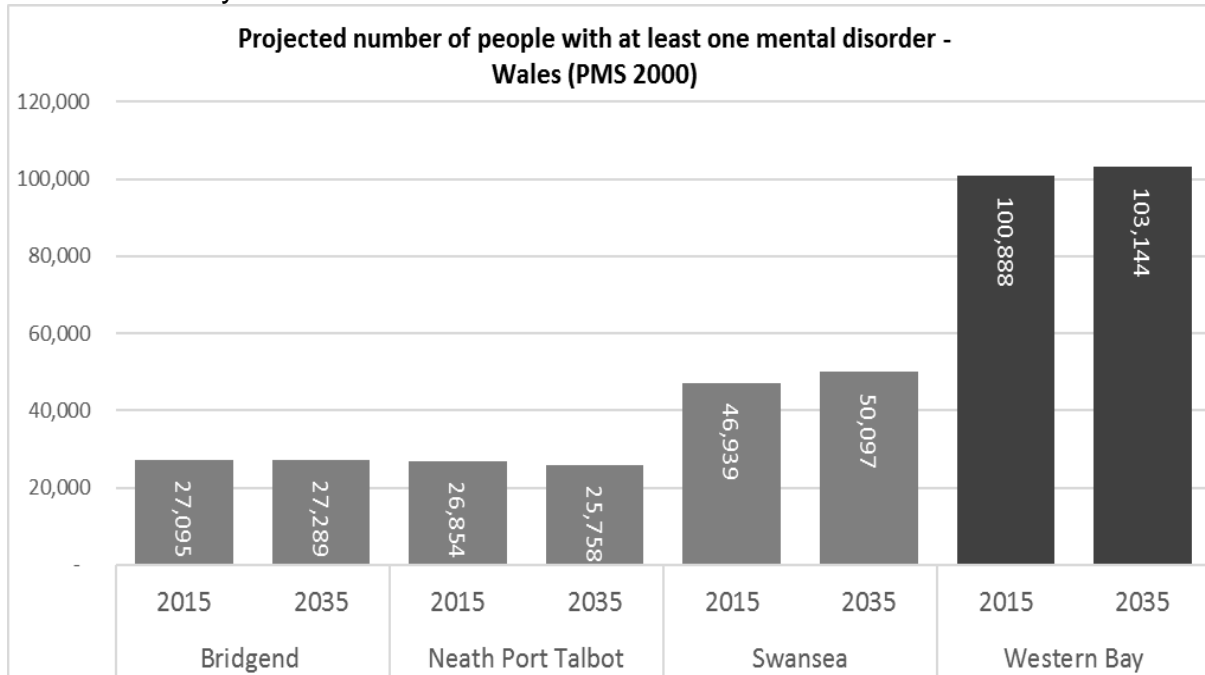
The 2000 survey also looked at drug and alcohol misuse and dependence, but this will be covered in more detail elsewhere.

The term **mental health disorder** refers to all mental illnesses covered by the survey, and thus includes all the above. The 2007 England survey extended the range of diagnoses covered by the survey and some material from that survey is extrapolated to Wales in this document.

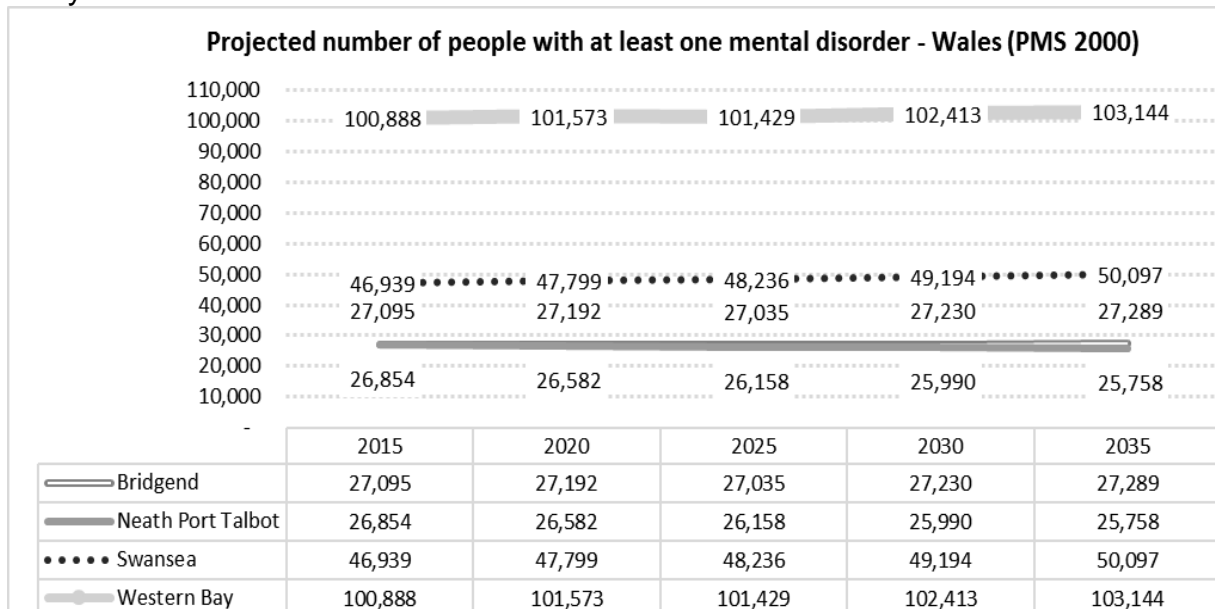
### Adults with a mental health disorder

Mental health disorders are very common. The overall proportion of people experiencing at least one mental health disorder within the previous year for the UK in 2000 was 23%. For Wales, this was 26%. The 23% figure for any mental disorder remained stable for England in 2007. As such I have assumed that the Wales prevalence estimate of 26% has also remained stable.

The chart below shows what 26% of the population represents in 2015 and in 2035 for Western Bay.



The following chart shows the projected numbers across Western Bay to 2035 at five-year intervals.



As the projections are essentially based on population sizes, the projected results are largely based on changes in population size. The figures above thus reflect modest increases in the population size of Swansea and Bridgend, but a modest reduction in adult population in Neath Port Talbot by 2035.

## Prevalence of Common Mental Disorders (CMDs), Personality Disorders and Probable Psychotic Disorder

The prevalence of Common Mental Disorders in Wales was slightly higher in Wales (19% of people) compared to the overall Great Britain result of 16.4%. The 16.4% figure for any CMD remained fairly stable for England in 2007, dropping from 16.4% to 15.1%. However, the prevalence for the age group 16-64 was much more stable: 16.3% in 2000 and 16.4% in 2007. Since the under 65s are the larger proportion of people, I have assumed that the Wales prevalence estimate of 19% has also remained stable.

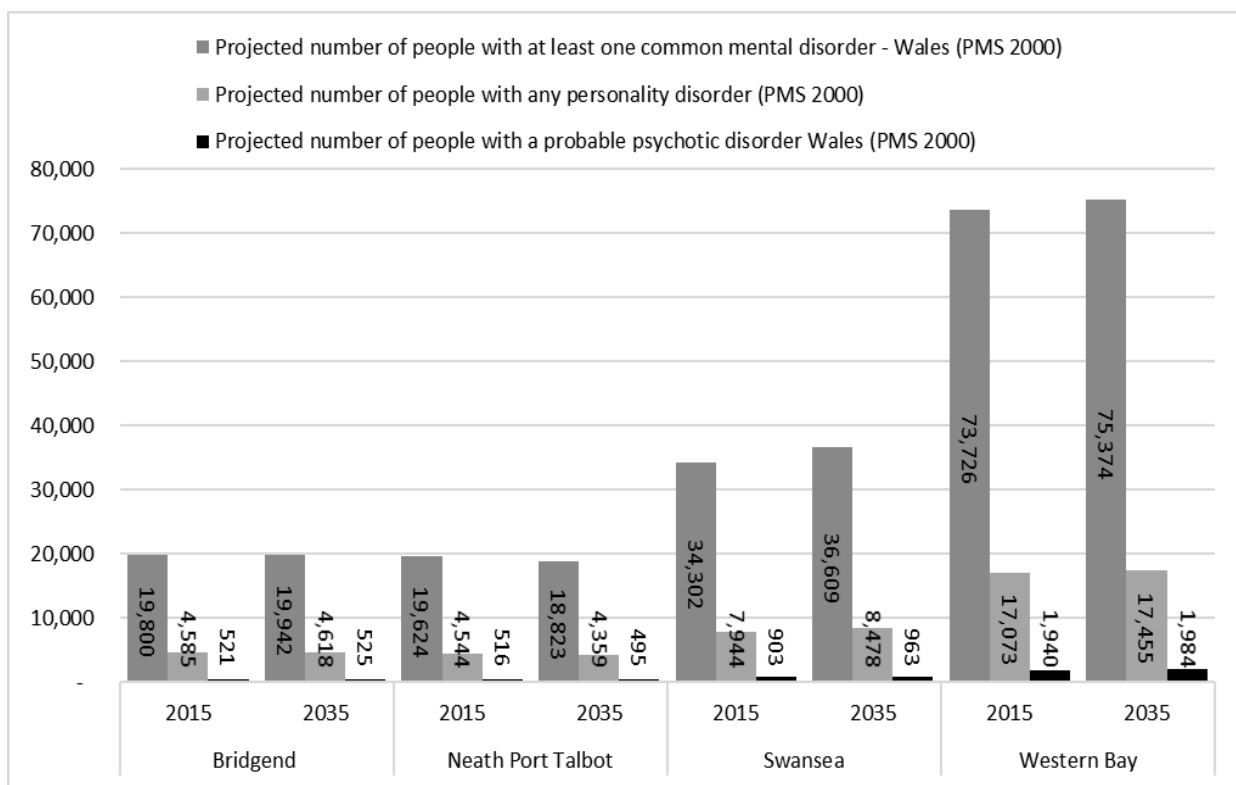
The prevalence of personality disorder in 2000 was 4.4% of the population. The 2007 survey focussed on only two personality disorders.

The prevalence of probable psychotic disorder was the same in 2000 for Wales as for Great Britain at 5% of the population. The prevalence rate in 1993 had been similar at 0.4% of population. The 2007 survey for England also found the same prevalence of 5%.

The chart below shows for 2015 and for 2035 the estimated prevalence expressed as % of people aged 16-74 for each category:-

- 19% with a CMD as per Wales figures in 2000 survey
- 4.4% with a personality disorder as per 2000 survey
- 0.5% with a probable psychotic disorder as per all surveys 1993-2007

Note that the following graphs show the two types of illness but there will be a level of overlap with some people experiencing both. See section below on co-morbidity.



As the projections are essentially based on population sizes, the projected results are largely based on changes in population size. The figures above thus reflect



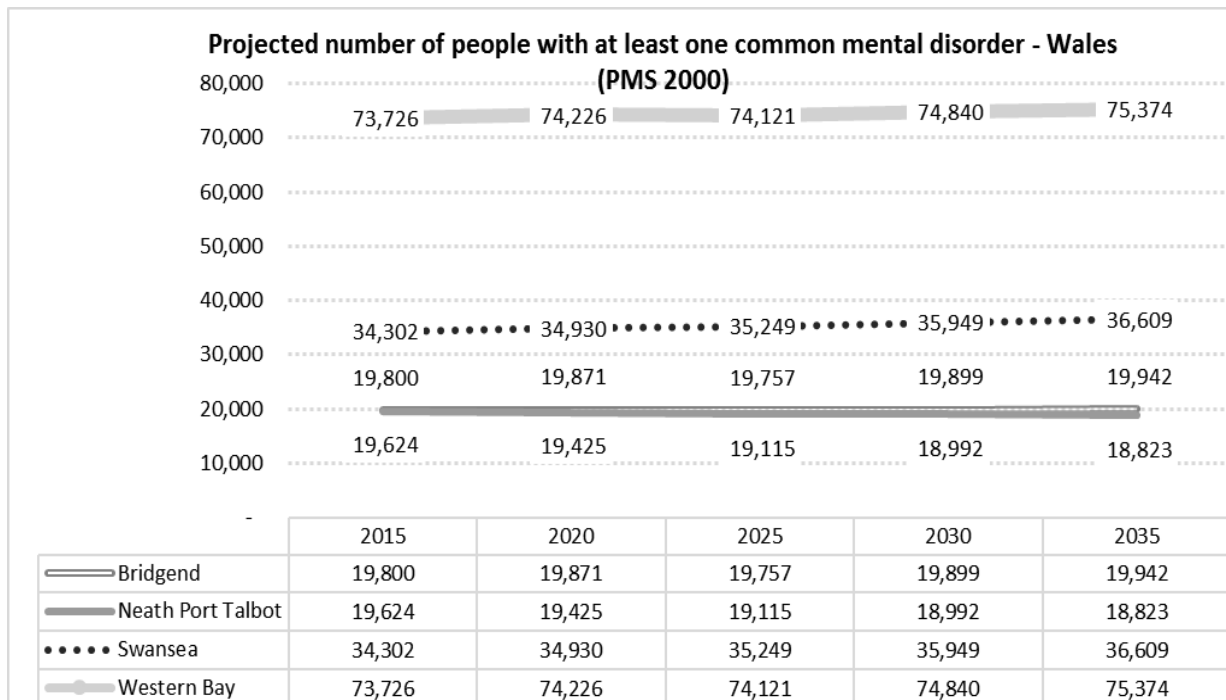
modest increases in the population size of Swansea and Bridgend, but a modest reduction in adult population in Neath Port Talbot by 2035.

### Projected Prevalence of Common Mental Disorders

CMDs are the most commonly occurring type of mental disorder for which people are likely to seek treatment or support. The disorders are:-

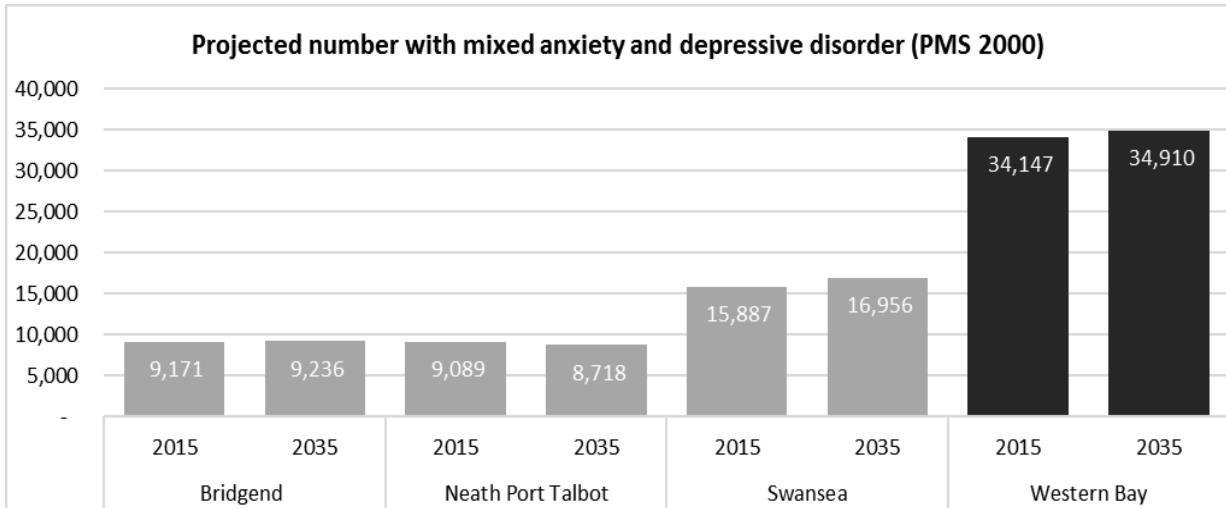
- mixed anxiety and depressive disorder,
- generalised anxiety disorder,
- depressive episode,
- phobias,
- obsessive compulsive disorder
- Panic disorder.

The following chart shows the projected numbers across Western Bay to 2035 at five-year intervals given a prevalence of 20% of the adult population.



### Specific Disorders

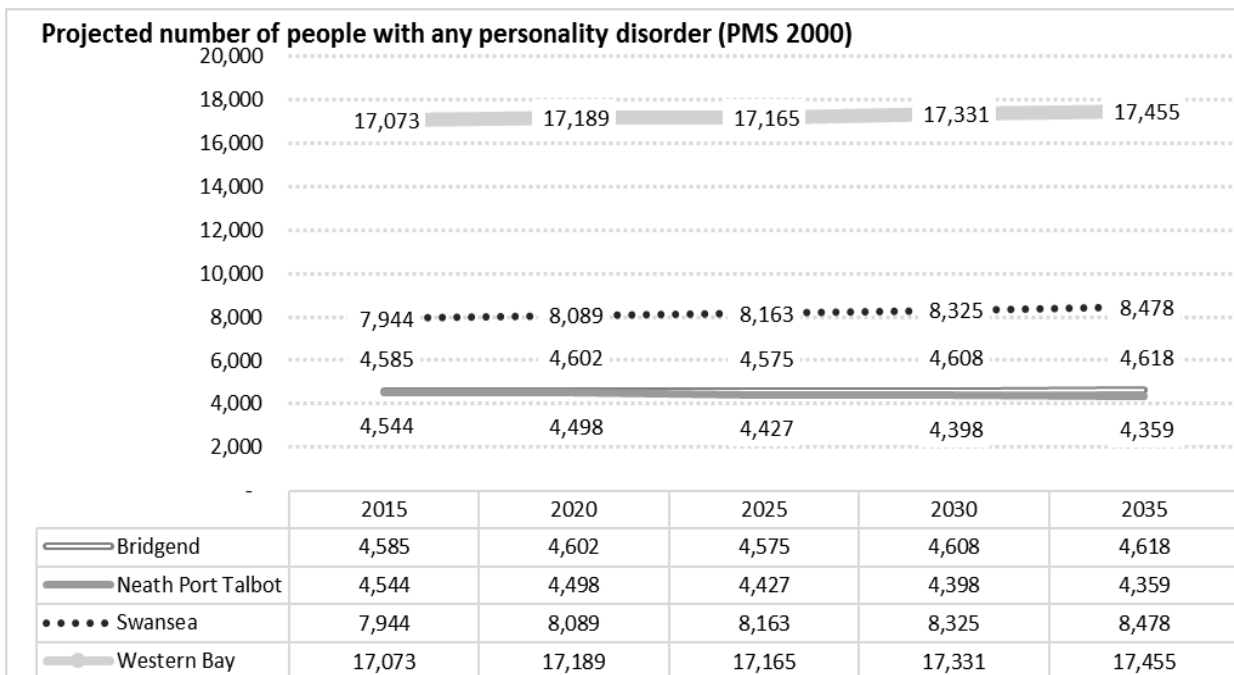
The most frequently-occurring CMD is mixed anxiety and depressive disorder, (sometimes called cothymia) with 8.8% of the adult population experiencing this disorder:-



**Projected Prevalence of Personality Disorders**

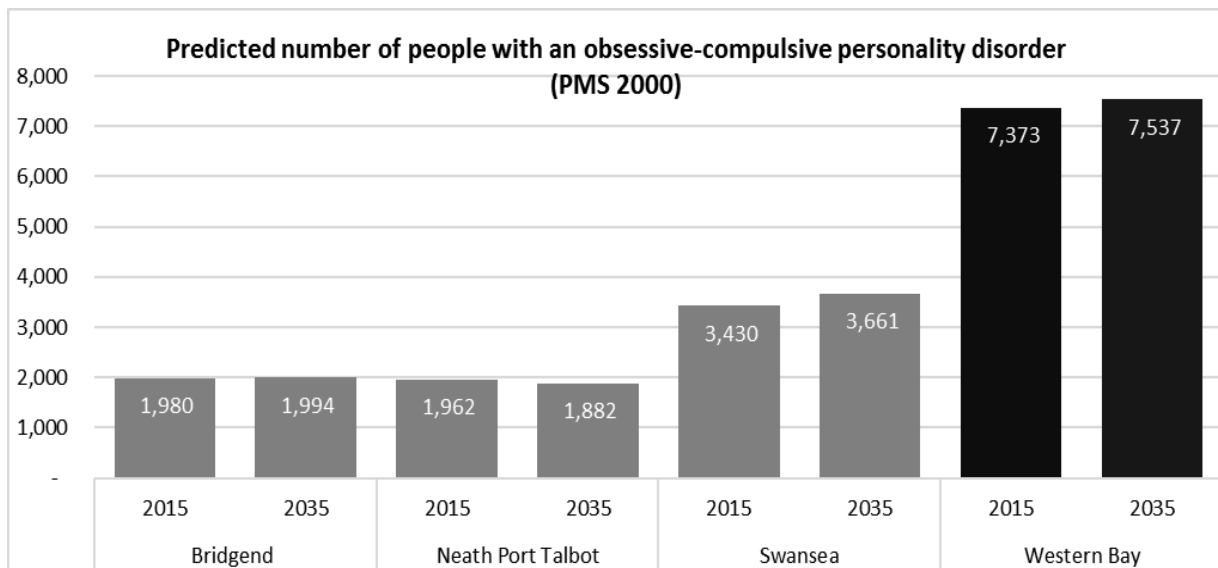
Personality disorders are persistent and they are often expressed as dysfunctional patterns of behaviour that are found to be pervasive and adversely affecting the person’s life. Levels of distress and treatment-seeking vary across the personality disorders. In many cases, personality disorders are extremely difficult to treat, if at all.

The following chart shows the projected numbers across Western Bay to 2035 at five-year intervals, given a prevalence of 4.4% of the adult population.

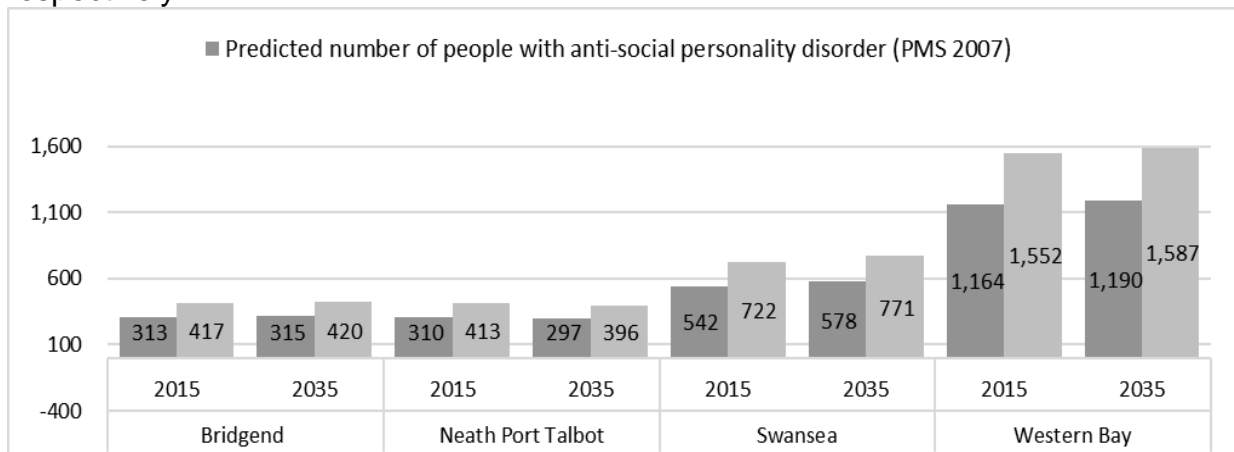


### Specific Personality Disorders

The most frequently-occurring personality is obsessive-compulsive personality disorder, (sometimes called co-thymia) with 1.9% of the adult population affected:-



Using estimates from the 2007 survey, it is possible to estimate the prevalence of antisocial and borderline personality disorders, at 0.3% and 0.4% of the population respectively.

