Neath Port Talbot
Castell-nedd Port Talbot
County Borough Council Cyngor Bwrdeistref Sirol

Social Services, Health and Housing Directorate – Strategic Delivery Plan for Mental Health Services

March 2018

Improving Outcomes, Improving Lives
promoting high quality, responsive, citizen centred social care

Contents

Strategic Delivery Plan for Mental Health Services

Foreword

This Delivery Plan explains how Neath Port Talbot County Borough Council (the Council) will deliver its vision for adults living in Neath Port Talbot who require a Mental Health Service. This Plan has been developed following Members' endorsement of the Strategic Business Plan for Adult and Children's Social Care 2018 – 2019, in order to set out the Council's future intention for Mental Health Services.

Mental Health Services supports people to achieve the goals and aspirations that matter to them, as well as helping to safeguard our most vulnerable residents from harm. Significant work is taking place to make sure that people requiring Mental Health Services receive high quality care that is personalised to their individual needs. This Plan builds on previous work and sets out our commitment to further improve services and responses that people receive over the next 12 months and beyond. The focus of our Plan is to ensure that people will receive support that is flexible to their changing needs, helps to build on their individual strengths, safeguards from harm and advocates choice and control. In this way, more people who require support will be able to live with greater levels of independence within their local communities and be better supported to accomplish their ambitions.

In keeping with the Directorate Strategic Business Plan, the focus of this document is the promotion of health and well-being of citizens and maximising independence in their own communities for as long as possible.

Councillor Peter D. Richards
Cabinet Member for Adult Social Services and Health

Andrew Jarrett
Director of Social Services, Health and Housing

Vision and Guiding Principles

The Council's vision is to create *a Neath Port Talbot where everyone has an equal opportunity to be healthier, happier, safer and prosperous*[1].

The Council's aim is to improve the mental well-being of people to – *"a state in which individuals realise their own abilities, can cope with the normal stresses of life, can work productively and can contribute to their community. It is about feeling good and functioning well."*[2]

This will be achieved by working in partnership with other agencies such as health, housing, education, the third sector, community organisations and the private sector. Through partnership working, people will receive high quality and sustainable responses that will meet the needs and demands of those requiring a service both now and in the future.

The Council, with its partners, will deliver a sustainable model of care and support that enables people with mental ill health to live as independently as possible. We are committed to meeting the needs and wishes of people with mental ill health in a way that is targeted, cost effective, of high quality and sustainable, so that they are enabled to achieve the things that matter to them.

Our ambition is to deliver modern social care within Neath Port Talbot and we are committed to ensuring that people requiring social care support have the best experiences possible. This will be achieved by social services working more closely with other organisations and agencies so that there is a more holistic approach to how we support people.

Our aim is underpinned by the principles that:

- ❖ People with mental ill health will:
  - Receive support that is personalised to their individual needs, goals and preferences
  - Have more choice and greater control and influence
- ❖ Those recovering from mental health problems will be enabled to enjoy as independent a life as possible

[1] NPTCBC Single Integrated Plan 2013-2023
[2] Together for Mental Health. A Strategy for Mental Health & Well-being in Wales, Welsh Government 2012

- Those experiencing mental ill health will be supported and rehabilitated to aid recovery
- Mental Health Services will be strengthened in line with national and local strategic priorities and assessed levels of need
- Support to carers of people with mental ill health will be further improved

And we will ensure:

- The best possible quality support through working in partnership with other organisations, including the private and voluntary sectors
- That partnerships are properly governed with a focus on the provision of high quality services and are accountable to those who use and pay for them
- Our services offer excellent value for money and are sustainable for the future
- That the valuable role of carers is recognised and that their own wellbeing needs are taken account of
- That we continually "challenge" the way that we do things, so that we consistently build on good practice
- That providers support the rehabilitation and recovery approach

Strategic Objectives

We want to move away from more institutionalised risk-averse practices and models of support and instead recognise and safely build on people's individual qualities, strengths and abilities. In doing so we will be able to ensure that people are able to live more independent lives including, where appropriate, supporting people to live in their own homes and communities. This is often called a '***Progression'*** approach

A ***'Progression'*** approach seeks to help a person achieve their aspirations for living life as independently as possible and requires working with the person and their support network to develop a personalised assessment, which identifies very specific development requirements in respect of activities of daily living; goal directed support planning; positive risk taking and outcome based reviews. This is then used to help understand how to best support the person and develop their skills so that they can transition into a more independent support model or receive lower levels of staff support. This may

include, where appropriate, a person moving from residential care into their own home.

An **Assessment** of the person's need will be ***'asset based'***, which means focusing on what a person can do, or could do with the right support, rather than focusing on what a person cannot do right now. This requires regular reviews to assess achievement against a set of goals or outcomes that have been developed and agreed with the person requiring support. This will require operational practice (such as social care, health and housing related support carers) and those responsible for commissioning services to work more closely.

The progression model is closely linked to the **rehabilitation and recovery approach**; an intervention that provides specialised mental health care for people with severe and enduring mental ill health which cannot be adequately met by general adult care services. The needs of people with enduring mental ill health are often complex and include treatment of long term illness and prevention of relapse, finding and maintaining accommodation, vocational and educational training, improvement of social skills and prevention of social isolation. Rehabilitation and recovery can enable individuals to lead as independent a life as possible while exercising control over their own lives. This will require a range of services including short term therapeutic support for those experiencing a period of crisis, ensuring there is a range of community based services and working with local communities so that they are best placed to support people with a mental health need.

At a regional level, the local authorities and health board within Western Bay have agreed that mental health services need to be transformed to provide modernised, integrated services aimed at earlier intervention with a focus on prevention. The aim is to support people to live as full a life as possible with community based help and support seen as the norm and hospital care the exception.

In order for us to achieve our objectives, we will work more closely with and better involve all those involved in the individual's personal network of support including family, carers, the third sector and the local community. We will also be looking to develop a new range of accommodation and community support

options, which will involve the establishment of a new commissioning framework for social care and housing related support services.

Achieving this will require us to focus on ensuring that those who work with people requiring services have the right skills to deliver responses that are enabling and support progression of independence.

Our commitments are that we will:

- ✓ Listen to what matters to those that require support and make sure they have choice and control by enabling people to be actively involved in making decisions about their lives
- ✓ Safeguard our most vulnerable residents from harm
- ✓ Develop a single point of access for mental health services
- ✓ Promote an integrated approach to treatment and care
- ✓ Help those that require support to achieve optimum levels of independence and live the lives they want to live
- ✓ Ensure that service delivery promotes recovery-based mental health services, helping people to realise their full potential and become citizens within their local communities, through participation in mainstream community and leisure activities
- ✓ Prevent people from being disenabled due to overprovision of support and disproportionate approaches to risk taking
- ✓ Implement modern responsive services with a progression / rehabilitation / recovery philosophy so that people can achieve their aspirations, including for those that want, and are able, to live in their own homes and communities
- ✓ Value the important role of carers an recognise their own wellbeing
- ✓ Help to ensure that the workforce has the right skills and resilience to help people achieve greater levels of independence by taking an asset based approach
- ✓ Work with partners to help ensure that people are supported to be more involved in their local communities so that they have increased opportunities to become involved in meaningful social and leisure activities as well as benefiting from natural support networks

- ✓ Strengthen working between departments to make sure that people experience smooth and positive transitions through services and pathways into adulthood
- ✓ Help communities to work in an asset based way
- ✓ Ensure there are high quality and cost effective specialist provision which support rehabilitation and recovery for those with the most severe and enduring mental health needs
- ✓ Create new, innovative models of care and support within the community that are flexible to meet changing needs and individual requirements
- ✓ Develop a sustainable market which can respond to changing demands in the future
- ✓ Engage in the development of prevention and well-being services so that the need for higher levels of ongoing care is reduced

Drivers for Change

There have been a number of changes at a national, regional and local level that has required us to review what we are doing and introduce a new approach so that we continue to be best placed to meet current and future needs and demands.

The following are key principles of this Delivery Plan:

- ➢ To reflect significant changes in local and national legislation and policy
- ➢ To reflect changing demographic pressures
- ➢ To ensure effective partnership working with key stakeholders
- ➢ To make effective use of our available resources, to ensure longer term sustainability and meet the requirements of the Council's Forward Financial Plan (FFP)
- ➢ To identify a range of approaches to promote independence
- ➢ To encourage creativity and innovation

People with Mental Ill Health and Current Service Provision

Neath Port Talbot has a total population of approximately 140,000 people, including around 40,700 children and young people (aged up to 25 years), and 29,200 people aged 65 and over.

Currently there are two multi-disciplinary Community Mental Health Teams (CMHT) in Neath Port Talbot; based at Gelligron in Pontardawe and The Forge in Port Talbot. These teams were recently subject of a supportive review jointly conducted by Neath Port Talbot Council and ABMU Health Board, which provided a number of recommendations ranging from patient flow to improvements in IT. The teams will continue to implement the recommendations via the action plan process.

People in the county borough who are experiencing severe and/or enduring mental ill health will be offered a Care and Treatment Plan by the CMHT, developed in discussion with them, to clearly define what care the person needs and how it is to be delivered. There are 534 people[3] aged 18+ years in Neath Port Talbot registered on the caseloads of The Forge (233) and Gelligron (301), with the biggest proportion being those aged in their 50s.