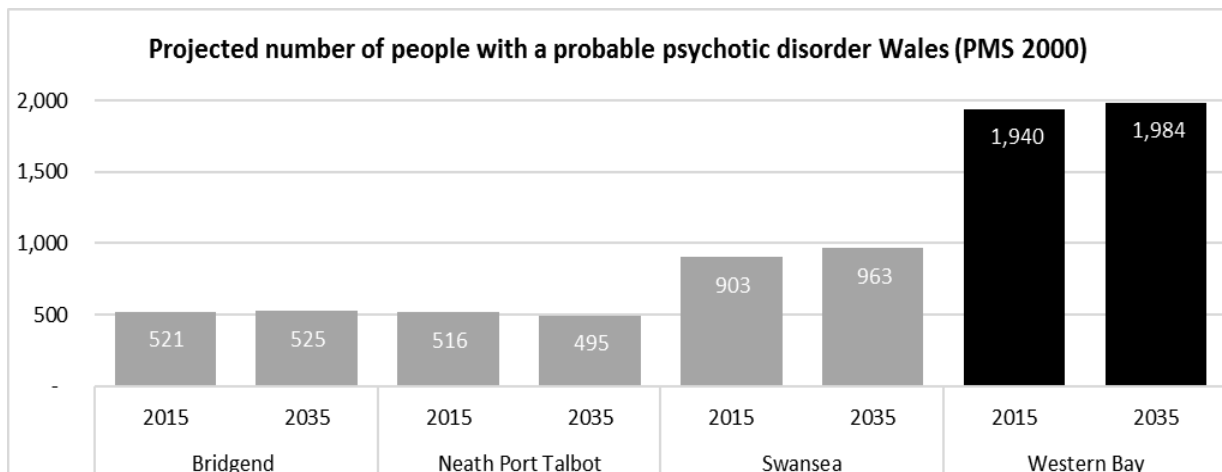
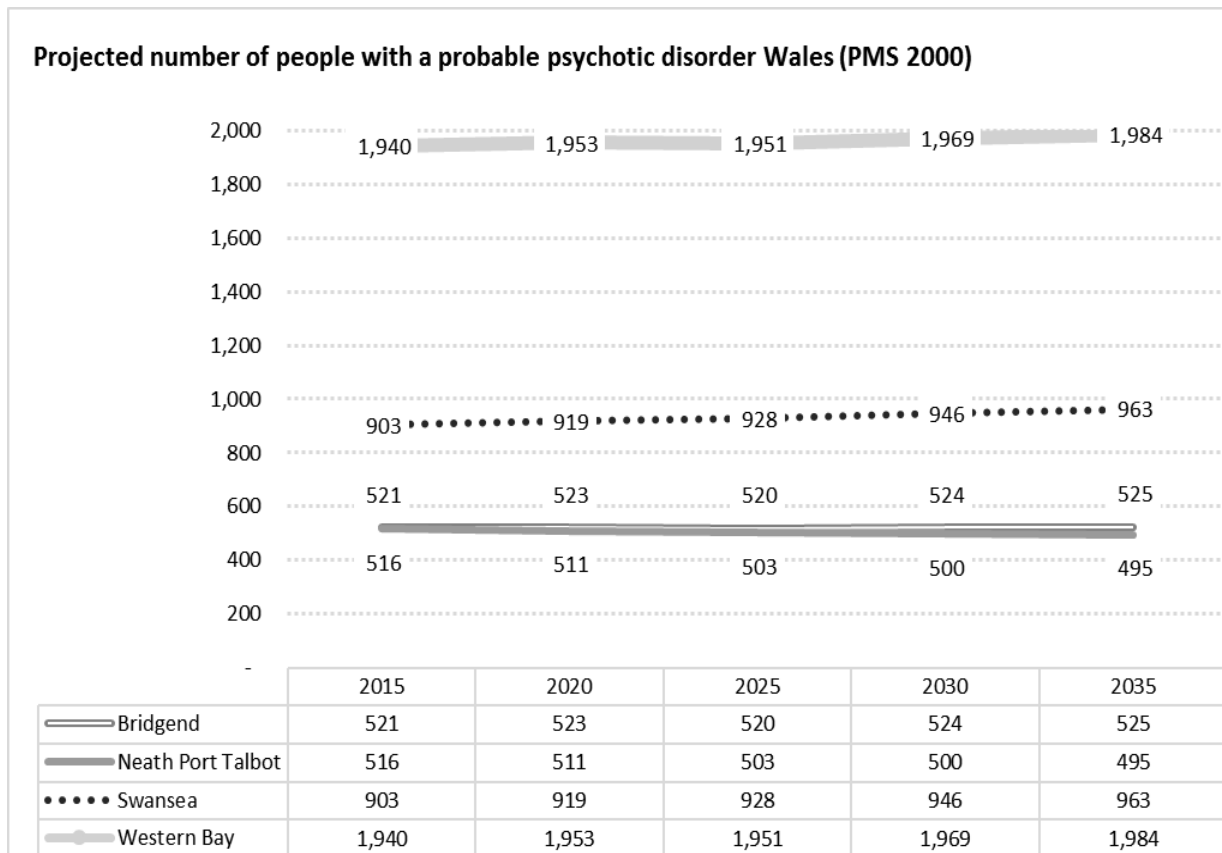


Note these two disorders may co-occur (probably rarely) so there could be some overlap between people in each category.

The least prevalent are dependent and schizotypal personality disorders, at 0.1% of the population.

### Projected Prevalence of Probable Psychotic Disorder

The following chart shows the projected numbers of people with probable psychotic disorder across Western Bay to 2035 at five-year intervals, given a stable prevalence of 0.5% of the adult population across the surveys carried out 1993-2007.



### Projected Numbers Receiving Treatment, Contact with GP & Receiving Community Services

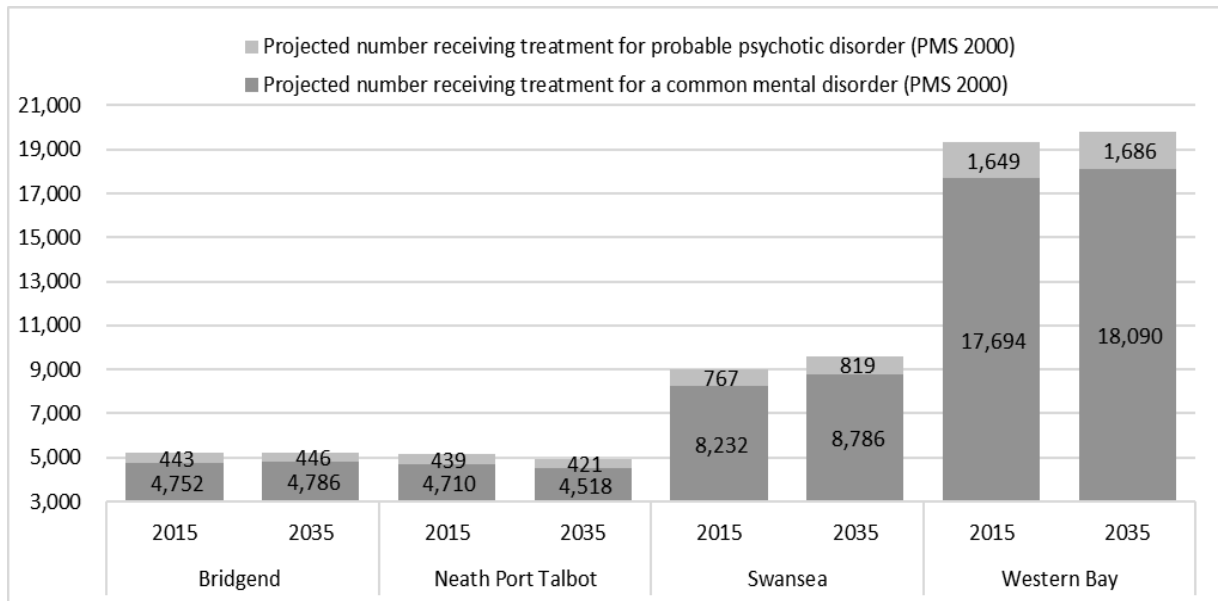
The projected numbers in these section are based on the projected prevalence rates set up above and compared to the findings of the 2000 survey regarding these topics as related to CMDs and probable psychotic disorders. We present only treatment data for CMDs and probable psychosis due to absence of data for personality disorder.

## Receiving Treatment

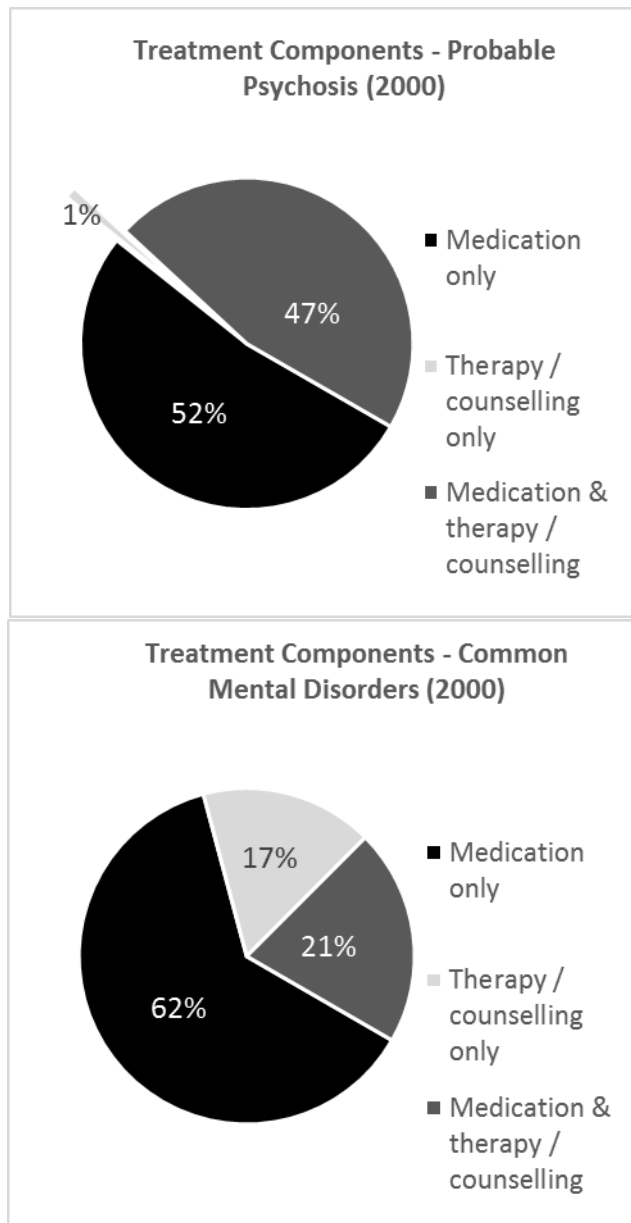
Treatment is explicitly defined in the survey as those receiving the following in the previous year:

- Receiving medication **and / or**
- Receiving counselling / therapy.

In 2000, 24% of people with CMD were projected to be receiving treatment, as were 85% of people with a probable psychotic disorder. The 2007 survey for England showed 81% for probable psychotic disorder while treatment for CMDs remained at 24%. I have retained the 85% treatment rate as the 2007 data for probable psychosis was regarded as less reliable due to smaller sampling rates. The 24% treatment rate for people with CMDs is also used.



It is possible for a person to experience both and therefore there will be some overlap in the two sets of numbers.



The treatment used most often for CMDs and probable psychosis is medication, with 99% of those with probable psychosis receiving medication as part of their treatment, and 83% of those with CMDs receiving medication as part of their treatment. 48% of those with probable psychosis receive some form of therapy / counselling, while just 38% of those with CMDs receive this form of therapy. 62% of those with CMDs receive only medication as treatment.

### Talking to GP About a Mental or Emotional Problem

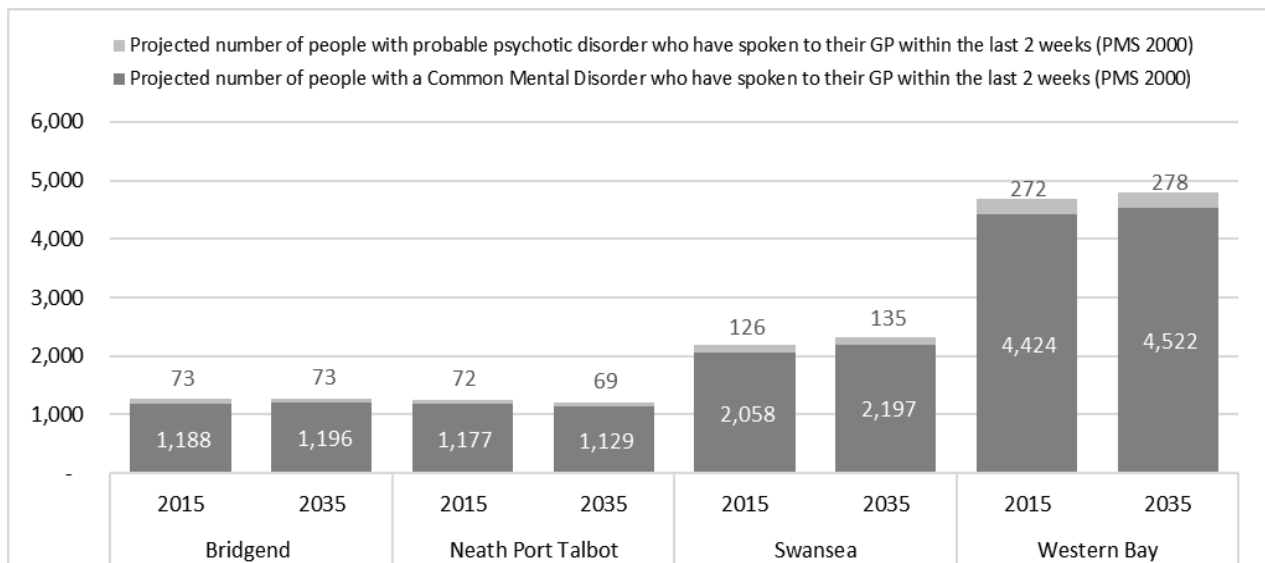
General Practitioners consider that a large proportion of their consultations relate to mental health problems. The data from the 2000 survey suggests people with mental health problems may be much more likely to speak to their GP about a mental or emotional problem than those who do not have such problems.

The table below shows that 14% of people with a probable psychotic disorder spoke to their GP about a mental or emotional problem in the last 2 weeks compared to 2% of people who do not have such a disorder: a seven-fold difference. Similarly, those

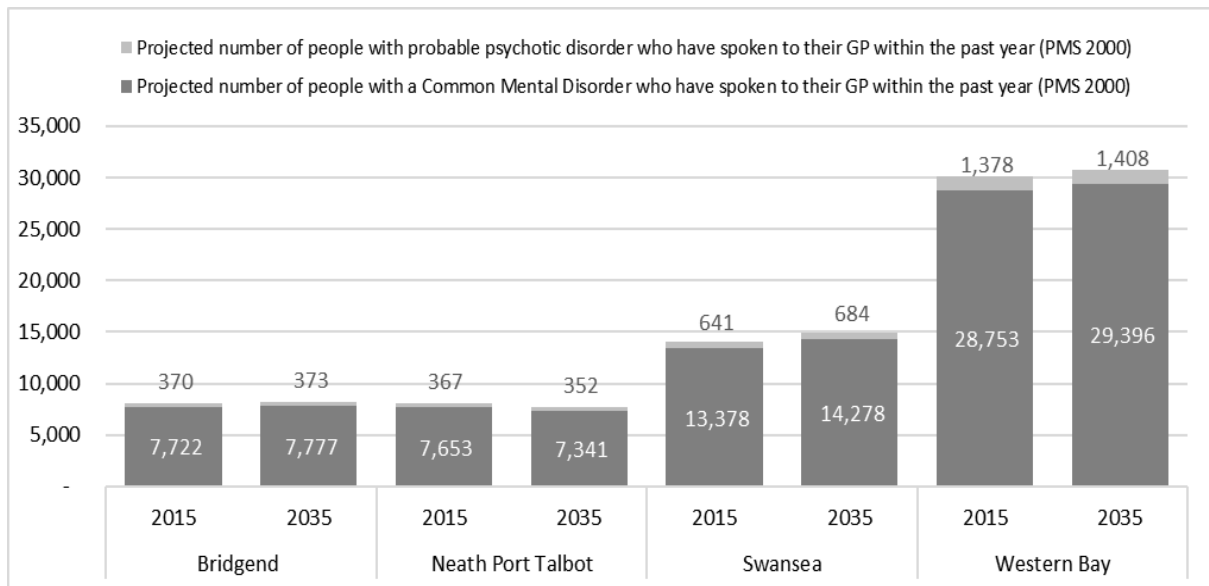
with CMDs are six times more likely to have spoken to their GP than those without CMDs.

	% of people spoken to GP about a mental or emotional problem			
	With CMD	Without CMD	With probable psychotic disorder	Without probable psychotic disorder
<b>Have spoken to GP about a mental or emotional problem</b>				
<b>Within previous 2 weeks</b>	6	1	14	2
<b>In the last year</b>	39	6	71	11

Looking at the whole of Western Bay using the projection for having seen GP within last 2 weeks for 2015 in the graph below, approximately 4,700 GP consultations in a fortnight were carried out with people with CMDs or a probable psychotic disorder. Over a 52-week period, this is over 122,000 consultations (125,000 by 2035). It should be remembered that there will also be a considerable number of additional consultations that relate to substance misuse or to personality disorder.



The graph below shows the projected numbers of people with CMD / probable psychosis who had spoken to their GP within the previous years.



For a whole of 2015, approximately 30,100 patients with CMD / probable psychosis will have spoken to their GP about a mental or emotional problem. Compared to the 122,000 calls, it could be suggested that each CMD / probable psychosis patient, on average, will speak to their GP about a mental or emotional problem roughly 4 times in a year.

### Accessing Community Services

#### Definition of community services

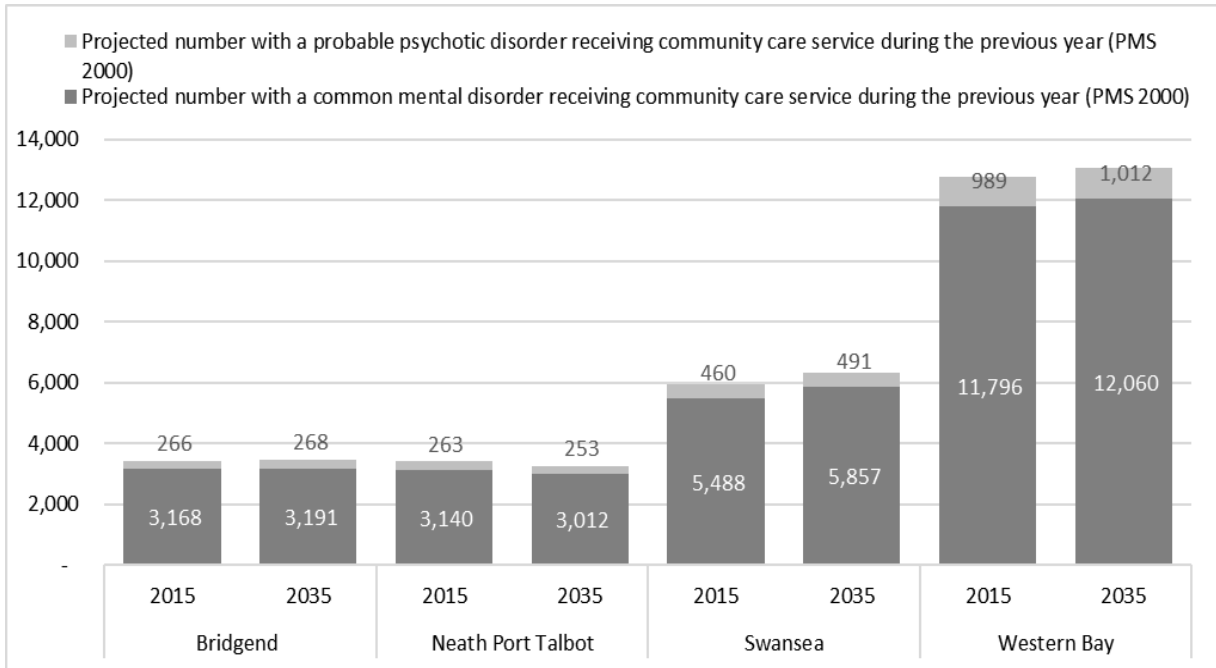
GPs treat the highest proportions and numbers of people with mental disorders. People who have more serious mental health problems would be more likely to access more specialist services. Within the psychiatric morbidity survey, these are known as **community services**.

The term community services relates to any of the following:-

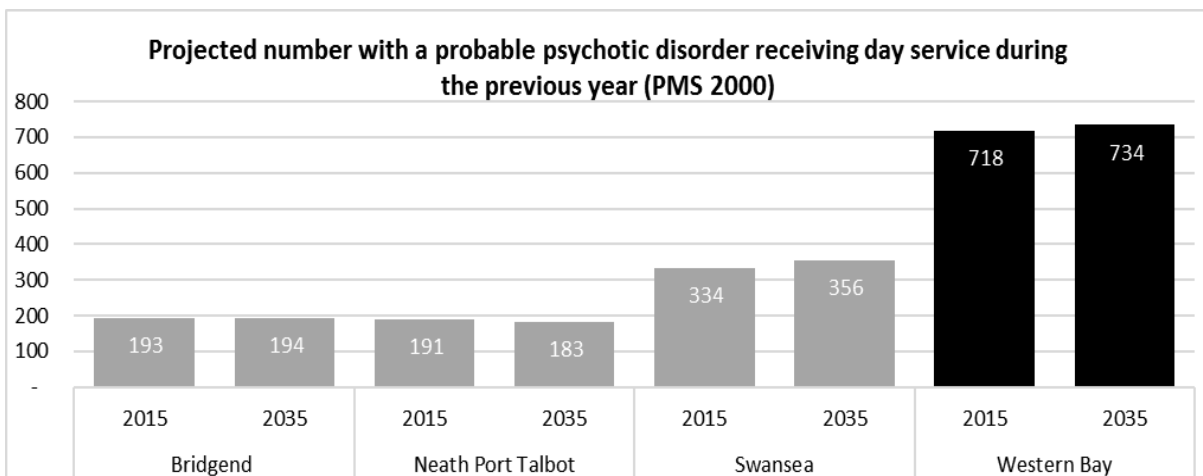
- Psychiatrist
- Psychologist
- Community psychiatric nurse
- Community learning difficulty nurse
- Other nursing services
- Social worker
- Self-help/support group
- Home help/home care worker
- Outreach worker

18% of people with a CMD are anticipated to use community care services within a year, while 51% of those with a probable psychosis are also anticipated to use community care services.



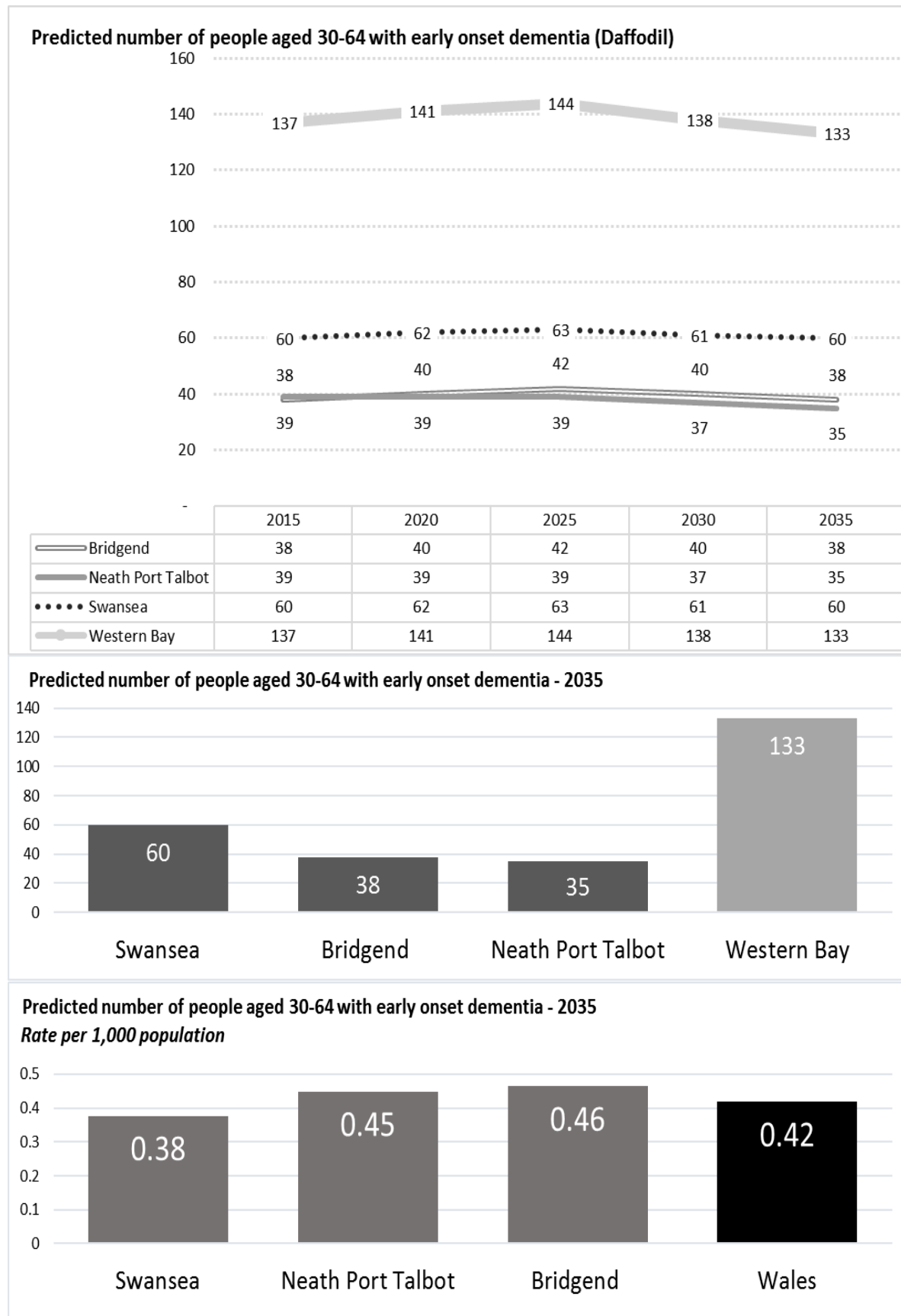


Day service is another aspect of community provision and is usually most focussed on those with the most serious disorders, particularly psychotic disorders. Only 3% of people with CMDs use day services compared to 37% of people with a probable psychosis.



## Early-Onset Dementia

Numbers in this population group are projected to remain stable.



## **Strategic Considerations**

The Mental Health Commissioning and Delivery Plan complements our Adult Social Care (ASC) Commissioning Plan, *Living Independently in Bridgend in the 21st Century (2010-20)*, it is intended to be a vehicle for implementing our vision for ASC and to align and deliver the values and objectives specified in key local and regional strategic commissioning documents. This plan embraces the principles set out in the Welsh Government strategy and delivery plan for mental health and wellbeing in Wales: *Together for Mental Health* and supports the Western Bay Health & Social Care Programme *Moving Forward Together: Joint Commitments for Mental Health Services* and will help to drive forward the implementation of *Social Services and Wellbeing (Wales) Act 2014*. To ensure that our direction of travel will deliver the outcomes that matter to those who require services, this plan has been developed in consultation with key stakeholders and partners, including Service Users and Carers.

Collaborative and integrated approaches to planning, commissioning and delivery are key elements to successfully taking forward our intentions and commitments. Our commitment to partnership working can be seen through our involvement with the Bridgend Local Services Board and our continuing work as a member of the Western Bay Health and Social Care Collaborative, which is a partnership between the City & County of Swansea, Bridgend County Borough Council, Neath Port Talbot County Borough Council and Abertawe Bro Morgannwg University Health Board (ABMU).

In the context of this Plan, support includes meeting the individual's health, social, housing, personal, wellbeing and educational needs. The main focus of this Plan is adults with mental ill health and their families and/or Carers within the county borough of Bridgend but also has links into the Children's and Adolescent Mental Health Team (CAMHT), the Older People Mental Health Team (OPMH) and the regional picture within the Western Bay Collaborative. It complements the development and implementation of Bridgend's ASC *Dementia Commissioning and Delivery plan*, which specifically concentrates on dementia and older people mental health services.

Our definition of mental health problem, mental illness and mental ill health has been taken from *Joint Commitments for Mental Health*:-

**Mental health problem** - emotional distress that may not constitute a mental illness but may be a predisposing factor to mental illness.

**Mental illness** – a diagnosable condition including both common mental health problems and severe and enduring mental health problems.

**Mental ill health** – a term which incorporates mental illness and mental health problems.

Our vision is for all the people who receive support from ASC and it applies to people requiring mental health services and Carers and families that require support. This vision supports the Council's improvement priorities of 'working

together to improve lives within the borough' as set out in our corporate plan, *Working Together to Improve Lives*.

**Our vision is:-**

“To promote independence, wellbeing and choice that will support individuals in achieving their full potential in healthier and vibrant communities” (Wellbeing Directorate Business Plan 2008-11).

This will mean promoting the principles of choice, independence, empowerment, opportunity, dignity and respect. It will involve safeguarding vulnerable people and developing preventative approaches to ensure that people receive the most appropriate level of assistance, in order to reduce the need for long term support from statutory Agencies.

The establishment of a new model of assistance and support will enable us to achieve our vision. This model requires a change in traditional commissioning practices to a person-centred approach that promotes positive outcomes for individuals and offers value for money. Our model has five key elements which are linked to our assessment process and strives to enhance a person's independence by providing appropriate responses to identified needs.

**Key Elements of our model:-**

**1. Enabling Approaches** that allow people to make better-informed decisions about the type of support they require.

This will be achieved by:-

- **Improving signposting and information** about support options to enable people to continue managing their needs themselves;
- **Expanding the range of independent advocacy support** available to assist people to make informed choices and decisions about support arrangements that impact on their lives;
- **Promoting and improving the take up of direct payments** and encouraging people to become involved in the planning of their support and to have more control over their own future;
- **Supporting Carers and families** by increasing the offering and take up of carer assessments, continually improving the involvement and engagement of Carers and improving the consultation process and flow of information to Carers.

**1. Preventative Approaches** that focus on early identification of changes to a person's needs that constitute a risk to their continued independence and ability to manage their own needs.

This will be achieved by:-

- **Supporting independence in the home** by increasing the range of options for maintenance of independence and targeted assistance in a person's own home;

- **Increasing community opportunities** by expanding the use of individually planned support arrangements in a range of integrated community settings that reduce high dependence on statutory services;
- **Increasing the range of short break options** in the community for Service Users and Carers which are appropriate, accessible and flexible outcome focused breaks;
- **Creating more opportunities for supported employment** which enable people to access voluntary or paid work and reduce the need for formal support;
- **Providing intermediate care and reablement approaches**, which offer short term intensive support that enables people to either regain or maintain their level of functioning for living independently;
- **Remodelling community support facilities** into integrated specialist community support resources that can deliver specialist and intensive support packages for people on a time limited basis.

1. **Specialist Preventative Approaches** that provides alternative options of support for those who are at high risk of requiring long term support and/or face unnecessary prolonged support in settings that reduce independence.

This will be achieved by:-

- **Providing rapid responses and supporting people at a time of personal crisis** by increasing the range of specialist support arrangements so that unnecessary admissions to traditional care settings which reduce a person's independence are reduced.
- **Integrated Living** that enables people with complex needs who have become socially isolated to access some form of flexible social care housing related support, and in some circumstances, to access integrated community based housing schemes where there is access to higher levels of social care support.

This will be achieved by:-

- **Consolidating and increasing the number of supported independent housing schemes** for people with more challenging needs through the development of a progression pathway model;
- **Refocusing and coordinating social care housing support arrangements** more closely with mainstream community and integrated health and social care responses and work with partners to enhance the range of housing and support options for people with a range of needs.

1. **Interventionist Approaches** for people who require more specialist inputs and whose needs cannot be met without intensive packages of support.

This will be achieved by:-

- **Developing integrated specialist health and social care resources** based on the reablement model of support and tailored to the individual needs of the person;
- **Developing a range of permanent interventionist support models** for people with specialist and complex needs in partnership with local and regional partners and preferably linked to their local community networks of support.

Successful delivery of our new model of assistance and support will be achieved through the development of effective evidence based commissioning and planning arrangements. Improving of our commissioning approach will enable us to respond to the assessed needs of individuals and maximise people's independence through the procurement of quality services that offer value for money and achieve positive outcomes for the individual.

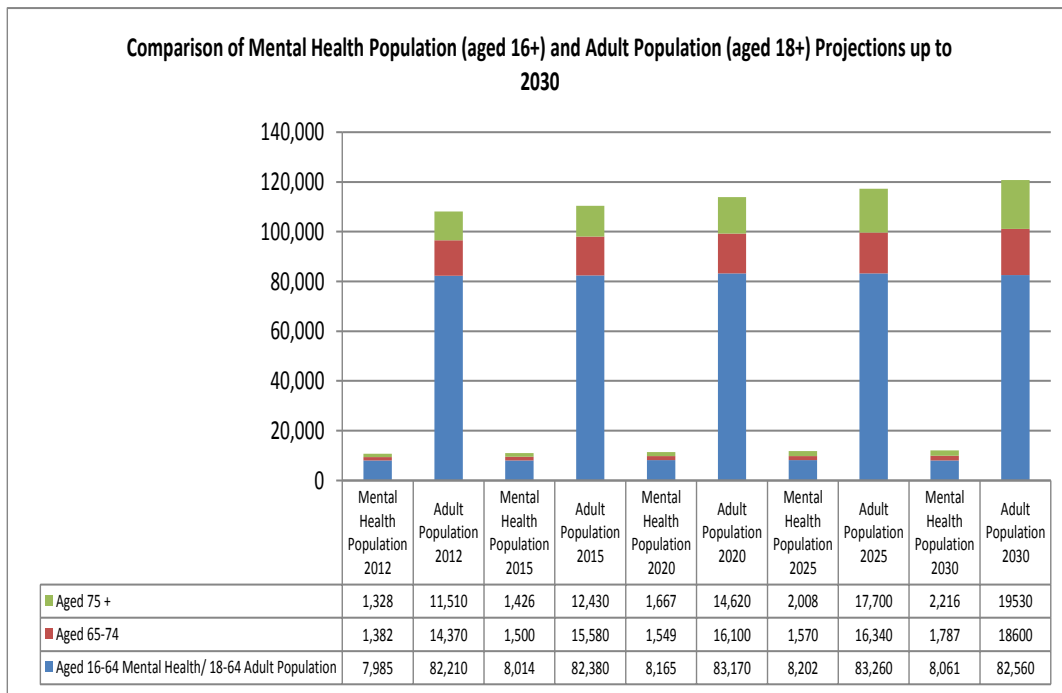
### **Current Position within Bridgend**

In Wales, 1 in 4 adults will experience some kind of mental health problem or illness within their lifetime and 2 in 100 people will have a severe mental illness such as schizophrenia or bipolar disorder (*Together for Mental Health 2012*).

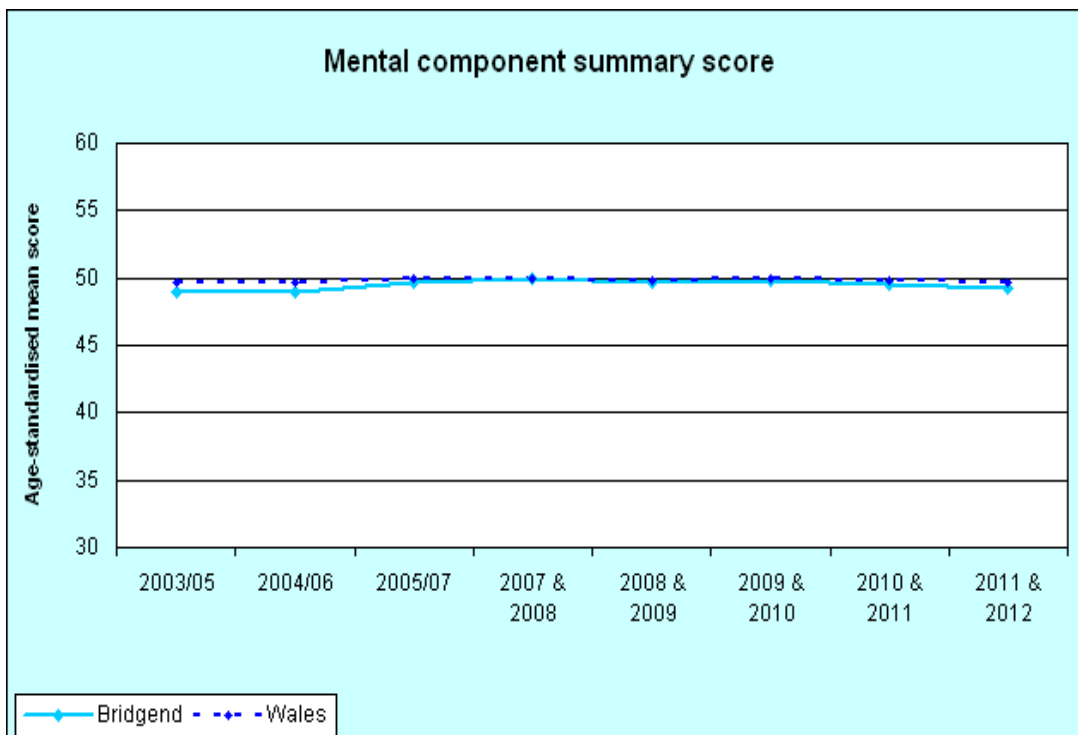
The below information helps to set out Bridgend's current picture and projected changes with regards to the boroughs adult mental health population, their needs and our available services. This data does not include dementia figures as this is contained within the Dementia Commissioning Strategy.

*The Welsh Health Survey (2012)* states that in Bridgend, 13% of adult respondents report as being treated for a mental health illness. The survey also highlighted that in Wales a higher percentage of women (14%) than men (8%) report being treated for a mental illness.

Projection of need: The below diagram shows the predicted number of people in Bridgend with a mental health problem. These predictions are based on projection data from *Daffodil* using information taken from the Welsh Health Survey. Adult respondents were classified as having a mental health problem if they reported as currently being treated for depression, anxiety or 'another mental illness'.



**Mental Component Score:** The below diagram taken from the Welsh Government's *Statistics for Wales: Local Area Summary Statistics for Bridgend* compares the mental component summary score for Bridgend against the trend for Wales. The score, which is a relative measure of well-being, shows that although there has been a slight decline over the last few years, the mean score for 2011/12 was not significantly lower than the Welsh average.



Our service and financial data indicates the following emerging themes:

- A significant proportion of the ASC mental health budget is spent on a small number of high cost residential and nursing placements. This demonstrates a need to review high cost placements to ensure that people are receiving appropriate levels of support in the most appropriate settings and that this is supported through models of support that promote the progression pathway. It also highlights the need to explore options for developing a brokerage service for high cost placements with our Western Bay partners.
- The number of people supported in residential or nursing placements has remained roughly the same over the last few years, yet at the same time, the number of Service Users receiving domiciliary care has risen. There has been an increase in the number of people receiving domiciliary care in Mental Health and a rise in the number of assessed and delivered hours. This may indicate that demand for traditional models of support has been reduced and that those who require services want to receive support within their own homes and communities.
- More people are choosing to receive direct payments and the net budget for this has significantly risen year on year to reflect this increase in demand although there is still low take-up in Mental Health services. We therefore need to ensure that those who choose to directly purchase services are able to access appropriate information and advice.
- The majority of accommodation based services, including supported living establishments, are located in or around Bridgend town centre and there is very little provision within the valleys. In order to enable people to remain within their own communities, we must look at the range of support models across the borough that supports independent living, including the promotion of community based support networks.
- There has been a reduction in the number of people being referred into the Crisis Resolution Home Treatment Team. We must continue to focus on early intervention and development of preventative models of support to ensure that Service Users receive appropriate and timely responses and we have clear pathways in place to support those who are experiencing a crisis.
- Since the introduction of the Mental Health Measure, there has been a reduction in the number of people being referred to the Mental Health team and an increase in people being referred to the Assisting Recovery in the Community Centre (ARC). This reduction appears to indicate that we are



successfully enabling more people to access primary care services in line with part 1 of the Mental Health Measure.

- Data shows that there has been a reduction in the number of people requiring services provided by ARC including community support day care provision. This combined with the increase in the number of people being referred to ARC appears to demonstrate that people are being successfully signposted to non-statutory community support services. By working collaboratively with community groups, third sector and voluntary organisations, we can further maximise opportunities for local services to offer support networks.

### **Challenges for the Future**

There are a number of national and local factors that impact on ASC, which are key drivers in terms of strategic planning such as:-

- **Demographics** - It is expected that demand on all social care services will grow due to the anticipated demographic changes in Bridgend. Projections indicate that Bridgend will see an increase of people with a mental health problem. In order to facilitate choice, control and long-term independence, we need to explore and invest in a range of preventative and supportive services within the community.
- **Citizen Directed Support** - The Welsh Government's approach to Citizen Directed support requires Local Authorities to:-
  - Extend the use of Direct Payments;
  - Work in a person-centred and outcome-focused way;
  - Develop support pathways in collaboration with key partners.

ASC expenditure on Direct Payments has significantly increased over the last five years. It is important to ensure that those who receive services directly commissioned from ASC and those who are in receipt of direct payments have sufficient information, advice and advocacy to make informed decisions about their care and are involved in their care planning as much as their capacity allows.

- **Prison Population** – A significantly high number of prisoners have a mental health problem, with 9 in 10 prisoners experiencing a diagnosable mental health and/or substance misuse problem (*Together for Mental Health 2012*). HMP/YOI Parc is the largest prison in Wales and there are plans to further expand the prison. Approximately 80% of prisoners from HMP/YOI Parc were released to live in Wales (HMP/YOI Parc Inspection Report, July 2013). Unless prisoners in Wales have made themselves intentionally homeless, they are guaranteed accommodation on release. Therefore, we must ensure

that services are able to meet the needs of those with offending behaviours in a timely manner and that we work in partnership with other agencies to ensure that they receive appropriate support.

- **Substance Misuse** – In Bridgend, 45% of adult respondents to the Welsh Health Survey reported that their daily alcohol consumption was above guideline amounts. The number of referrals in Bridgend for alcohol misuse in 2012/13 was 364 and in the same year there were 304 referrals for drug misuse (StatsWales). The Welsh Government's 2008-18 substance misuse strategy *Working Together to Reduce Harm* highlights that substance misuse can be both a symptom and cause of a mental illness and notes the negative effects that a person's substance misuse can have on the health and wellbeing of their families. In order to deliver effective support that meets the complex needs of Service Users with co-occurring substance misuse problems, it is important to work collaboratively with other organisations and Agencies to deliver coordinated treatment pathways.
- **Complexity of need and co-occurring conditions** – There has been an increase in the number of people with a mental illness who also have other health and/or wellbeing issues. It is important to work in partnership with Health and other Agencies to develop services that can meet these needs and develop integrated pathways to ensure that Service Users receive a holistic response. Some of the most frequent co-occurring conditions in Bridgend include:-
  - Substance Misuse;
  - Personality Disorders;
  - Offending Behaviours;
  - Autistic Spectrum Disorder;
  - Women with complex, chaotic and offending behaviours;
  - Sensory Impairment;
  - Physical frailty and physical disability.
- **Carers** – According to 2011 Census data there were 17,919 Carers in Bridgend. It is acknowledged that this figure is likely to be much lower than the actual number of Carers in the area. Local Authorities are keen to find ways of offering and providing support and assistance to help Carers and families care for their loved ones. The Social Services and Well-Being (Wales) Act 2014 places Carers on an equal footing to those they care for and ensures access to assessments and the appropriate services. In addition, The Carers Strategy (Wales) Measure 2010 also places new legal duties on the NHS and Local Authorities to work together in consultation with Carers to publish and implement a joint Carers Information and Consultation Strategy.
- **Financial drivers** – Local Authorities are facing a challenging financial future and will have to face difficult decisions in terms of services and how they will be delivered. The financial climate and the need to make significant

efficiencies requires us to look at innovative ways of service improvement, including collaborative models and to review the balance between what is directly owned and provided by the Authority and what is provided by external partners. Despite the challenges posed by the current financial situation, the **key** driver for this plan is to develop the way services are delivered to make them person-centred and focused on delivering independence, rehabilitation and recovery approaches.

- **Section 117 of the Mental Health Act** – Health and Social Services have a statutory joint duty to work in partnership with other relevant agencies to provide aftercare to certain patients that have been detained for treatment in hospital under particular sections of the Mental Health Act. Service Users in receipt of aftercare provided under S117 cannot be charged for these services.
- **Rurality-** Bridgend has a number of rural and valley communities. Current accommodation based support commissioned by ASC is largely based in and around Bridgend town centre. It is important to look at the services we commission to ensure that Service Users can remain within their own homes when possible and receive support and care within their communities.
- **Deprivation** – Evidence suggests that there is a link between poor mental health and deprivation. Factors including homelessness, poverty, abuse, social isolation and poor working conditions can have a negative impact on a person's mental wellbeing.
- **Enabling Independence** – Moving away from traditional care models will require us to work closely with Service Users, Carers and families to help vulnerable people attain the skills and confidence that will enable them to attain maximum independence and also to support people to maintain their levels of independence for as long possible. This will also require changes to our care co-ordination and assessment processes to ensure that there are positive responses to risk taking and that support is appropriate to the level of need.
- **Collaboration** – The progression of the collaboration agenda requires robust governance procedures and the need to develop processes for sharing risks, funding and ownership in order to progress our shared agendas.

## **Strategic Drivers**

There are a number of national, regional and local strategic drivers that have and continue to shape the development and delivery of mental health services.

### **National objectives -**

**Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales and Delivery Plan; 2012 16** – Aims to improve outcomes for those who require mental health services, their Carers and their families and improve the wellbeing of the wider population. It places the Service User at the centre of service delivery, emphasises the importance of partnership working and promotes a ‘recovery and enablement’ approach to help people to live independently and reach their full potential. The Strategy focuses on six high level outcomes:-

1. To improve whole population mental health and wellbeing;
2. To reduce the impact of mental health problems and/or mental illness on individuals, families, Carers and their communities;
3. To reduce inequalities amongst people experiencing mental illness and mental health problems;
4. To increase the feeling of control that people in receipt of assessment, treatment and services have over decisions made that affect them;
5. To demonstrate the long term economic advantage of a whole population, all ages approach to improving mental health and wellbeing and treating mental illness;
6. To improve the values, attitudes and behaviours of staff within the public, independent and Third Sector in relation to mental health and wellbeing.

The associated Delivery Plan sets out key actions for the Welsh Government and key partners to deliver the six high level outcomes.

- **Mental Health (Wales) Measure 2010** - Places a legal duty on Local Health Boards and Local Authorities with regards to the assessment and treatment of people with mental health problems and will improve access to independent mental health advocates. The Measure will result in an increase of services available within primary care, ensure that all patients receiving secondary services have a Care and Treatment plan, enable adults discharged from secondary services to refer themselves back into services for assessment and provide opportunities for all in-patients to receive help from an independent mental health advocate if required. The four Parts of this Measure are:-
  1. Part 1 - Local and Primary Mental Health Services – places a legal duty on Local Authorities and Health Boards to establish local primary

mental health services across Wales within and alongside GP settings, including assessment, short term interventions, information and advice, and where appropriate, onward referral to other services;

2. Part 2 – Care Co-ordination and Treatment Planning - gives all people who receive secondary mental health services an individual Care and Treatment plan;
  3. Part 3 – Assessments of Former Users of Secondary Mental Health Services – allows eligible adults discharged from secondary care to self-refer directly into secondary services without the need to see a GP if they believe their mental health is worsening;
  4. Part 4 – Independent Mental Health Advocacy – extends the Independent Mental Health Advocacy (IMHA) scheme to enable all inpatients in Wales in receipt of assessment or treatment to request support from an IMHA.
- **Social Services and Wellbeing (Wales) Act 2014** - Aims to empower those in need of social care services and their Carers and to promote their independence by affording them a stronger voice and giving them more control over the services they receive. The Act emphasises the promotion of equality, improvement of service quality and provision of information and stresses the need for commissioners to achieve a shared focus on prevention and early intervention. Key elements of the Act include:-
    - Revised assessment, eligibility and care support and review arrangements and practices;
    - New ways of providing information, guidance and wellbeing support for the public;
    - Strengthening early intervention, re-ablement and prevention services;
    - Further strengthening our work with and support for Carers;
    - Revising safeguarding arrangements;
    - Strengthening Direct Payments arrangements;
    - Promoting social enterprises, co-ops and the third sector in the provision of care, support and preventative services;
    - Duties to meet the needs of self-funders on request;
    - Clarification charging arrangements.
  - **Carers Strategies (Wales) Measure 2010** – Intends to improve the lives of Carers by placing a legal duty on Health Boards to lead on the development of a joint carer's information and consultation strategy with partner Local Authorities. Both the Health Board and Local Authorities have a responsibility to commit to and implement the joint strategy, which will ensure Carers:-

- Receive appropriate information and guidance;
  - Are actively engaged with and involved in decisions about the provision of services they, or the person they care for, receive.
- **The Williams Commission Report 2014** – Recommends a proposed reduction in the number of Local Authorities in Wales based on mergers of the existing 22 Local Authorities. At date of publication, the future shape of local government in Wales was still uncertain; however, this report emphasises the importance of collaboration and partnership working with neighbouring authorities.

### **Local and Regional Objectives –**

**The Western Bay Health and Social Care Collaborative** – Aims to provide improved sustainable services that meets people’s needs by working in partnership to identify gaps in service provision, reduce duplication and deliver new service models. The Western Bay Mental Health Project sits within this collaborative and has identified the following work streams to progress:-

- Development of community resources;
- Provision of effective unscheduled care models;
- Implementation of the Mental Health Measure;
- Development of community support and accommodation models.

**Western Bay Health and Social Care Programme: Moving Forward Together, Joint Commitments for Mental Health** – Sets out how we, with our Local Mental Health Partnership Board partners will deliver the high level outcomes within *Together for Mental Health*. The commitments place a focus on:-

- Promoting mental wellbeing and helping to build resilience for people, families and communities;
- Working together with people in providing support and care;
- Working together between and within organisations;
- Holistic care for the most vulnerable.

**Abertawe Bro Morgannwg Carers Partnership Carers Information and Consultation Strategy 2013-16** – This is a response to the Carers Strategies (Wales) Measure 2010 and sets out how the partnership will support Carers through the provision of information and ensuring Carers are involved in decisions about the services that they, and those they care for, receive.

**The Local Services Board (LSB) Single Integrated Partnership Plan: Bridgend County Together April 2013 – March 2018** - Sets out the vision for Bridgend as ‘*a healthy, prosperous and safe county where people can reach their full potential*’. One of the four priority areas within this vision is to

ensure that *'people in Bridgend are healthier'*. To achieve this priority, the Plan goes on to state that it will focus on care within the community as opposed to hospital or residential care.

**BCBC Corporate Plan: Working Together to Improve Lives (2013-2017) –**

Explains the Council's vision for the borough and identifies its priorities for improving the lives of citizens within Bridgend. These improvement priorities include:-

- Priority 4 - working together to help vulnerable people to stay independent;
- Priority 5 - working together to tackle health issues and encourage healthier lifestyles;
- Priority 6 - working together to make best use of resources.

The Plan emphasises the need to work with partners to develop a range of accommodation and support options to help sustain or achieve independence and the development of services that enable people to live healthy independent lives.

**BCBC Wellbeing Directorate Business Plan 2014-15 –**

Identifies how the Wellbeing Directorate will contribute to the Council's improvement priorities in 2014-15. The Plan sets out the Directorate's priorities, commitments and milestones for 2014-15. With regards to mental health these include:-

- Pilot the single point of access to Mental Health services in Bridgend;
- Co-ordinate the wellbeing information and advice service so that Service Users know about support that is available to them;
- Develop a dementia plan to ensure that the right services are available to support people with dementia.

**BCBC Adult Social Care Commissioning Plan: Living Independently in Bridgend in the 21st Century (2010-20) -**

Sets out a range of principles that meets the requirements and objectives of local strategies and provides a framework for exploring the potential of integrating the ASC and local NHS agenda. A key theme of the strategy is to promote collaboration and partnership across organisations, communities and individual people. It highlights that there is a need to move from traditional commissioning practices to more person-centred enabling approaches that promote positive outcomes for individuals.

**BCBC Supporting People Local Commissioning Plan 2013/14 –**

Highlights mental health as one of the dominant lead needs for housing related support (7%). The Plan's vision is to develop a range of 'joined-up' services that will provide a number of options to support a person's independence. A key message within the Plan is the need for preventative and emotional support

services, the creation of community support networks and the development of a range of care models that offer more flexible levels of support.

### **Journey So Far**

Over the last few decades there have been significant changes to the delivery of Mental Health services, not only in Bridgend but across the UK. Current models of support have moved away from traditional inpatient based care, which focused on 'treatment', towards multidisciplinary community based approaches that promotes the 'recovery' philosophy.

There are many interpretations of the recovery philosophy but the underlying concept within the Mental Health (Wales) Measure 2010 is 'the belief that it is possible for someone to maintain, gain or regain skills that help them to live as fulfilling a life as possible, despite serious mental illness'.

### **Current Services**

The current model for mental health services in Bridgend is largely a result of incremental changes in service design in response to policy developments, local pressures and organisational transformations. There is a recognition locally that there needs to be a greater investment in the development of a wider range of mental health services, for example the expansion of more community based approaches. We must therefore work in partnership with stakeholders to ensure that the services we provide meets, and continue to meets, the changing needs of the population through effective planning and commissioning.

Key components of our current model include:-

- CMHT's are the main source of community mental health services. They are at the core of the mental health system and are specialist, multidisciplinary, multiagency teams which provide mental health assessments and support to individuals accessing services. CMHT's prioritise interventions based on need, risk, and vulnerability for individuals whose complexity of care cannot be met within primary care services;
- The multi-disciplinary and multi-agency Home Treatment Team to support people experiencing crisis within their own homes in order to avoid admission or readmission into mental health inpatient services;
- Outpatient consultant clinics to support people within the community;
- A Primary Mental Health Support Service developed in partnership with ABMU HB under the provisions of Section 2 of the Mental Health (Wales) Measure 2010 to support and secure local provision of mental health services;
- Structured day opportunities, psychological and psychotherapeutic interventions provided out of the ARC centre;
- The specialist Perinatal Response Management Service (PRAMS) for those experiencing significant stress and/or other mental ill health in pregnancy and up to a year after birth;



- A range of inpatient specialist services at Princess of Wales Hospital and Glanrhyd, including assessment, respite, rehabilitation and long-stay beds;
- Residential and nursing care establishments for people with high or intensive support needs;
- Glyn Cynffig Hostel to provide support and assistance to adults recovering from serious mental illness, including those with co-occurring serious mental illness and substance misuse;
- Supported living accommodation providing supportive environments to enable people to live independently within the community;
- Floating support to provide targeted and flexible responses to assessed need;
- Domiciliary care providing personal and practical support within a person's home;
- A range of voluntary sector services providing a range of information, support, advocacy, activities and befriending for Service Users and Carers.

### **What have we done and what are we doing**

Within the last few years, there has been a great deal of activity across mental health services in order to drive forward our commissioning and service objectives. Some recent and upcoming projects include:-

- Working with our colleagues in Supporting People to create a short-term fixed accommodation service for individuals with mental health problems who are also experiencing 'vulnerable and chaotic' lifestyles;
- Progressing the development of a community service model based on a circle of support in partnership with our colleagues in Supporting People;
- Appointing a Mental Health Elected Member Champion to help tackle stigma and discrimination attached to mental illness;

Creating of a local primary Mental Health Support Service, which delivers:-

- Comprehensive primary mental health assessments;
  - Short term interventions;
  - Information and advice about treatment to Service Users and Carers;
  - Support and advice to GPs and other primary care workers;
  - Support to Service Users in regards to their onward referral to secondary mental health services.
- Developing a service to boost community resilience, combat discrimination and provide services to those affected by suicide;
  - Progressing the development of community support services that will focus on prevention, information, signposting, early intervention and improving community resilience with our Western Bay partners;

- Establishing a complex case panel to ensure that Service Users leaving hospital are appropriately supported in the community;
- Moving away from traditional day centres by providing day opportunities within the community.

### **Opportunities**

We have been able to identify a number of opportunities to further progress our commissioning and service objectives, including:

- Supporting people to move into services that offer more appropriate levels of support through the development of a progression pathway model;
- Developing a range of accommodation options, including crisis provision and alternatives to traditional inpatient facilities for those with complex needs;
- Working with accommodation providers to develop a more flexible market, which is able to meet demand and provides greater independence;
- Reviewing high cost placements to ensure that people are receiving appropriate support in an appropriate model of care;
- Working with colleagues in Supporting People to maximise joint commissioning opportunities;
- Improving information flow from Social Workers to the Commissioning Team so that practice knowledge informs commissioning activity;
- Building on our collaboration with partners in Health to develop integrated services. In the context of Western Bay, consider ways to pool budgets and holistically purchase services and expand the range of therapeutic responses for individuals exhibiting behaviour deemed to challenge services;
- Evaluating the quality and outcomes of Care and Treatment Plans to ensure that they are person centred and deliver outcomes that are important to Service Users;
- Developing a single point of access across the Western Bay area so that there is equitable and consistent access into mental health services across the region;
- Undertaking a review of unscheduled care and crisis provision to reduce likelihood of hospital admission and support early discharge;
- Encourage the take up of Carers assessments and exploring opportunities to further support Carers to continue in their caring role;

- Improving the way we measure outcomes of services for Service Users so we know what difference our modernised services are making.

### **What we want to Achieve**

We aim to work with our stakeholders and partner organisations to reshape existing services in order to achieve our vision of providing person centred services that enable independence, maximise personal potential and are flexible and responsive to need, whilst ensuring effective use of funding within the context of BCBCs Medium Term Financial Strategy. Below are some high level objectives, which we intend to take forward over the next three years.

### **Care Coordination**

Continue to ensure that care plans and reviews are person centred;

- Build on current assessment processes to deliver clear outcome focused care planning that supports the recovery approach and the progression pathway;
- Work with colleagues in children's services at earlier points to develop more effective transitions to adult services;
- Promote positive approaches to risk taking with partner agencies and Service Users by building on current risk management approaches to enable independence and reduce the need for more intensive support whilst identifying and appropriately supporting those who are at increased risk of suicide, self-harm, self-neglect and/or harm to others;
- Ensure that Service Users are supported to be involved in the decisions that affect them as much as their capacity allows and follow best practice to assess mental capacity, to enhance mental capacity and utilise the most appropriate ways of helping Service Users make their own decisions;
- Continue to develop processes that enable Service Users to define the outcomes that matter to them;
- Provide information to Service Users and Carers so they can play an informed part in their Care and Treatment pathway;
- Develop a single point of access for people requiring mental health services.

### **Range of Care Models**

Develop a clear progression pathway through different models of support and accommodation, which provides alternatives to hospital admission and supports the recovery approach;

- Establish effective care pathways that promotes integrated support, care planning and service delivery so that Service Users who have a

mental illness alongside other health and social problems experience holistic support and treatment;

- Work with the provider market and stakeholders to develop a wider choice of and increased access to 'move on' accommodation and housing related support models, including enabling, step down and floating support;
- Create needs-led services that supports Service Users at the appropriate level and for appropriate periods of time and promotes 'move-on' into lower levels of support in order to attain maximum independence;
- Increase opportunities for people to receive support that enables them to remain in their own homes;
- Support the maintenance of mental health by working proactively with other agencies and partners to encourage the development of community based support networks and models, including information, community and non-specific mental health services;
- Develop appropriate and specialist models of care to support those with complex needs and co-occurring conditions;
- Provide robust care pathways for those in crisis and develop a range of support models to ensure that those in crisis receive appropriate and timely responses;
- Develop preventative and specialist models that help people remain out of traditional care services and reduce the likelihood of crisis situations.

### **Independent Living**

- Promote the development of local support networks in the community and prevent social isolation by maximising opportunities for local services to offer natural support networks;
- Continue to expand opportunities for individuals to develop life skills that promotes and enables independence;
- Work with community groups, third sector and voluntary organisations to collaboratively develop localised support networks;
- Improve opportunities for individuals to access training, education and work;
- Further develop ways to enable Carers to continue in their caring role by providing appropriate information, advice and services.

### **Collaboration**

Respond to national policies and objectives, such as the implementation of the Social Services and Wellbeing (Wales) Act, the Mental Health (Wales) Strategy, the Cares Strategy (Wales) Measure and Together for Mental Health;

- Progress the Western Bay Collaboration agenda and respond to the Williams Report by working with neighbouring Authorities and Health Boards to identify possibilities for jointly commissioning and delivering services;

- Seek further opportunities to pool budgets and align services to improve experiences for Service Users through the provision of coordinated care models;
- Work alongside partners to help people to move on from traditional care settings to more community based and needs led services that offer flexible levels of support;
- Work with colleagues in Supporting People to identify housing related support solutions in order to develop effective and sustainable community based lower level support and preventative services, which promote independence;
- Work with other agencies, including Health and the Third Sector to enhance quality of services and improve effectiveness of services provided to Service Users, especially those with co-occurring conditions;
- Optimise opportunities to identify and attract funding from partner agencies to further develop services;
- Explore opportunities to develop a regional brokerage service for high cost placements.

### **Commissioning and Planning**

- Implement clear mechanisms for improving the information flow from practice to commissioning so that practice knowledge informs commissioning activity;
- Carry out further development activity to ensure that the local market can respond to future demand;
- Strengthen engagement approaches so that Service Users and Carers are involved in the planning, development and implementation of the services they require;
- Produce a robust and transparent market position statement that outlines our commissioning intentions to transform and shape services for the future.

### **Equalities**

Underpinning everything we do is our commitment to our public sector duties of advancing equality of opportunity between people who have protected characteristics and people who do not, fostering good relations between those who have a protected characteristic and those who do not and eliminating discrimination, harassment and victimisation. With this in mind, we will continue to progress our commitment of ensuring that:-

- There is equitable access to services which are responsive to, and inclusive of, the individual needs of those with protected characteristics;
- People are not discriminated against or stigmatised because of their mental ill health;
  - Welsh speakers are able to receive services that meet their linguistic preferences



## 2. Profile of Spend and Activity

Social Services & Wellbeing - Adult Social Care (SERBA) Budget Monitoring Summary											
15/16											
	FULL YEAR BUDGET			ACTUAL TO DATE			FULL YEAR FORECAST			Projected Variance (Under) / Over	Comments
	Budget Exp	Budget income	Net Budget	Actual Exp	Actual Income	Net Actual to Date	Full Year Forecast Exp	Full Year Forecast Income	Full Year Net Forecast		
<b>AOSBAD - ADULTS MENTAL HEALTH NEEDS</b>											
<b>DOSB24 - RESIDENTIAL CARE</b>											
7412 RESIDENTIAL/NURSING MH	1,949,510	(805,280)	1,144,230	1,989,162	(864,916)	1,124,246	1,989,162	(864,916)	1,124,246	(19,984)	0
<b>Total</b>	<b>1,949,510</b>	<b>(805,280)</b>	<b>1,144,230</b>	<b>1,989,162</b>	<b>(864,916)</b>	<b>1,124,246</b>	<b>1,989,162</b>	<b>(864,916)</b>	<b>1,124,246</b>	<b>(19,984)</b>	
<b>DOSB25 - SUPPORTED &amp; OTHER ACCOMM</b>											
7400 GLYN CYNFFIG	567,720	(422,580)	145,140	460,138	(376,360)	83,777	460,138	(376,360)	83,777	(61,363)	project spend
<b>Total</b>	<b>567,720</b>	<b>(422,580)</b>	<b>145,140</b>	<b>460,138</b>	<b>(376,360)</b>	<b>83,777</b>	<b>460,138</b>	<b>(376,360)</b>	<b>83,777</b>	<b>(61,363)</b>	
<b>DOSB26 - DIRECT PAYMENTS</b>											
7418 DIRECT PAYMENTS MH	76,680	(7,000)	69,680	84,189	(45,167)	39,022	84,189	(45,167)	39,022	(30,658)	
<b>Total</b>	<b>76,680</b>	<b>(7,000)</b>	<b>69,680</b>	<b>84,189</b>	<b>(45,167)</b>	<b>39,022</b>	<b>84,189</b>	<b>(45,167)</b>	<b>39,022</b>	<b>(30,658)</b>	
<b>DOSB27 - HOME CARE</b>											
7411 MH SUPPORTED LIVING	119,060	(2,870)	116,190	123,914	(960)	122,954	123,914	(65,179)	58,735	(57,455)	
7413 INDEPENDENT DOM CARE-MH	256,190	0	256,190	464,309	(45,828)	418,482	464,309	(45,828)	418,482	162,292	
7419 HOME CARE MENTAL HEALTH	0	0	0	0	0	0	0	0	0	0	
<b>Total</b>	<b>375,250</b>	<b>(2,870)</b>	<b>372,380</b>	<b>588,223</b>	<b>(46,788)</b>	<b>541,435</b>	<b>588,223</b>	<b>(111,006)</b>	<b>477,217</b>	<b>104,837</b>	
<b>DOSB28 - DAY OPPORTUNITIES</b>											
7421 ASSISTED RECOVERY IN THE COM.	636,610	(296,800)	339,810	625,463	(296,806)	328,657	625,463	(296,806)	328,657	(11,153)	
<b>Total</b>	<b>636,610</b>	<b>(296,800)</b>	<b>339,810</b>	<b>625,463</b>	<b>(296,806)</b>	<b>328,657</b>	<b>625,463</b>	<b>(296,806)</b>	<b>328,657</b>	<b>(11,153)</b>	
<b>DOSB29 - OTHR SERV MENTHLTH NEED ADULT</b>											
7444 BRIDGEND ASSERTIVE OUTREACH TM	0	0	0	239	0	0	481	0	481	481	
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>239</b>	<b>0</b>	<b>0</b>	<b>481</b>	<b>0</b>	<b>481</b>	<b>481</b>	
<b>DOSB30 - ASSESSMENT &amp; CARE MANAGEMENT</b>											
7430 MENTAL HEALTH (ACMT)	775,810	(190,770)	585,040	740,978	(191,432)	549,546	740,978	(191,432)	549,546	(35,494)	
7438 CASWELL CLINIC	294,290	(258,880)	35,410	292,211	(258,877)	33,334	292,211	(258,877)	33,334	(2,076)	
<b>Total</b>	<b>1,070,100</b>	<b>(449,650)</b>	<b>620,450</b>	<b>1,033,190</b>	<b>(450,309)</b>	<b>582,881</b>	<b>1,033,190</b>	<b>(450,309)</b>	<b>582,881</b>	<b>(37,569)</b>	
<b>Total AOSBAD</b>	<b>4,675,870</b>	<b>(1,984,180)</b>	<b>2,691,690</b>	<b>4,780,603</b>	<b>(2,080,346)</b>	<b>2,700,018</b>	<b>4,780,845</b>	<b>(2,144,565)</b>	<b>2,636,280</b>	<b>(55,410)</b>	
<b>AOSBAF - OTHER ADULT SERVICES</b>											





### **3. Current Priorities**

#### **Priority Actions, Outcomes, Delivery and Monitoring**

The Reshaping Mental Health Project Board has been established with the strategic aim of working with key stakeholders, to review and remodel current mental health services. The overall aim of the Project Board is to create a sustainable mental health service that focuses on the prevention of mental illness and recovery for those who become unwell. This will be achieved by:-

- Responding to national and local strategies through the reshaping of existing services;
- Creating sustainable services that can continue to respond to the future needs of citizens within the Borough and are responsive to demographic changes;
- Improving outcomes for people with a mental illness through the development of a range of suitable accommodations options.

The key objectives of the Project Board are to:-

- Optimise opportunities for community networks and support systems;
- Create a progression pathway model for accommodation based services, which promotes the recovery philosophy;
- Review current unscheduled care and crisis provision;
- Undertake a review care coordination and CMHTs;
- Develop a local dementia commissioning and delivery plan that provides a response to future demographic pressures.

This Plan sits under the Project Board and we have a clear project plan to deliver the changes and progress our strategic objectives as part of the ASC Remodelling Programme.

Our vision for the future of mental health services is ambitious; we must therefore prioritise our strategic objectives in order to deliver these changes within the next 3 years. Prioritisation of our objectives has taken into account the following factors:-

- Responding to the individual needs of people with a mental illness who potentially require ASC services;
- Delivering statutory duties;
- Meeting national, local and regional objectives and performance targets;
- Effectively managing allocated resources;
- Meeting the financial demands within the Council and meeting the requirements of our Medium Term Financial Strategy.

The key priority actions for change over the next 3 years, the outcomes and the leads for taking forward our priorities within our timescale are set out in the below table. Progression against the priority actions by the relevant leads will be overseen by the Reshaping Mental Health Project Board, who will report to the ASC

Remodelling Programme Board. An annual report by the Director of Social Services will set out how we have progressed against our identified priorities within the previous year, which will help us to focus our attention on achieving our aims and identify how to proceed over the following 12 months.

The Commissioning and Transformation team regularly obtain information on incidence, prevalence, activity and demographic data in order to assess and project need within the borough. This information, alongside service performance and quality data obtained by the Contract Monitoring Team, will help us to understand the way in which this Plan is delivering our identified outcomes and monitor the impact of this Plan on those requiring ASC services.

We will regularly review our plan to ensure that the identified actions are relevant and responsive to changes this will be undertaken through population needs mapping, market analysis, service reviews, Service User and carer feedback and evaluating our practice against national policy, local strategic plans, research and best practice.

PRIORITY ACTION	OUTCOME	LEAD
<b><u>Collaboration Agenda</u></b>		
Progress the Western Bay Mental Health Programme agenda to identify opportunities to pool budgets, align services and develop mechanisms to jointly commission and procure services.	The development of collaborative approaches to the commissioning and delivery of support and care will provide a joined up approach between the Western Bay partners. This will result in seamless services, improved individual outcomes for Service Users and financial efficiencies.	Western Bay Mental Health Programme Board
Work with Partners within the ABMU HB footprint to respond to national policies, such as the Social Services and Wellbeing Act, Carers Strategy (Wales) Measure and Together for Mental Health.	The overall health and wellbeing outcomes of citizens will be improved.	Western Bay Carers Executive Group  Western Bay Mental Health Programme Board  Western Bay Partnership Board
Work with colleagues in CAMHT and Children's Services to develop a transition strategy. Implement practices and cultures which ensure identified support needs are continued and planned at the right time.	The development of a Mental Health Transition Strategy for young people entering into adulthood.	Avril Bracey

<p>Work with other agencies to deliver coordinated, joined-up support to those with co-occurring conditions.</p>	<p>Service Users with co-occurring conditions will receive holistic, timely and seamless responses for their individual needs.</p>	<p>Avril Bracey Chele Howard</p>
<p>Develop a single point of access for people requiring mental health services.</p>	<p>Those that require services will have improved experiences through the provision of seamless and timely responses, which provides consistency and avoids unnecessary duplication of information.</p> <p>Service Users will have equitable and consistent access into mental health services across the Western Bay region.</p>	<p>Western Bay Mental Health Programme Board</p>
<p>Develop robust care pathways and crisis provision and models of support that prevent hospital admission and promotes early hospital discharge.</p>	<p>Those who experience a crisis will receive safe, appropriate and timely responses that are recovery and reablement based so that disruption to their lives is minimised and they are enabled to achieve more control over their lives and discover/rediscover a sense of personal identity which is distinct from their mental illness.</p> <p>Services will be able to respond to the individual needs of those requiring urgent responses in a manner that is least restrictive to the Service Users independence.</p>	<p>Western Bay Partnership Board</p>

<b><u>Reshaping CMHT</u></b>		
Have a planned approach and rationale to specialist placements to ensure people receive the right levels of support and that specialist placements are achieving positive outcomes for Service Users.	People receiving specialist care are supported to achieve their maximum independence. Reviewing these models of care with our stakeholders will help ensure longer term sustainability of specialist placements.	Western Bay Mental Health Programme Board
Enhance person centred assessment and review process by ensuring Service Users are better able to play an informed role in the development of care and treatment plans through the provision of information and advice.	Service Users will feel supported to realise their aspirations which are central to the support planning process. Goals will be clearly set and reviewed, and progress will be effectively monitored so that Service Users are able to lead meaningful and satisfying lives as defined by themselves.	
Enable Carers to support their loved ones by encouraging the take up of carer assessments and through the provision of appropriate information and advice.	<p>Providing Carers with the right support and information at the right time will improve the health and wellbeing of Carers as individuals in their own right.</p> <p>Supporting Carers to maintain their caring role at their chosen level will reduce instances of crisis intervention and result in more planned transitions.</p> <p>Carer support will empower both the Carer and Service User to make informed choices about future care arrangements and where appropriate, prepare both parties for transition into alternative support arrangements.</p>	
Implement clear and consistent protocols for the sharing of information between agencies, Service Users and Carers	Agencies, Staff, Service Users and Carers will have access to appropriate information and will have a clear understanding of the legal protocols.	Western Bay Carers Executive Group
Develop clear mechanisms to improve the information flow from practice to commissioning, to ensure that	An evidence based approach to commissioning will ensure services are responsive to identified support needs and	

<p>practice knowledge informs commissioning activity through a seamless approach.</p> <p>Reinforce Social Workers and the CMHT's role in the commissioning and monitoring process of mental health services. Ensure that assessment and reviews systems are strengthened and link into the planning and commissioning process, including the development promotion of preventative services.</p>	<p>create sustainability of the care market.</p> <p>Service users will have a range of support options to meet their individual needs. Options will offer the right levels of support in order to maximise their independence and fulfil their aspirations.</p> <p>Preventive services will reduce the need for more intensive support and reduce risk to Service Users independence.</p>	
<p>Enhance processes for Service Users and Carers to inform commissioning activity and improve their role in the commissioning process.</p>	<p>Services and responses will be informed by those that require them and ensure that they are responsive to need.</p>	
<p>Take a positive approach with partner agencies and Service Users around risk taking. Build on current risk management approaches to promote greater independence and reduce the need for managed interventions to help empower citizens.</p>	<p>Integrated working will provide partner agencies with a better understanding of how they can support the Service User to take positive risks.</p> <p>Creating a supportive environment in which the Service User feels safe to take positive risks will empower the Service User to have greater control, choice and independence over their lives.</p>	

<b>Accommodation Progression Model</b>		
<p>Work with colleagues in Supporting People to identify housing related support solutions to help refocus energy to community based services and lower level support services which stimulate independence. Strive to develop preventative models of intervention which help people remain out of traditional care services.</p>	<p>A comprehensive range of appropriate and flexible accommodation and housing related support services, which will provide Service Users with opportunities to live as independently as possible, for as long as possible, within their communities.</p> <p>Evidence progression through the mandatory Supporting People Outcomes Framework tool.</p>	Supporting People Planning Group
<p>Work with colleagues in Supporting People to identify housing related support and care solutions, which encourage independence and promotes the recovery philosophy through the utilisation of community based and lower level support services.</p>	<p>A comprehensive range of appropriate and flexible accommodation and housing related support services will provide opportunities for Service Users to live as independently as possible, for as long as possible, in their own communities.</p> <p>Progression will be evidenced through the mandatory Supporting People Outcomes Framework tool.</p>	Supporting People Planning Group
<p>Carry out further market development activity to ensure that the local market for support and accommodation is able to meet demand for support from Service Users.</p>	<p>Local support and accommodation services will be sustainable and responsive to future demands and will meet the needs of Service Users that are not currently having their needs met locally.</p> <p>Service Users will have appropriate accommodation options that will meet their support needs and promote their independence within their local communities.</p>	Mental Health Accommodation Group
<p>Drive forward and develop a clear "Progression" pathway building on transition through support planning that focuses on the support needed to help each Service User "Progress" to be as independent as is possible for them as an individual.</p>	<p>Support packages will be as individualised as possible, utilising a range of community-based options, so that Service Users are encouraged and facilitated to live as independently as possible and enabled to reach their full potential.</p>	Mental Health Accommodation Group
<p>Work with our current provider market and stakeholders to</p>	<p>A range of robust accommodation and housing</p>	Mental Health Accommodation Group

<p>develop a wider choice and increased access to appropriate accommodation and housing related support. In particular, flexible and enabling support models that encourage “progression” and supports reablement approaches so that Service Users are supported to move towards and/or retain maximum independence.</p>	<p>related support options will be made available to Service Users, which will empower them to live independent lives within their local communities.</p> <p>Service Users will be appropriately placed in care settings that offer the correct levels of support and maximises their independence.</p>	
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**Local Area Coordination on Mental Health**

<p>Strengthen approaches to community development by maximising opportunities for local services to offer natural support networks for people with mental ill health. Work with community groups, third sector and voluntary organisations collaboratively to offer localised support networks.</p>	<p>Greater choice of sustainable community based opportunities will reduce the number of Service Users requiring long term paid support.</p> <p>Good community networks will reinforce and promote the role of Service Users as important and valued members of their community and reduce stigma relating to mental ill health.</p> <p>Service Users will be given further opportunities to make positive contributions to their local community as equals and reduce instances of social exclusion.</p>	<p>Western bay Community Services Project</p>
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<p>Promote and improve the mental and emotional wellbeing of the general population within Bridgend.</p>	<p>Citizens of Bridgend will be able to better deal with the stresses of everyday life and be productive members of their communities.</p> <p>Bridgend will be a healthier, fairer and more productive society.</p>	<p>Western bay Community Services Project</p>
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<p>Ensure that Service Users are supported to access a range of social and day time opportunities within their local communities, including education, volunteering and employment.</p>	<p>Service users will have access to a wide range of meaningful activities that will develop their confidence and independence. These opportunities will empower Service Users to fulfil their ambitions and reach their full potential.</p>	
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**Development of a Dementia Commissioning and Delivery Plan**

Develop a vehicle for	The development of a	
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<p>implementing our vision for ASC dementia services and to align and deliver the key principles and objectives specified in key local and regional strategic documents.</p>	<p>commissioning strategy and the implementation of a delivery plan will ensure people in the borough with a diagnosis of dementia receive flexible and supportive care interventions, which promotes or maintains their independence for as long as possible.</p> <p>People with a diagnosis of dementia will receive appropriate and flexible interventions based on good practice to maintain their quality of life and lead fulfilling lives.</p>	
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#### **4. Existing Strategic Groups**

##### **Platforms for Engagement**

We recognise the importance of developing robust mechanisms to ensure that stakeholders, partners, Service Users and Carers are involved in the planning, consultation and monitoring process of ASC services. To facilitate effective planning and delivery of support, it is essential that commissioners take full account of stakeholders' experiences when assessing the effectiveness of commissioned services.

We also recognise that Service Users and Carers are central to the development of future plans. We believe that their contribution in shaping our commissioning objectives will help place them at the heart of all we do and enable us to deliver effective, outcome focused service models.

Our vision for engagement models for people with mental ill health places Service Users and Carers at the centre of the process and we are committed to further developing the way in which those who receive services, and their Carers, are involved within the commissioning process. The aims of engagement are to achieve robust platforms that will enable stakeholder to help us:-

- Shape current and future objectives;
- Influence and test priorities;
- Help facilitate delivery of priorities;
- Help drive forward and develop localised community services;
- Focus on what matters to Service Users and families;
- Facilitate better planning and coordinated market development.

This Plan has been developed in consultation with all stakeholders, including Service Users, Carers, practitioners, the third sector, providers and strategic partners from Health and Supporting People. Below is a summary of the emerging themes from feedback received from a series of consultation events we held to help inform our commissioning objectives.



## **Service Users**

Develop mechanisms to ensure that Service Users and Carers are involved in the planning, development and implementation of the services they require;

- Support Service Users to be involved in the decisions that affect them as much as their capacity allows;
- Continue to develop processes that enables Service Users to define the outcomes that matter to them;
- Provide information to Service Users and Carers so they can play an informed part in their care and treatment pathway;
- Ensure there are robust care pathways for those in crisis and develop a range of support models to ensure that those in crisis receive appropriate and timely responses;
- Support the maintenance of mental health by working proactively with other agencies and partners to encourage the development of community based support networks and models, including information, community and non-specific mental health services;
- Develop processes to help people progress to be as independent as possible in their own communities;
- Promote the development of local support networks in the community and prevent social isolation by maximising opportunities for local services to offer natural support networks;
- Continue to expand opportunities for individuals to develop life skills that promotes and enables independence and improve opportunities for individuals to access training, education and work;
- Work with community groups, third sector and voluntary organisations to collaboratively develop localised support networks;
- Improve the understanding of mental health problems within the community and combat the stigma attached to poor mental health;
- Explore uses of information technology in the support and care process;
- Ensure that that there are clear information sharing processes across all agencies;

## **Carers**

Engagement approaches should be strengthened so that Service Users and Carers are involved in the planning, development and implementation of the services they require;

- Ways to enable Carers to continue in their caring role by providing appropriate information, advice and services should be further developed;
- Put in place mechanisms to improve the take up of carer assessments;

- Have a focus on promoting day time opportunities that will offer respite for families and Carers – perhaps by maximising opportunities for local services to offer support;
- Develop process to help people progress to be as independent as possible in their own communities;
- Ensure there are robust crisis pathways and provision;
- Continue to progress person centred Service User assessments and review processes;
- Work with CAMHT to ensure that transitions into adult services are well planned and that young people are supported to make the transition into adulthood;
- Improve the provision of information and focus on ensuring Carers are involved in decisions about the services that they, and those they care for, receive;
- Further strengthen links between agencies responsible for the delivery of support to a Service User;
- Continue to respond to the Social Services and Wellbeing (Wales) Act 2014 so that those in need of social care services and their carers are empowered by affording them a stronger voice and giving them more control over the services they receive;
- Ensure that there are clear information sharing process across all agencies.

### **Practitioners**

Young Service Users need to be supported to make the transition from CAMHT to CMHT in order to help prepare for the move into adulthood;

- Clear crisis pathways should be developed to provide Service Users with timely and appropriate responses;
- The development of robust community links and improving social inclusion could help Service Users to remain within their own communities and reduce reliance on statutory support services;
- There is a need to ensure that Service Users can be supported within their own homes and communities;
- Carers should be provided with education, advice and support to help enable them to support their loved ones;
- Accommodation-based support should be person-centred and needs led;
- Consideration should be given to increasing the provision of independent accommodation options with floating support;
- Services need to be responsive to changing needs and able to meet the wider needs of those with co-occurring conditions.

### **Providers of Mental Health Services and the wider Third Sector**

Ensure there is equitable access to services and improve availability of services across the borough;

- Develop a wider range of community and social opportunities that are more age and gender appropriate, including opportunities that are open to the wider population not just those with mental health problems;
- Continue to work with partner agencies to deliver holistic care and support to those with co-occurring issues;
- Promote person centred and outcome focused approaches, including time-limited support, which is tailored to the individual and/or fluctuating needs of Service Users;
- Implement practices that focus on building the resilience and confidence of Service Users so that they are able to live more independent and fulfilling lives without the need for formal staff support;
- Expand the range of accommodation models to enable progression into more independent living arrangements;
- Further enhance promotion of independent advocacy and increase access to information and advice so those who receive care are able to be fully involved in decisions that affect them as much as their capacity allows;
- Look at ways to help the wider community and Carers acquire the knowledge and skills to help support those with mental ill health and assist the development of natural support networks;
- Develop robust crisis pathways and signposting to ensure timely and appropriate responses;
- Explore opportunities to pool budgets and collaboratively commission services with other Local Authorities and Health;
- Have a range of appropriate 'step-down' and 'move-on' accommodation

## **5. Existing Strategic Plans**

Mental health services have changed hugely over the last few decades. There is a shift away from an illness and 'treatment' model to a 'recovery' model with an emphasis on community provision as opposed to hospital and institutional care. Within the Council there is recognition that mental health services need to be improved and have service users and carers at the heart of the commissioning process.

Collaborative and integrated approaches to planning, commissioning and delivery are key elements to successfully taking forward our intentions and commitments with respect to mental health services. Our commitment to partnership working regionally can be seen through our involvement with the Western Bay Health and Social Care Collaborative. Locally, collaboration is evident in our work with the Bridgend Local Health Board and our Reshaping Mental Health project which is part of our Remodelling Adult Social Care programme.

The Mental Health (Wales) Measure 2010 has introduced important changes to the support available for people living with mental health issues in Wales. It places new legal duties on Local Health Boards and Local Authorities regarding assessment, treatment and access to independent mental health and advocacy.

Welsh Government has also embraced its responsibility to deliver improvements in mental health and wellbeing. It has published 'Together for Mental Health' (2012), a cross cutting strategy that sets out the vision for improvement of mental health and wellbeing for the people of Wales and recognises that mental health and wellbeing are not the sole responsibility of one organisation.

As part of the Western Bay Collaborative, a joint strategy for mental health services was published in 2013. During 2014 we have produced a Bridgend Mental Health Commissioning and Delivery plan which is currently out for consultation. This plan will be the main vehicle for implementing our vision for mental health services over the next three years.

The Caswell Clinic Social work team has continued to provide a service for the patient population detained in the medium secure service which maintains regular numbers of approximately sixty patients. The team also currently provides aftercare and monitoring to between 20 and 25 service users discharged from the Caswell Clinic across the sixteen local authorities who the service represents.

#### **Priorities identified for 2015/16**

- Improve access to availability information advice and assistance.

#### **Key Objectives for 2015/16**

- Detailed needs mapping to inform service developments with respect to accommodation.
- Improve the interface between Parts 1 and 2 of the Mental Health Measure to ensure a seamless service and positive outcomes for individuals.
- Fully integrated I.T. and client data base system and information sharing protocol.
- Improve engagement with service users and carers.
- Work with colleagues in Western Bay to review the model for CMHTs
- Work with colleagues in communities to maximise supporting people opportunities.
- Develop a crisis provision.
- Enhance prevention and wellbeing provision in preparation for the Social Services Wellbeing Act.
- Progress S 33 agreement in respect of the Caswell integrated team
- Review the outcomes of the Caswell social work/community team

#### **What did we do in 2015/16?**

The Local Primary Mental Health Support Service (LPMHSS) continues to go to from strength to strength.( MH01) Customer service questionnaires have indicated that 90% of those who have received the service have regarded it as helpful and would recommend it to others. Comments from those who have used the service include; **“it has helped me come off my medication and keep my job”**, **“My new interests will help me negotiate my blackest days”**. With respect to how the service

could be improved the Directorate received the following comment; **“I would have liked the service for longer”**.

The ARC service is also developing innovative approaches to respond to need such as mindfulness and stress control programmes. (MH02) 104 people have attended drop-in stress control sessions, 68 people have attended activity sessions and 56 people have attended anxiety and depression sessions. One service user who attended made the following comment “this is just the first step in my life of change”

In relation to GP referrals, the introduction of a new system for signposting referrals has been piloted. This prescription for signposting involves the GP completing a form with the service user to present at Arc when attending regularly arranged drop in clinics. Since the trial of this system 48 people have attended signposting clinic.

A single point of access (SPA) for GP referrals into secondary mental health services has been successfully piloted in Bridgend. This is currently being evaluated with a view to rolling out the scheme in Neath, Port Talbot and Swansea. Interviews are being undertaken with staff who operate the system and with General Practitioners who refer into the SPA. The Bridgend scheme will be developed this year to include all referrals to secondary mental health services which will improve access for those who are most vulnerable. (MH03)

A review of community mental health teams is currently being undertaken in order to establish a new model of service. This review is in response to a regional review of mental health services commissioned by Western Bay which identified a number of recommendations such as; enhancing the single point of access, reviewing current models and improving crisis interventions. Visits are taking place to crisis units in other parts of the country which will help inform a future model. (MH04)

An accommodation work stream has put in place a single procurement and brokerage process for high cost specialist mental health placements. Within Bridgend we have seen more cost effective placements as a result of adopting the process as well as better outcomes for individuals. A common policy and procedure for aftercare services (under s117 of the Mental Health Act 1983) has been agreed enabling consistency across the region. Recently the work stream has undertaken an accommodation needs mapping exercise. This data is being used in Bridgend to inform adult social care commissioning plans. It is also enabling us to collaborate with colleagues in communities to develop specific mental health housing projects such as increasing the provision of floating support and a specialist housing project for those with complex mental health issues. (MH05)

Improving provision for those in crisis is a key objective in the mental health commissioning plan. Work is currently being undertaken with health colleagues to scope the development of a crisis service and Bridgend was represented on visits to Crisis facilities in Leeds and Hereford. This is in

response to service user and carer feedback which has indicated that it is an area which needs improvement. (MH04)

Within the Caswell Clinic integrated team the outcomes in terms of aftercare has demonstrated that the established systems are achieving satisfactions for over 50% of the service users who are now living independently or other community placements. This does also indicate that 50% are transferred to low or high secure units and/or returned to prison. Whilst this may not be a satisfactory outcome for the service user it does evidence that the team is also meeting the public protection remit of the service.

Engagement with service users and carers is improving. A 'Stronger in Partnership' group (SIP) brings together professionals, service users and carers across the Western Bay region. This ensures mental health plans are more responsive to need. An example of this is that carers had raised concerns about the sharing of information. A guidance document has been produced which will be promoted and circulated widely and training for staff on information sharing is ongoing. (MH06)

The Time to Change Wales (TTCW) campaign is a Welsh Government initiative aimed at changing attitudes within the Welsh workforce in relation to mental health. TTCW aims to work with organizations to sign a pledge and develop action plans to create 'mentally healthy' workplaces where staff are actively encouraged to talk about mental health. It is also designed to raise awareness, understanding and tolerance of poor mental health. Bridgend will be signing this pledge as part of a Western Bay commitment in February 2016. (MH07)

Addressing issues of stigma and discrimination is also a priority in the mental health commissioning plan. Training concerning mental health and wellbeing is being rolled out across the Council to raise awareness. An E learning package will be launched across the Council in November to raise awareness of mental health; the different conditions and interventions and issues of stigma and discrimination. (MH08)

A meeting has been arranged with head teachers to enable the Authority to raise awareness regarding young people and mental health and wellbeing in schools. This initiative also aims to help early identification of mental health concerns regarding young people and facilitate early intervention. (MH09)

As part of the Western Bay collaborative the Authority has supported the development of an electronic library of on line self-help guides to offer information and advice on a wide range of subjects including anxiety, dealing with bereavement and alcohol dependency. In the first two months there has been 1624 visits to the electronic library across the region. (MH010)

Supporting carers to continue in their caring role is a priority in the commissioning plan and a specific forum for carers who support people with mental health issues has been established. There have also been

initiatives to support carers at work such as events to raise awareness and provide information as well as a Facebook page for council employees. To date, seven employees have accessed this page; the intention is to further promote this to encourage carers at work to share their experiences. (MH011)

As part of the preparation for the Social Services and Wellbeing (Wales) Act 2014, a Local Area Coordinator has been appointed to focus on early intervention and signposting. 30 individuals with mental health issues have accessed the service to date. Individuals are being supported within their community networks to access wellbeing activities which is resulting in better outcomes for those individuals. One example is that a gentleman suffering from depression and anxiety was unable to work. He has since been referred into a woodworking work project to regain confidence and share his skills with view to eventually returning to work. (MH012)

### **Who is better off?**

- The process of Care Co-ordination under Part 2 of the Measure ensures that objectives are set for individuals which are outcome focussed. It is also empowering to uses of the service. (MH013)
- The Measure continues to improve performance in relation to the number of service users who have now a valid care and treatment plan. (MH014)
- The consultation undertaken in relation to the Mental Health Commissioning and Delivery Plan has improved communication with service users and carers. (MH015)
- There has been improved collaboration between health and social care which resulted in better outcomes of individuals. An example would be the Single Point of Access Development. (MH03)
- The Western Bay Brokerage and Complex Case Panel has enabled better outcomes for service users requiring community accommodation. (MH016)
- The drop in referral system at ARC combats high rates of referrals , re referrals and non-attendance as well as increasing the responsibilities of the individuals to have control over their support needs and interventions.
- Between Oct and Dec 236 people were seen for assessment or initial contact with the Arc service and 97% people were seen within the target of 28 days.
- 204 individuals were referred for support in relation to employment and training between April and Dec. Of these 46 people were already in work and were supported to maintain their employment.
- The accommodation needs mapping has informed supporting people and adult social care commissioning plans. (MH05)
- The range of accommodation has increased which has improved outcomes for those individuals with accommodation needs. (MH015)
- Service users have reported positive outcomes from attending ARC services – **“it has helped me negotiate my darkest days”**.
- The electronic library of mental health self-help guides received 1600 hits during the first two months of operation.

- The initial evaluation of the Single Point of Access with those operating the service has been positive. (MH03)

### **Preparation Core Processes**

- Whilst there is general compliance with the Mental Health Measure requirements, there is need to ensure that monitoring of care and treatment plans is undertaken by managers routinely to ensure quality outcomes for service users.
- Assessment and Care Co-ordination Processes are currently being revisited to ensure consistency across Adult Social Care in preparation for the Social Services and Wellbeing Act implementation.
- Clear systems with respect to financial processes need to be established and mental health services need to be compliant (especially with regard to Section 117 of the Mental Health Act).

### **Social Services and Wellbeing Act**

The Social Services and Wellbeing Act aims to empower those in need of social care services and their carers to promote their independence by affording them a strong voice and giving them more control over the services they receive. The Act emphasises the promotion of equality, improvement of service quality and provision of information and stresses the need to achieve a shared focus prevention and early intervention. Current priorities and service objectives will respect to mental health fully reflect the Act's vision for delivering services.

### **Partnership Working/Collaboration**

With respect to mental health services, partnership working is integral to all service developments. This can be evidenced at a national, regional and local level. The Local Primary Mental Health Support Service, Community Mental Health Teams and Mental Health Older Peoples team are multi-disciplinary. The ARC service is provided in collaboration with health and is subject to a Section 33. Arc continues to forge positive and productive links with community groups to provide opportunities for individuals and supports the Act's prevention and wellbeing agenda. The future aim is to forge stronger collaborative links in the delivery of opportunities, networks and support services.

The Western Bay programme is collaboration between Bridgend, Neath and Swansea local authorities plus ABMU. Third Sector organisations as well as service users and carers are also represented on the Western Bay Project Board.

A number of multi-agency forums meet to steer the implementation of the Mental Health Measure and progression and delivery of the Joint Strategy for Mental Health.

The strength of the Caswell social work team lies in the experience of the team in working in a multi-disciplinary team and in forensic practice.



It is also a service which collaborates with the 16 local authorities it serves which is dependent on good communication and liaison.

Developments in relation to reshaping mental health services are also being progressed with colleagues in Communities, Third Sector and independent providers.

### **Service User/ Carer Engagement**

- Service user and carer engagement has been an integral component in developing services for adult mental health and sit on planning forums such as the regional mental health partnership. Feedback has informed service priorities and plans have been amended accordingly.
- Engagement with service users and carers is improving. A stronger in partnership group brings together service users and cares across the Western bay region. This ensures future plans are more responsive to need. An example of this is that carers had raised concerns about the sharing of information. A guidance document has subsequently been produced and is being circulated widely and training for staff on information sharing is ongoing( MHO7)
- Officers regularly attend service user and carer forums to improve communication and engagement.

### **Summary**

With respect to the Adult Mental Health service, we are able to demonstrate improved access to early interventions, the Local Primary Mental Health Service is going from strength to strength and improved care and treatment planning is resulting in better outcomes for service users and enabling them to have better control over their lives – **“my life is so much better with these tools and I am slowly on the road to recovery”**.

We have also improved our relationship with colleague in Supporting People and we are developing new accommodation projects specifically for mental health. There is however, still much to do.

The following priorities for improvement have been identified for 2016/17 –

- Bridgend is an early adopter of the integrated Health and Social Care Systems. ( CCIS) The Mental Health Service will need to fully implement the new system during 2016/17.
- Development of a collaborative approach to wellbeing across sectors including service users, cares and the public.
- The authority is seeing a change in the profile of those requiring mental health supports. More than 60% have a substance misuse issue or other conditions such as physical frailty or a sensory impairment. There are many who have a Personality Disorder, an offending history or are a concern to their

communities. The service needs to be remodelled to be able to respond to those complex individuals.

- A crisis provision needs to be developed in collaboration with health as an alternative to hospital.
- Whilst relationships with partners are positive, some arrangements/problems need revisiting such as the use of 136 and conveyance concerning the Mental Health Act.
- Efforts to progress a S 33 in relation to the team at Caswell have not progressed during 15/16 , it will be necessary to confirm during 2016/17 that health do not wish to proceed.
- There is a need to have clear transitional plans for young people with mental health issues.
- People who live with mental health issues are telling us that they still face discrimination and hostility which needs to be tackled.
- There is a need to improve emotional wellbeing resources and mental health support for council employees.
- Focussed attention is required to implement the early intervention, information and prevention requirements of the Social Services and Wellbeing Act in mental health.

**Neath Port Talbot  
Topic Paper 5  
Mental Health**

**1) Overview of Current and Forecasted Needs**

The majority of people with mental health issues either live in the local community with minimal support from Adult Social Care (ASC) or from specialist mental health services i.e. they self-manage, have family/community support and access primary health care.

There are also a significant number of people with mental health support needs who are supported to live in the community by specialist community mental health services. This table details the range of community based mental health services and teams that serve NPT. Notably 961 people are currently supported by two Multi-Disciplinary Community Mental Health Teams (CMHT). (August 2016)

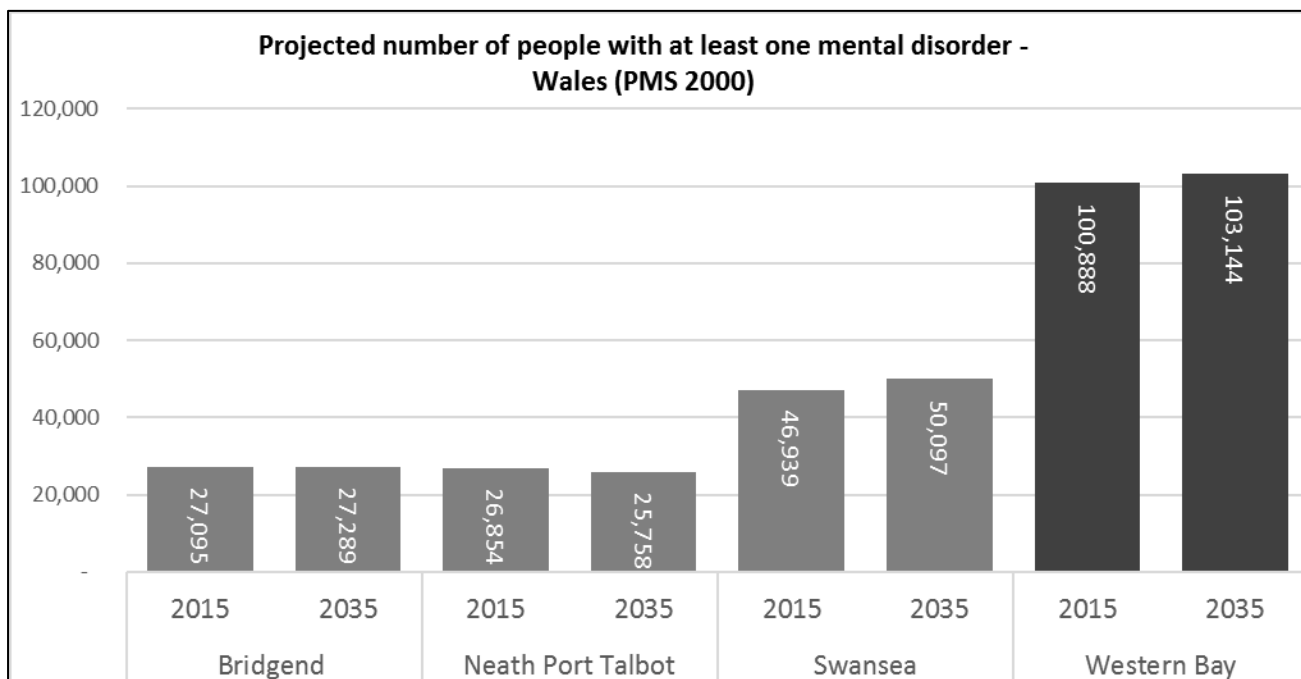
Service/Team	Description
<u>Complex Needs Services for Women – Dechrau Newydd</u>	Community Dialectical Behaviour Therapy service for women with mental health complex needs (primarily borderline personality disorder). This service works with patients in secondary care in close partnership with CMHTs and in-patient services.
Crisis Resolution Home Treatment teams (CRHTT)	Function is to offer support and care for those people who without it would be admitted to hospital. They are act as the gatekeeper to inpatient beds in order to ensure that all alternatives to inpatient care have been explored. Also support the early discharge of those people who have required inpatient care. Provide advice and signposting to people referred to them, but who they assess as not requiring their services.
Crisis Recovery Units (CRU).	A day hospital type environment for people who require more support than can be delivered in their own home but do not require hospital admission.

Prison In-Reach Team (PIR)	Community Mental Health Team based within both HMP Parc and HMP Swansea. The service provides assessment, management and Care Co-ordination of prisoners who are presenting with serious mental illness. Close liaison with probation (MAPPA) and wider third sector services to manage presenting risks.

There are 72 people from NPT who have more complex mental health needs and who are either jointly supported by ASC and ABMU or who are supported in NHS low or medium secure settings, but who will probably need joint support from ASC/ABMU if and when they are discharged from secure NHS settings.

Mental health disorders are very common. The overall proportion of people experiencing at least one mental health disorder within the previous year for the UK in 2000 was 23%. For Wales, this was 26%. The 23% figure for any mental disorder remained stable for England in 2007. As such I have assumed that the Wales prevalence estimate of 26% has also remained stable.

The chart below shows what 26% of the population represents in 2015 and in 2035 for Western Bay.



## 2) PROFILE OF SPEND AND ACTIVITY

### Current support models

An effective mental health care pathway will ensure:

- People experiencing an acute mental health episode are kept safe and provided with a therapeutic environment to begin to recover. Often these settings need to be secure,
- Access to recovery and rehabilitation services when the initial crisis has passed and the person is ready to continue their recovery,
- Resettlement/step down services to help people make the move back to the community when they no longer need more intensive support, and
- Medium to long term on-going community based support so people with mental health needs are supported to live where they choose e.g. in supported living, in their own tenancies, with host families etc.

### How we expected people would be supported in NPT

With the above care pathway in mind it is expected that people with complex issues would be accessing services at each stage in the pathway with the community based segment using a mixture of supported living, shared lives,

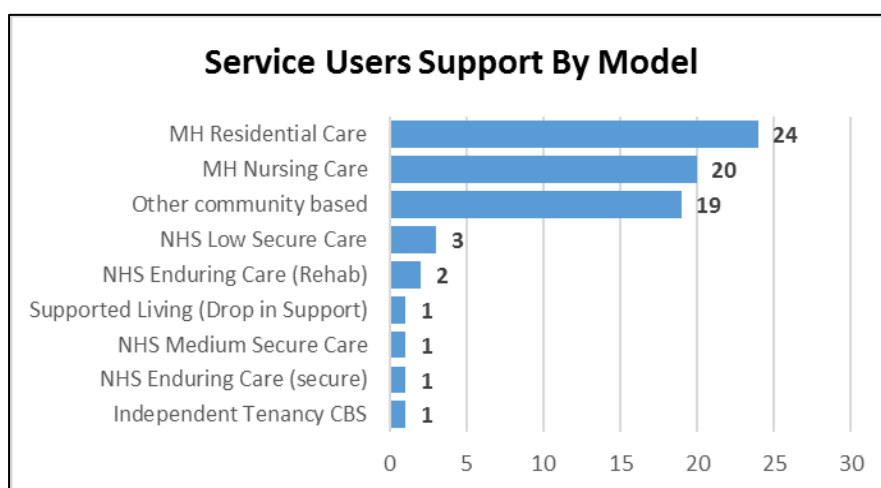
independent tenancies and a small number temporarily in residential/nursing care settings.

### How people are actually supported in NPT

Figure 1 shows that a small number of people (5 or 7%) are temporarily supported in secure settings, as expected, but:

- Very few (just 2 or 3%) are in recovery/rehab services,
- None at all are in services that focus on step down, and
- Long/medium term on-going care and support is over reliant (44 or 61%) on residential and nursing care with other community based options being under represented (21 or 29%)

**Figure 1: Support Models Currently Used:**



The current pattern of mental health support is not yet in line with the model laid out as an effective mental health care pathway concern and individual service user outcomes, levels of independence etc. may be better supported. (17<sup>th</sup> March 2016 Cabinet Report.)

### Mental health support now

Whilst progress is being made a lot more still needs to be done. For example, a paternal ethos still exists and that leads to risk adverse practice too often.

This risk aversion is further reinforced by a lack of:

- Community based services such as supported living schemes and shared lives within Neath Port Talbot.

- A 24/7 crisis response service that could respond out of normal office hours if a service user had a mental health relapse.
- Joined up approaches between different services highlighting that managers said resembled “silos” with tight gate keeping.

All these factors combine to create the conditions whereby residential or nursing care (often out of area) is over used.

### **Over reliance on secure, residential and nursing care**

Secure settings, residential care and nursing care are used more than it should be and service users can stay in them longer than is ideal. Reasons for this include a lack of:

- Specialist mental health respite/short term crisis beds to use to stabilise a person during a mental health relapse so to be safe staff may opt to use residential care,
- Specialist mental health step down services to help people make the transition from hospital or from a residential care setting back to the community so there is a tendency to support people residential setting for longer,
- Acute mental health beds which means there is significant pressure to discharge people from hospital as quickly as possible. Sometimes this is before people are ready to move back to their home in which case a safe place needs to be found,
- Specialist community mental health recovery/ rehabilitation service to continue to support people to recover in a community setting, and
- Community based support services that can meet the needs of people with complex mental health needs, notably behaviour that is challenging to services. This includes a lack of:
  - Mental health supported living services
  - Shared lives carers with mental health expertise
  - Housing (specialist and disbursed) that is suitable for adults with mental health needs

### **3) CURRENT PRIORITIES**

The strategy being implemented to transform services for people with mental health needs is based on the following principles:

- To change social work practice adopting more proportionate risk based management, rather than risk adverse practice. This should both lead to improved outcomes for service users and their carers, with added benefit of a reduction in unit costs of service provision;
- To adopt progression-based models that support people to maximise their independence and quality of life, at whatever point in their life and whatever their needs;
- Increasing the profile of people with learning disabilities in safeguarding arrangements.

The adoption of this strategy means:

- Upskilling of the social work workforce to adopt less risk averse practice;
- Remodelling of service provision, working with housing and other support providers to ensure progression based models of service replace the existing dependency-inducing models;
- Encouraging use of models that enable more personalised services, for example direct payments and social co-operatives;
- Reviewing s117 Mental health Act after care arrangements
- More effectively responding to transition cases from children's services

Operationally, key changes we are planning for include:

- Maintaining a multi-disciplinary single point of entry and associated assessments;
- Operating a multi-disciplinary resource allocation model to ensure that the allocation of resources is transparent and equitable and person-centred;



- Continuously seeking to ensure interventions/support are aimed at early intervention and prevention, seeking to always avoid the need for reactive responses
- Identifying gaps in provision and ensure this is effectively fed back into commissioning processes to address the gaps
- Ensuring that there is effective integration of mental health services, with substance misuse and anti-social behaviour services to as to holistically meet the needs of the service user
- Increasing the profile of people with mental health within safeguarding arrangements
- Taking forward our plans to re-model day service opportunities:
  - Developing our Bspoked<sup>6</sup> service to provide employment and training opportunities for adults with a learning disability, mental health need or physical disability
  - Developing our Cyfle y Dyfu<sup>7</sup> service to provide employment and training opportunities for adults with a learning disability, mental health need for physical disability
  - Developing the community connector<sup>8</sup> model to move away from establishment based provision to supporting people to have their care and support needs met through mainstream community resources

### **Need to improve Transitions from Children's Services**

Transitions planning should start at an early age and needs to focus on skills development and building resilience for young people. Currently mental health needs are not always detected during transitions work and plans to meet mental health needs are not put in place

### **Adult Population**

Currently people with mental health needs can often only access generic support until they experience a mental health crisis that brings them into

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<sup>6</sup> SCHH Cabinet Board 31/07/15 – Work, training and employment service proposals – renaming and rebranding of the vocational skills service

<sup>7</sup> SCHH Cabinet Board 14/05/15 – Work, training and employment service proposals – partnership project with Cyfle y Dyfu

<sup>8</sup> SCHH Cabinet board 26/11/2015- Direct Services, Integrated Community Model

contact with specialist services. When this is the case, individual outcomes and wellbeing suffer and support costs escalate.

Specialist mental health respite/short term crisis beds are used to stabilise a person during a mental health relapse which could lead to use residential care

### **Need to build up the community infra-structure to better support people with mental health needs**

There is a need to develop:

- The skills of staff so they better support people with mental health needs,
- Provider services to better support people with complex mental health needs and in particular to better support people with behaviour that is challenging,
- Better information and advice so that service users and staff are better able to access or advice on how to access the existing community infrastructure,
- A clinical crisis response service that provides a 365 24/7 response as the current service only operates from 9 a.m to 9 p.m.
- Non-clinical crisis house services in the main towns. These could also house an information hub, drop in services etc. to help people self-manage their mental health needs,
- More effective employment support for people with mental health needs.
- Peer support networks to offer low level support to people self-managing their mental health needs (including social activities) across all of NPT e.g. MIND is known to be active in Neath but not in Port Talbot.
- The Mental Health care and support market and the local community infrastructure each need to be improved.
- Improve the “Whole System” of care and support for adults with mental health needs so that new and existing service users from across the whole spectrum of need all have support that:
  - Maximises their overall health, well-being and resilience,
  - Supports them to exercise self-determination,
  - Facilitates them to achieve autonomy, and

- Enables them to participate as fully as possible in their local community.

Key areas to prioritise are to:

- Improve transition planning and access to children's mental health services so the transition is as smooth as possible.
- Improve early intervention services so mental health crisis are minimised.
- Reduce reliance on residential/secure care models by resettling people where possible when their existing residential placement is not appropriate and by reducing new admissions to a minimum.
- Develop community capacity as an alternative to res/secure care so there are:
  - Less new admissions to res/secure care, and
  - A range of alternatives for people to choose from when they are resettled from an existing placement.

Improve the "Fluidity" and "Flexibility" between existing services so support can more easily be flexed as the mental health needs of individual service users fluctuate

#### **4) FUTURE USE OF RESOURCES**

##### **Mental health support needed in future**

There is a need to develop the "*Whole System*" of care and support for citizens living with mental illness in Neath Port Talbot in line with the Welsh Government's 10 year strategy to improve mental health services and outcomes - "*Together for Mental Health*"<sup>9</sup>.

In particular the "*Whole System*" needs to become more co-operative, more integrated and it needs to take a more proportionate approach to risk that enables people with mental illness to:

- Maximise their overall health, well-being and resilience,
- Exercise self-determination,
- Achieve autonomy, and
- Participate as fully as possible in their local community.

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<sup>9</sup> "*Together for Mental Health*".

This requires a more joined up, responsive and flexible “*Whole System*” of care and support that enables citizens living with mental illness in Neath Port Talbot to access “*just enough*” of the support they need, at the “*right time*” and for “*just long enough*” to maximise their recovery from mental illness and build their resilience against future threats to their mental health and overall health and wellbeing.

# ***Current & Forecasted Needs***

## **Estimating Adult Mental Health**

The estimated prevalence of adult mental health problems has been surveyed within the UK every seven years since 1993, with the survey in 2000 the last year for which data has been published which included estimates relating to Wales, as well as for England and Scotland. The 2000 survey and subsequent surveys looked at those aged 16-74.

It was published as *Psychiatric morbidity among adults living in private households, 2000*, and was described as 'the report of a survey carried out by Social Survey Division of the Office for National Statistics on behalf of the Department of Health, the Scottish Executive and the National Assembly for Wales'.

The 2007 survey was England-only Results of the 2014 survey have yet to be published.

The term 'survey' understates the range of methodologies involved in the periodic assessment of the prevalence of mental health problems: a range of screening instruments are used and face-to-face interviews are also involved, including both lay and clinical researchers.

The estimates of prevalence and service use in this section are derived from the Psychiatric Morbidity for 2000, unless otherwise specified. Furthermore, the headline figures from the 2000 survey that reported Wales-specific estimates for Common Mental Disorders (CMD) and probable psychosis have been used throughout. The graphs showing 'Wales (PMS2000)' in the titles are calculated from prevalence rates for Wales in 2000. GB (PMS2000) denotes whole-survey results for 2000. Projections marked as '(PMS2007)' denote derivation from the England / Scotland 2007 survey.

## **Defining Mental Illnesses**

The terms used in this document relate to the terms used within the survey of psychiatric morbidity.

The term **Common Mental Disorders (CMD)** refers to a specific range of six of the most common mental illnesses:-

- mixed anxiety and depressive disorder,
- generalised anxiety disorder,
- depressive episode,
- phobias,
- obsessive compulsive disorder
- panic disorder.

In the 2000 survey, CMDs were referred to as 'neurotic disorders', which is terminology no longer used.

The term **probable psychosis** is used in the 2000 survey to describe mental illness that is more severe than the CMDs and mostly relates to schizophrenia and schizotypal illnesses, as well as more serious affective illness (mood disorders), such as bipolar affective disorder. Given the nature of the survey methodology, an accurate diagnosis of psychosis is not possible and is therefore described as 'probable'. The 2007 survey found that methods used to assess 'probable psychosis' resulted in a

slightly higher proportion of people (0.5%) identified than survey instruments that more accurately assessed a diagnosis of psychosis (0.4%).

The term **personality disorder** relates to the following categories:-

- Avoidant
- Dependant
- Obsessive compulsive
- Paranoid
- Schizotypal
- Schizoid
- Histrionic
- Narcissistic
- Borderline
- Antisocial
- Passive-aggressive
- Depressive

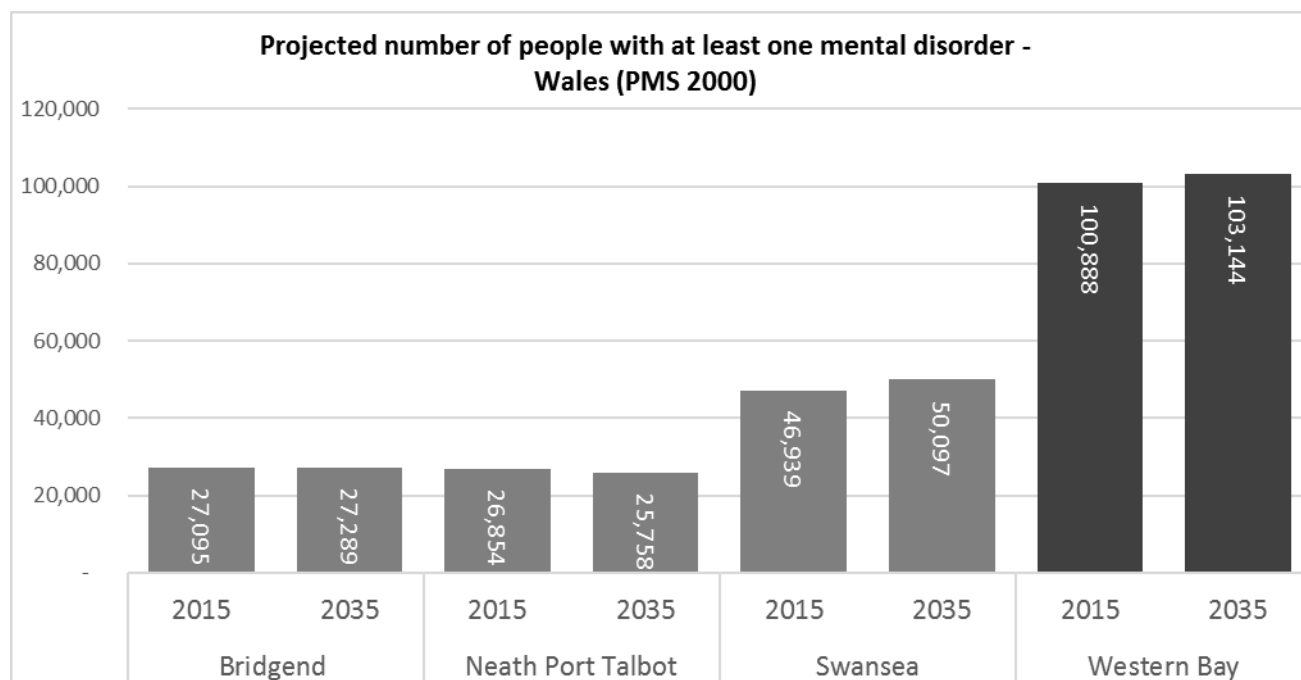
The 2000 survey also looked at drug and alcohol misuse and dependence, but this will be covered in more detail elsewhere.

The term **mental health disorder** refers to all mental illnesses covered by the survey, and thus includes all the above. The 2007 England survey extended the range of diagnoses covered by the survey and some material from that survey is extrapolated to Wales in this document.

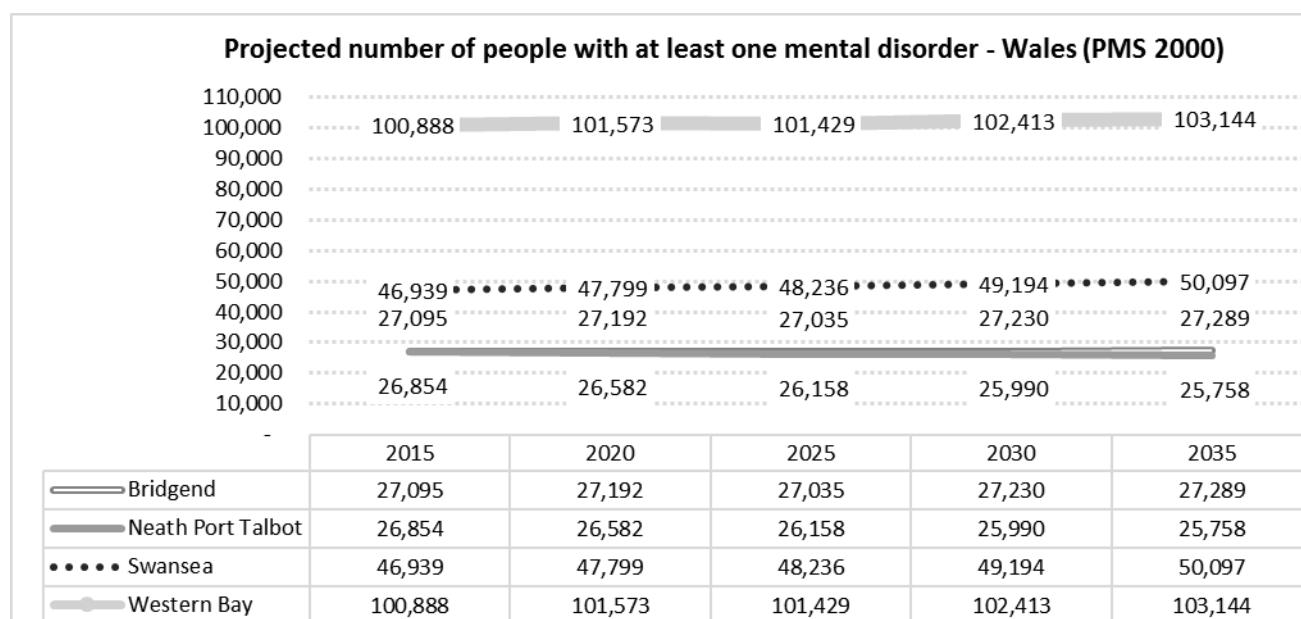
## Adults with a mental health disorder

Mental health disorders are very common. The overall proportion of people experiencing at least one mental health disorder within the previous year for the UK in 2000 was 23%. For Wales, this was 26%. The 23% figure for any mental disorder remained stable for England in 2007. As such I have assumed that the Wales prevalence estimate of 26% has also remained stable.

The chart below shows what 26% of the population represents in 2015 and in 2035 for Western Bay.



The following chart shows the projected numbers across Western Bay to 2035 at five-year intervals.



As the projections are essentially based on population sizes, the projected results are largely based on changes in population size. The figures above thus reflect modest increases in the population size of Swansea and Bridgend, but a modest reduction in adult population in Neath Port Talbot by 2035.

## Prevalence of Common Mental Disorders (CMDs), Personality Disorders and Probable Psychotic Disorder

The prevalence of Common Mental Disorders in Wales was slightly higher in Wales (19% of people) compared to the overall Great Britain result of 16.4%. The 16.4% figure for any CMD remained fairly stable for England in 2007, dropping from 16.4% to 15.1%. However, the prevalence for the age group 16-64 was much more stable: 16.3% in 2000 and 16.4% in 2007. Since the under 65s are the larger proportion of people, I have assumed that the Wales prevalence estimate of 19% has also remained stable.

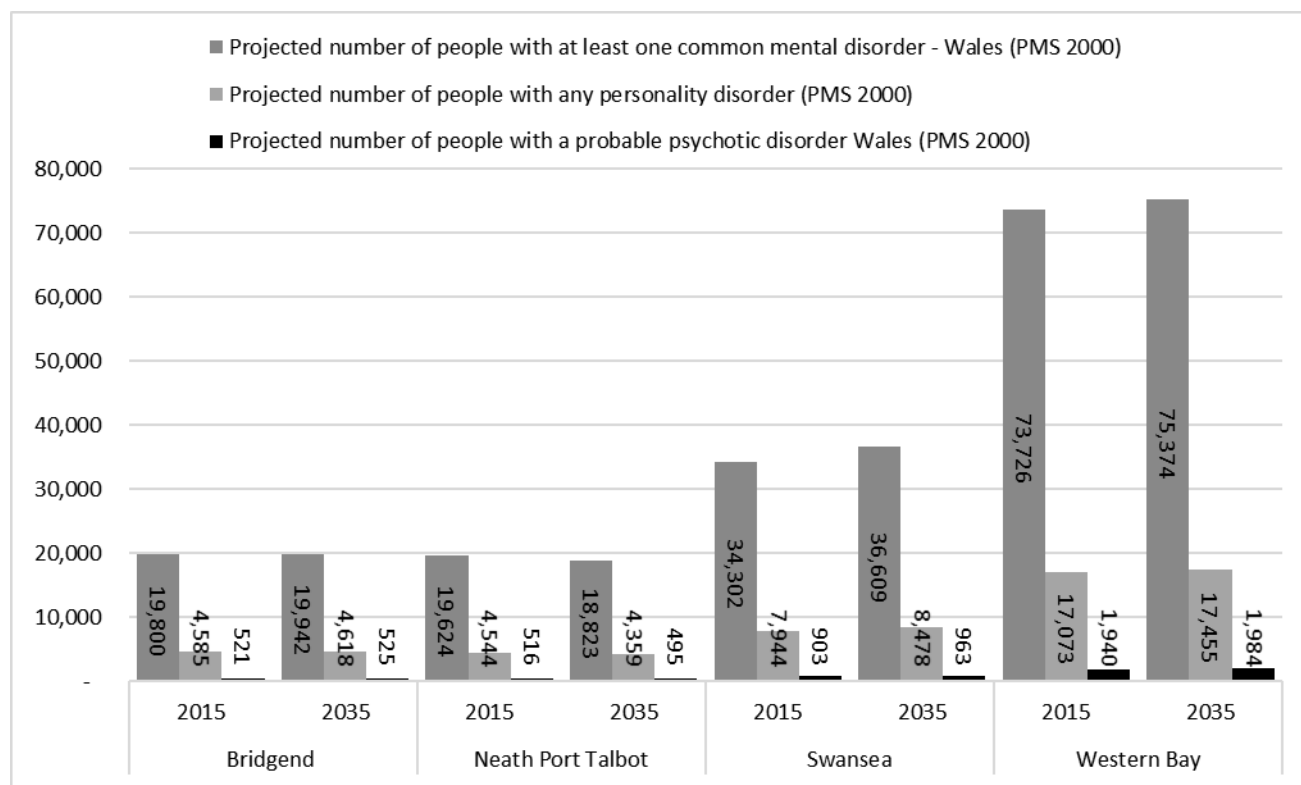
The prevalence of personality disorder in 2000 was 4.4% of the population. The 2007 survey focussed on only two personality disorders.

The prevalence of probable psychotic disorder was the same in 2000 for Wales as for Great Britain at 5% of the population. The prevalence rate in 1993 had been similar at 0.4% of population. The 2007 survey for England also found the same prevalence of 5%.

The chart below shows for 2015 and for 2035 the estimated prevalence expressed as % of people aged 16-74 for each category:-

- 19% with a CMD as per Wales figures in 2000 survey
- 4.4% with a personality disorder as per 2000 survey
- 0.5% with a probable psychotic disorder as per all surveys 1993-2007

Note that the following graphs show the two types of illness but there will be a level of overlap with some people experiencing both. See section below on co-morbidity.



As the projections are essentially based on population sizes, the projected results are largely based on changes in population size. The figures above thus reflect modest increases in the population size of Swansea and Bridgend, but a modest reduction in adult population in Neath Port Talbot by 2035.

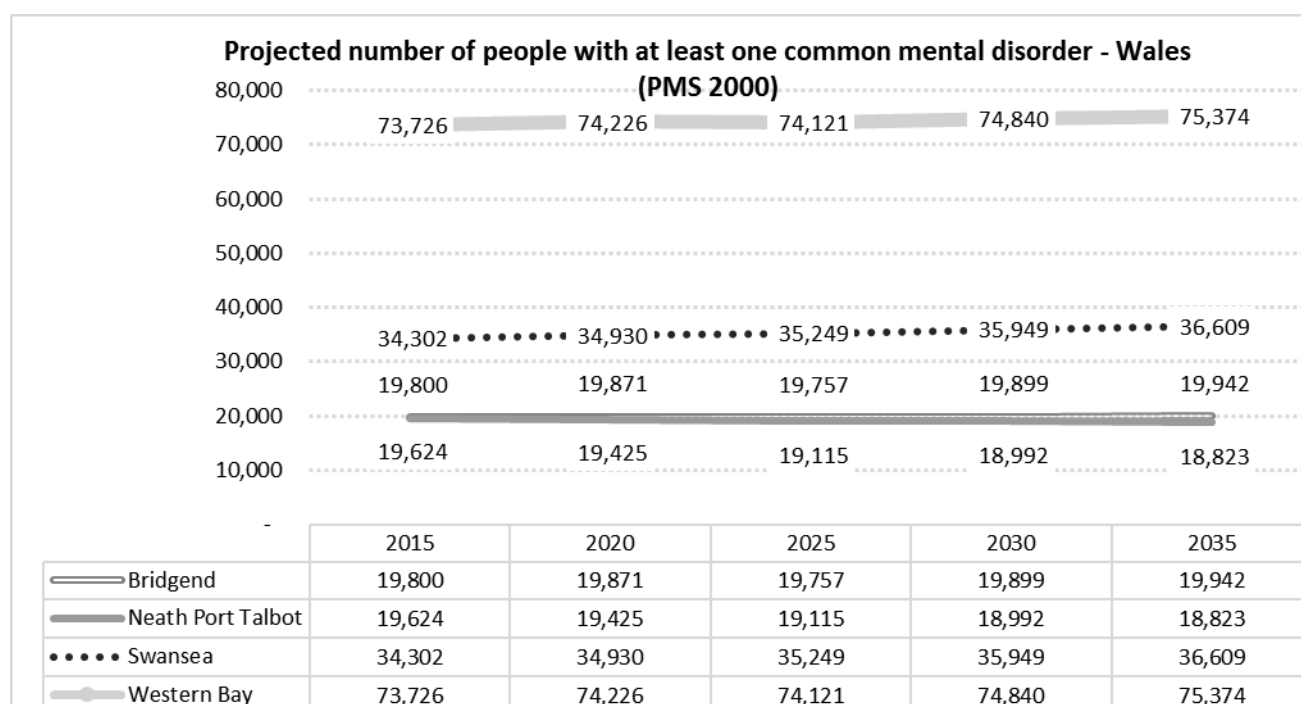


## Projected Prevalence of Common Mental Disorders

CMDs are the most commonly occurring type of mental disorder for which people are likely to seek treatment or support. The disorders are:-

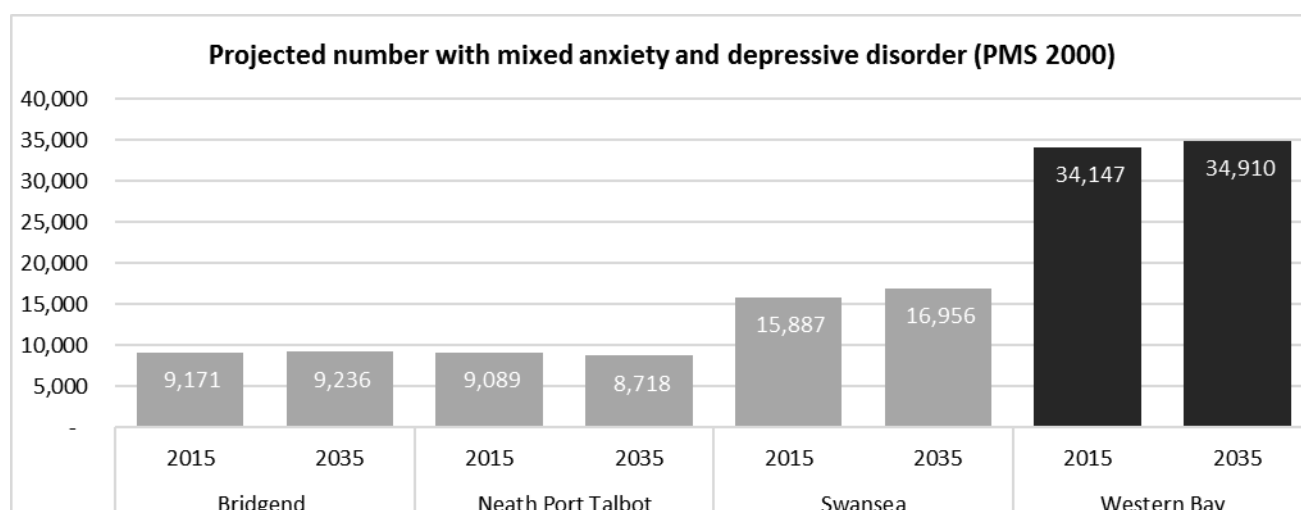
- mixed anxiety and depressive disorder,
- generalised anxiety disorder,
- depressive episode,
- phobias,
- obsessive compulsive disorder
- panic disorder.

The following chart shows the projected numbers across Western Bay to 2035 at five-year intervals given a prevalence of 20% of the adult population.



## Specific Disorders

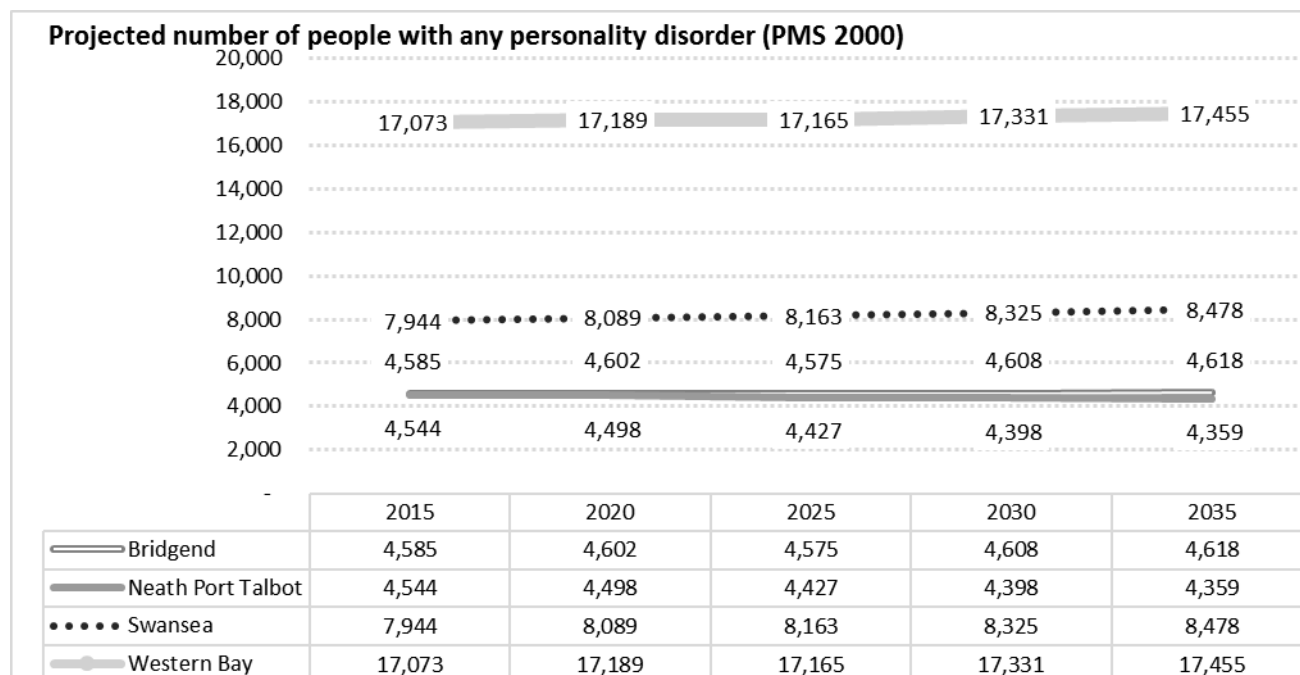
The most frequently-occurring CMD is mixed anxiety and depressive disorder, (sometimes called cothymia) with 8.8% of the adult population experiencing this disorder:-



## Projected Prevalence of Personality Disorders

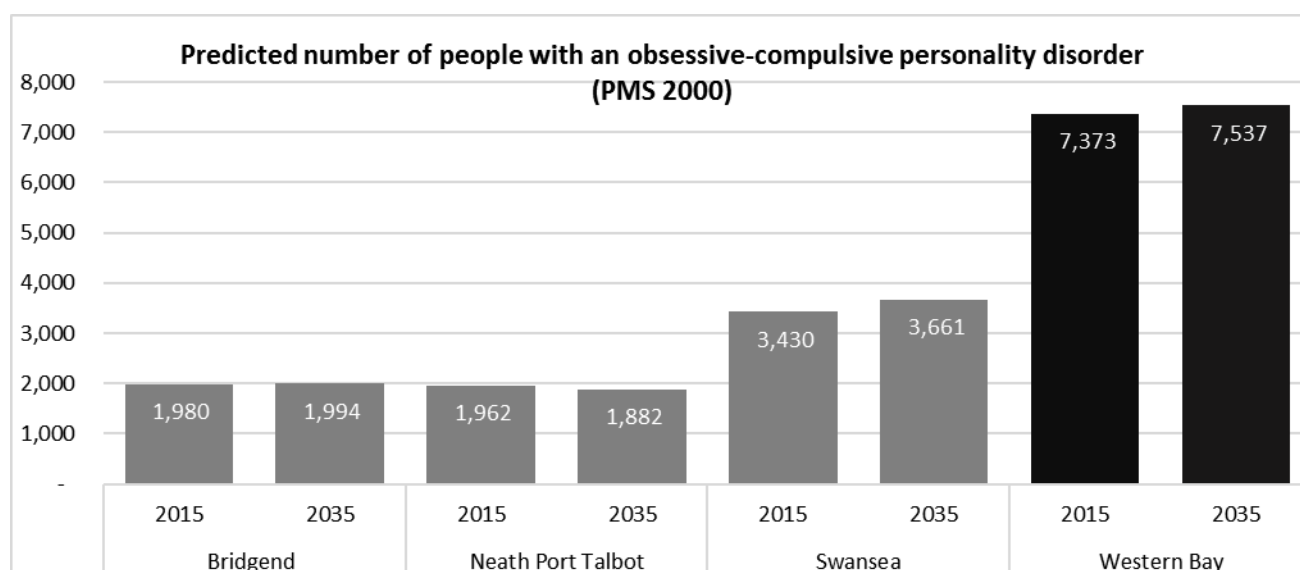
Personality disorders are persistent and they are often expressed as dysfunctional patterns of behaviour that are found to be pervasive and adversely affecting the person's life. Levels of distress and treatment-seeking vary across the personality disorders. In many cases, personality disorders are extremely difficult to treat, if at all.

The following chart shows the projected numbers across Western Bay to 2035 at five-year intervals, given a prevalence of 4.4% of the adult population.

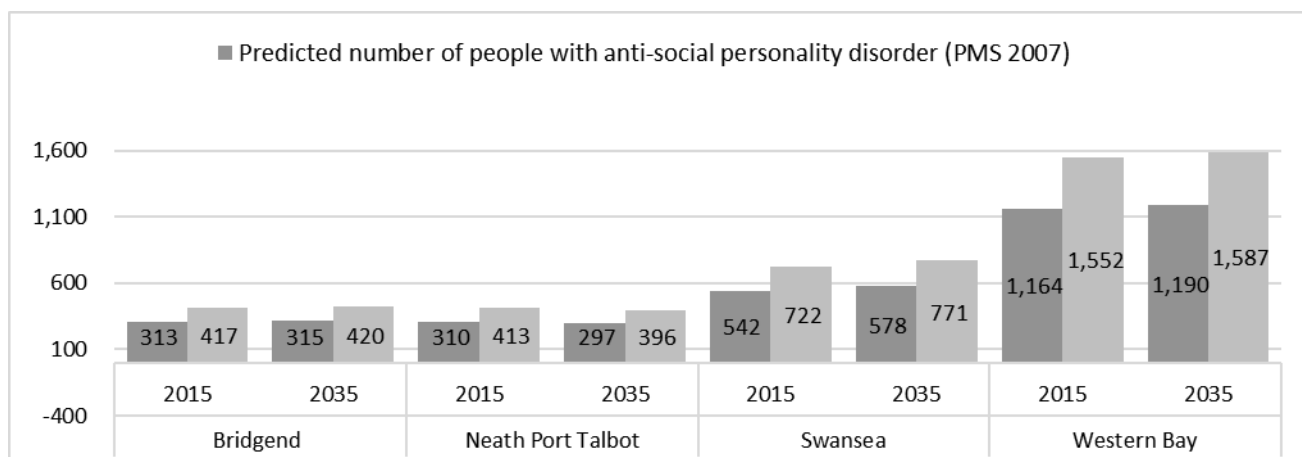


## Specific Personality Disorders

The most frequently-occurring personality is obsessive-compulsive personality disorder, (sometimes called co-thymia) with 1.9% of the adult population affected:-



Using estimates from the 2007 survey, it is possible to estimate the prevalence of antisocial and borderline personality disorders, at 0.3% and 0.4% of the population respectively.

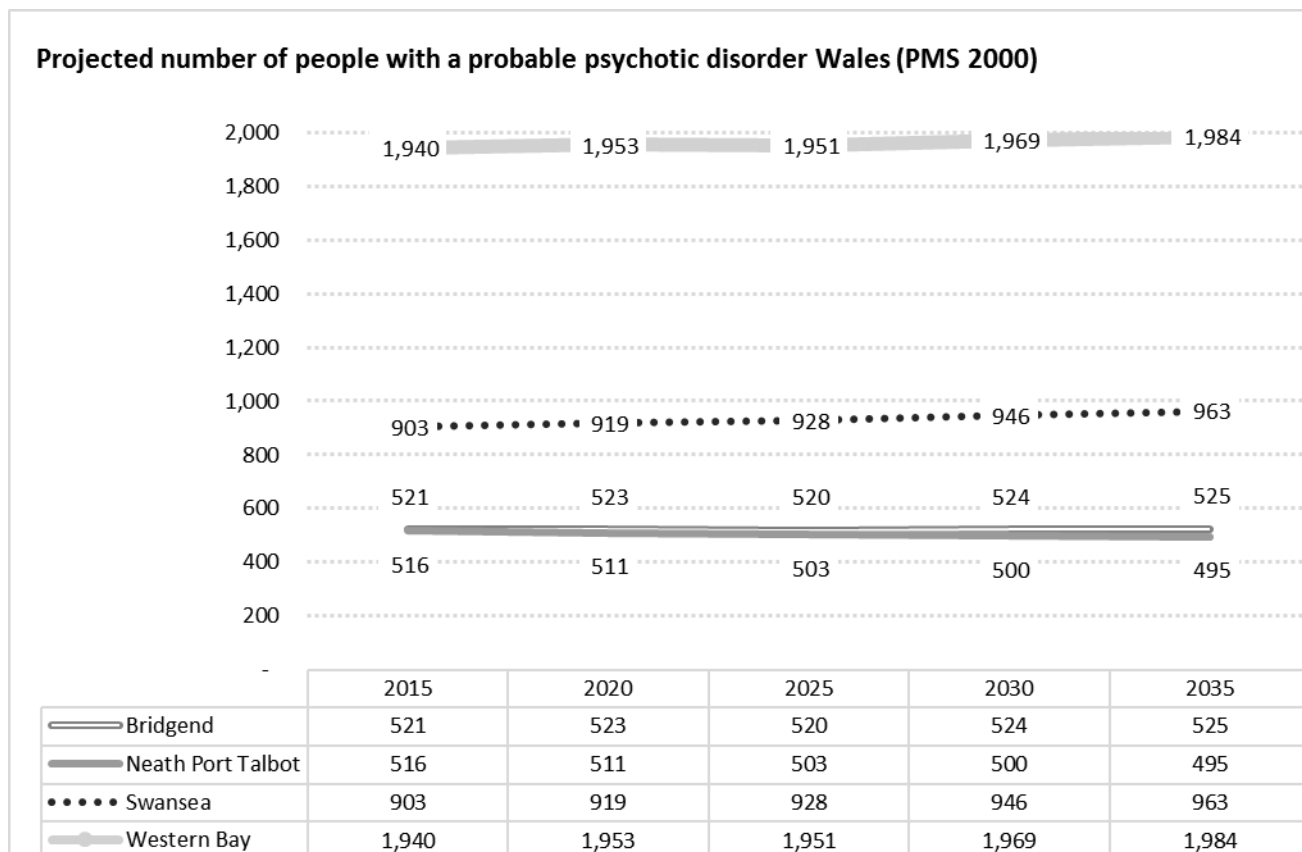


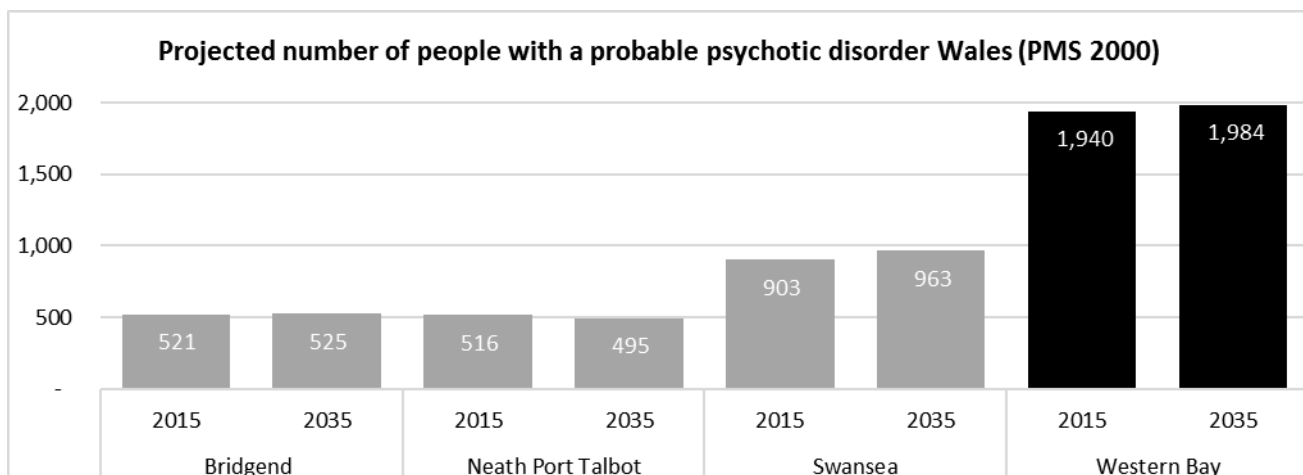
Note these two disorders may co-occur (probably rarely) so there could be some overlap between people in each category.

The least prevalent are dependent and schizotypal personality disorders, at 0.1% of the population.

### Projected Prevalence of Probable Psychotic Disorder

The following chart shows the projected numbers of people with probable psychotic disorder across Western Bay to 2035 at five-year intervals, given a stable prevalence of 0.5% of the adult population across the surveys carried out 1993-2007.





## Projected Numbers Receiving Treatment, Contact with GP & Receiving Community Services

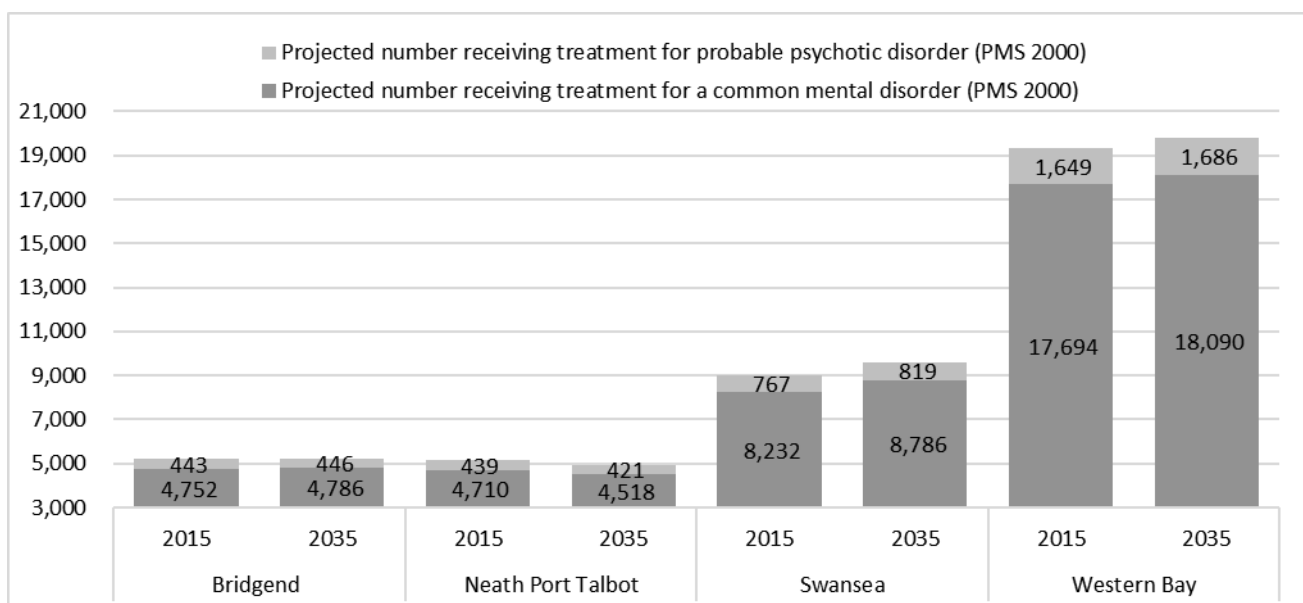
The projected numbers in these section are based on the projected prevalence rates set up above and compared to the findings of the 2000 survey regarding these topics as related to CMDs and probable psychotic disorders. We present only treatment data for CMDs and probable psychosis due to absence of data for personality disorder.

### Receiving Treatment

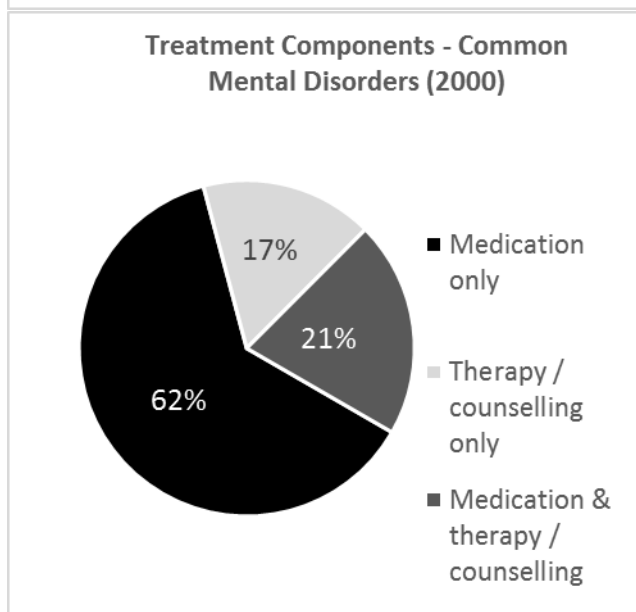
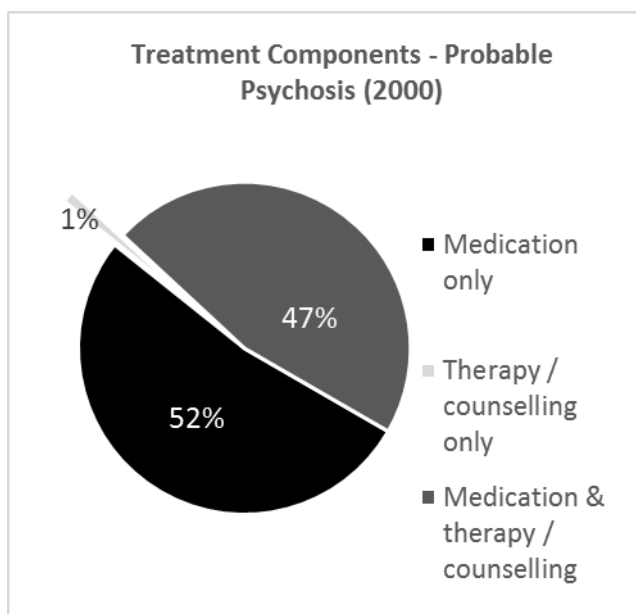
Treatment is explicitly defined in the survey as those receiving the following in the previous year:

- Receiving medication **and / or**
- Receiving counselling / therapy.

In 2000, 24% of people with CMD were projected to be receiving treatment, as were 85% of people with a probable psychotic disorder. The 2007 survey for England showed 81% for probable psychotic disorder while treatment for CMDs remained at 24%. I have retained the 85% treatment rate as the 2007 data for probable psychosis was regarded as less reliable due to smaller sampling rates. The 24% treatment rate for people with CMDs is also used.



It is possible for a person to experience both and therefore there will be some overlap in the two sets of numbers.



The treatment used most often for CMDs and probable psychosis is medication, with 99% of those with probable psychosis receiving medication as part of their treatment, and 83% of those with CMDs receiving medication as part of their treatment. 48% of those with probable psychosis receive some form of therapy / counselling, while just 38% of those with CMDs receive this form of therapy. 62% of those with CMDs receive only medication as treatment.

### Talking to GP About a Mental or Emotional Problem

General Practitioners consider that a large proportion of their consultations relate to mental health problems. The data from the 2000 survey suggests people with mental health problems may be much more likely to speak to their GP about a mental or emotional problem than those who do not have such problems.

The table below shows that 14% of people with a probable psychotic disorder spoke to their GP about a mental or emotional problem in the last 2 weeks compared to 2% of people who do not

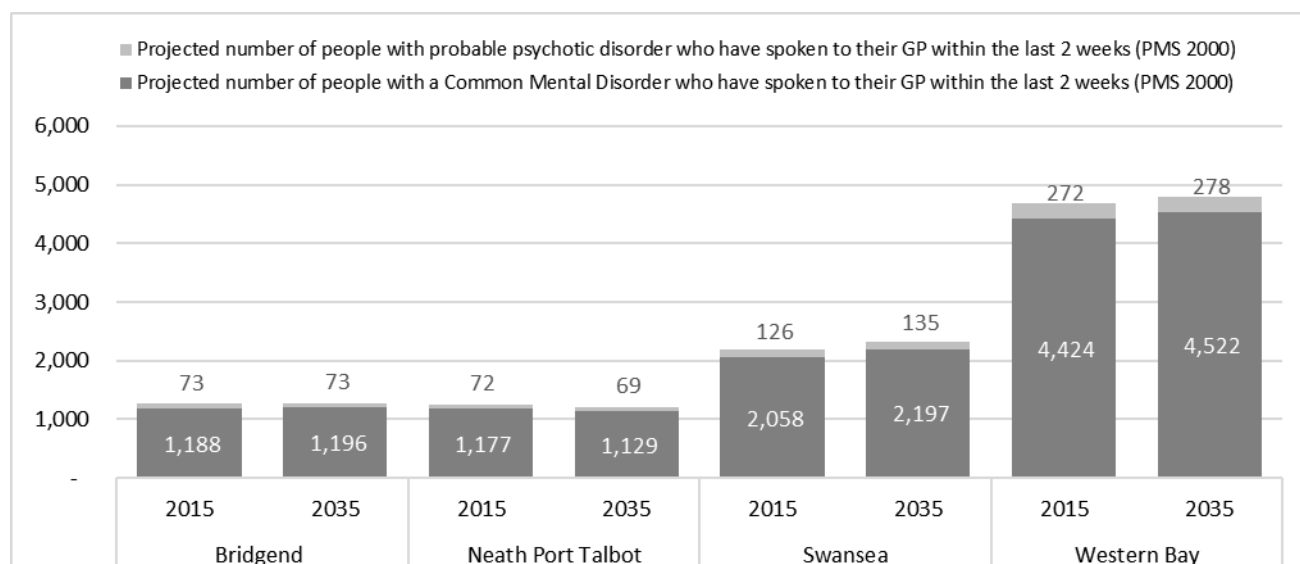
have such a disorder: a seven-fold difference. Similarly, those with CMDs are six times more likely to have spoken to their GP than those without CMDs.

Have spoken to GP about a mental or emotional problem	% of people spoken to GP about a mental or emotional problem			
	With CMD	Without CMD	With probable psychotic disorder	Without probable psychotic disorder
Within previous 2 weeks	6	1	14	2
In the last year	39	6	71	11

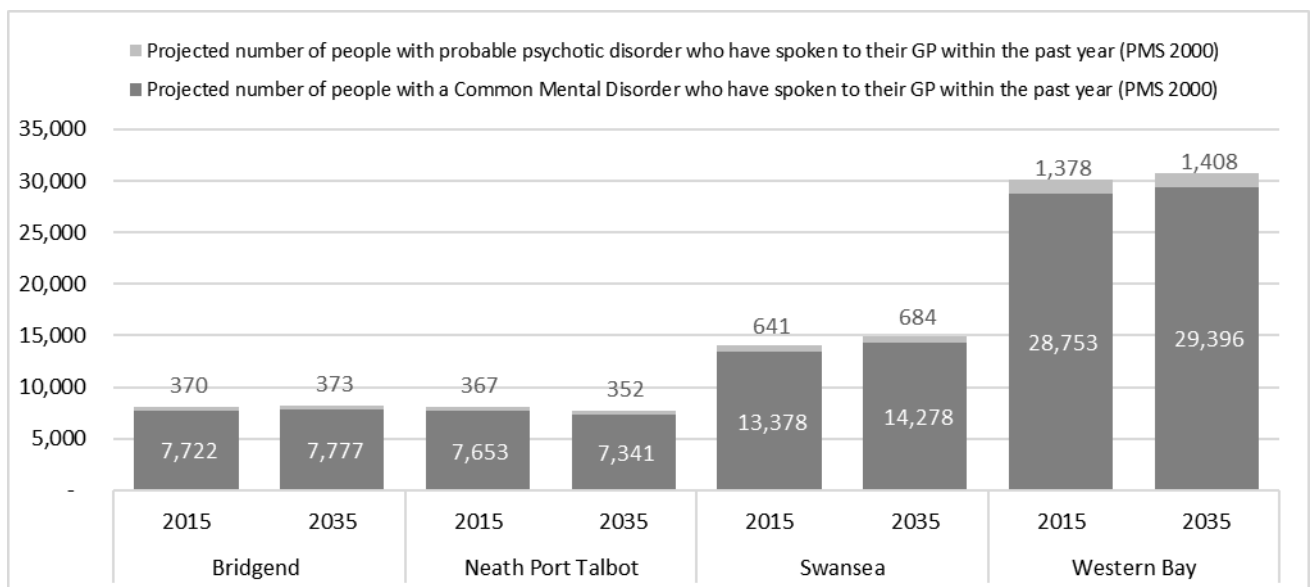
Looking at the whole of Western Bay using the projection for having seen GP within last 2 weeks for 2015 in the graph below, approximately 4,700 GP consultations in a fortnight were carried out with people with CMDs or a probable psychotic disorder.

Over a 52-week period, this is over 122,000 consultations (125,000 by 2035).

It should be remembered that there will also be a considerable number of additional consultations that relate to substance misuse or to personality disorder.



The graph below shows the projected numbers of people with CMD / probable psychosis who had spoken to their GP within the previous years.



For the whole of 2015, approximately 30,100 patients with CMD / probable psychosis will have spoken to their GP about a mental or emotional problem. Compared to the 122,000 calls, it could be suggested that each CMD / probable psychosis patient, on average, will speak to their GP about a mental or emotional problem roughly 4 times in a year.

## Accessing Community Services

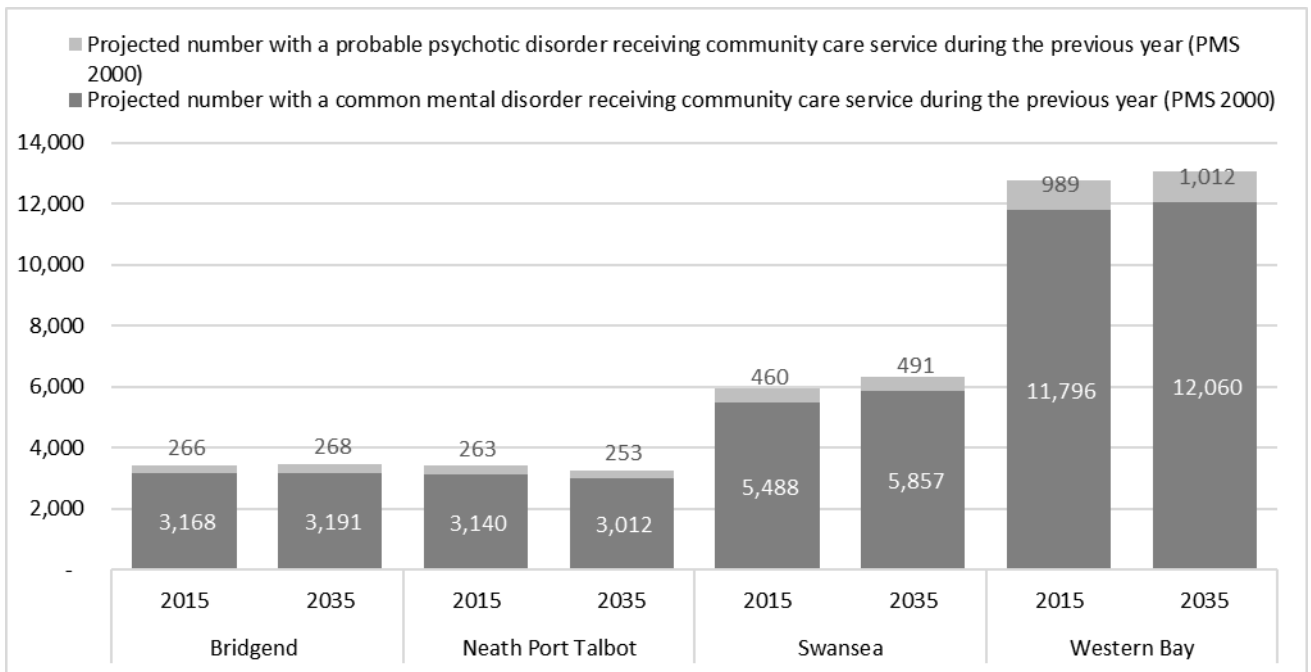
### Definition of community services

GPs treat the highest proportions and numbers of people with mental disorders. People who have more serious mental health problems would be more likely to access more specialist services. Within the psychiatric morbidity survey, these are known as **community services**.

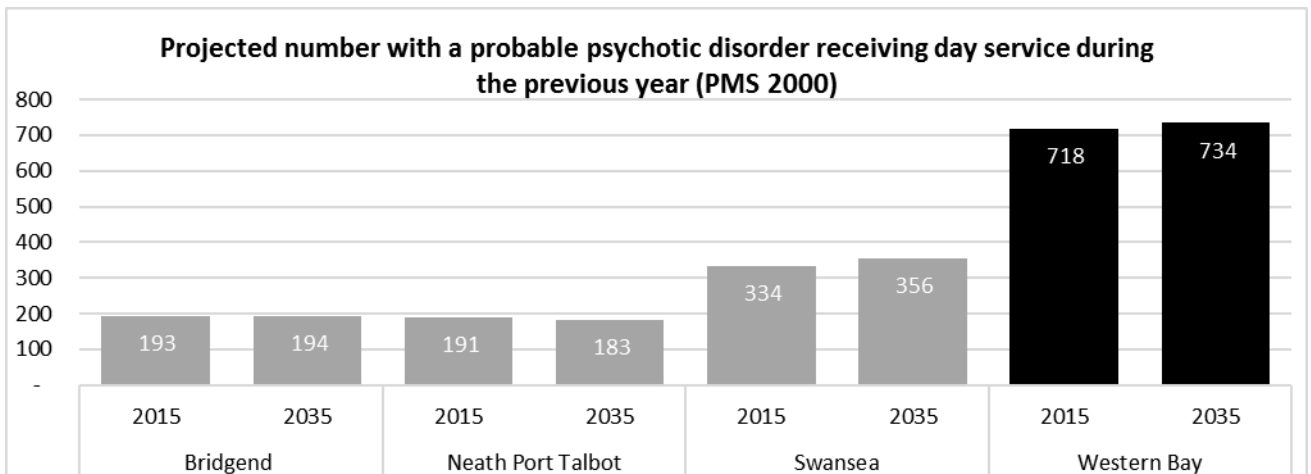
The term community services relates to any of the following:-

- Psychiatrist
- Psychologist
- Community psychiatric nurse
- Community learning difficulty nurse
- Other nursing services
- Social worker
- Self-help/support group
- Home help/home care worker
- Outreach worker

18% of people with a CMD are anticipated to use community care services within a year, while 51% of those with a probable psychosis are also anticipated to use community care services.



Day service is another aspect of community provision and is usually most focussed on those with the most serious disorders, particularly psychotic disorders. Only 3% of people with CMDs use day services compared to 37% of people with a probable psychosis.





## Early-Onset Dementia

Numbers in this population group are projected to remain stable.