	Age Group								
CMHT	**<20**	**20s**	**30s**	**40s**	**50s**	**60s**	**70s**	**80s**	**Total**
The Forge	5	37	41	43	45	40	21	1	233
Geligron	4	38	49	56	82	51	14	7	301
Total	**9**	**75**	**90**	**99**	**127**	**91**	**35**	**8**	**534**

Long-term mental ill health can combine with age-related health problems leading to an increase in people with more complex needs, which in future could lead to greater demand for accommodation placements. Therefore we see it as essential to work with a rehabilitation and recovery model.

[3] Source: CMHT caseloads as at 1st March 2018

Current Service Model

There are currently[4] a total of 68 individuals accounted for on the external placements budget sheet, i.e. people (aged 18+) with mental ill health in receipt of accommodation or support services from private providers. This figure includes 45 people in residential care and supported living, provided by around ten different service providers across 12 locations, including 25 people currently living outside of Neath Port Talbot.

The breakdown of total full year costs, those attributable to Social Services[5] only, and average costs by service type are summarised in the table below:

	Total (SS & Health)			Cost to Social Services		
	People	Full Year Costs	Average Cost in Service Type	People	Full Year Costs	Average Cost in Service Type
Residential	31	£2,217,753	£71,540	31	£1,446,880	£46,674
Standard Res	10	£253,760	£25,376	10	£202,294	£20,229
Domiciliary	5	£70,823	£14,165	5	£52,842	£10,568
Day Care	1	£5,170	£5,170	1	£5,170	£5,170
Supported Living	4	£184,598	£46,150	4	£129,387	£32,347
Direct Payment	17	£110,773	£6,516	17	£110,773	£6,516
Total	68	£2,842,878	£41,807	68	£1,947,346	£28,637

Note that the people known to the CMHTs may be receiving therapeutic services or other community-based interventions; the table above shows number of people in external placements only.

The current service model is not as progressive as it could be, being heavily reliant on care provided in a residential home. This has resulted in an under-developed market for more enabling services which promote greater levels of independence.

The cost of each care package, even within similar service provision, can vary widely and a breakdown is provided in the table[6] below which groups cost ranges by the number of care packages currently being delivered:

[4] Monthly Placements Budget Sheet February 2018. Note figures are for approved placements and may include placements approved and not yet started

[5] The cost borne by Social Services, net of any ABMU Health contributions for joint funded care packages

Analysis of Cost Splits (Current placements FYE Cost)				
	Total (SS & Health)		Cost to Social Services	
	People	Full Year Costs	People	Full Year Costs
Less than £10,000	16	£78,302	16	£70,374
£10,000 - £19,999	8	£116,975	15	£230,938
£20,000 - £29,999	11	£263,523	13	£313,183
£30,000 - £39,999	8	£297,779	7	£257,721
£40,000 - £49,999	3	£134,217	9	£384,175
£50,000 - £59,999	4	£220,549	3	£159,757
£60,000 - £69,999	1	£68,638	2	£129,158
£70,000 - £79,999	2	£154,109	0	£0
£80,000 - £89,999	9	£757,341	2	£167,137
£90,000 - £99,999	3	£288,138	0	£0
£100,000 - £109,999	1	£103,849	0	£0
£110,000 - £119,999	0	£0	0	£0
£120,000 - £129,999	0	£0	0	£0
£130,000 - £139,999	1	£124,553	0	£0
£140,000 - £149,999	0	£0	0	£0
£150,000 +	1	£234,904	1	£234,904
Total	68	£2,842,878	68	£1,947,346

Financial Position

Neath Port Talbot continues to face significant financial constraints and the Council's FFP sets out the budgetary savings requirements across the main service areas of each directorate.

The Council is committed to supporting its most vulnerable residents and as such spends[7] approximately £2.6 million per year on providing, commissioning, and managing services for people with mental ill health, including £0.8 million on care management and £1.8 million on residential care, external day services, supported living and direct payments. In addition to this, there is further funding provided through the 'Supporting People' programme to address housing support needs; the contribution made by Supporting People consists of 3% of their total grant budget (or approximately £154,000).

The overall savings required of Social Services in 2018-19 is £4.55 million, of which a target of £0.1 million[8] has been assigned to Mental Health Services – a 5.5% saving on the £1.8 million mental health placements budget.

Against the backdrop of a challenging financial climate is the knowledge that we will also see more demands for social care services, adding further pressure to the Council's budget.

[6] Budget Monitoring data as at February 2018
[7] Budget 2017-18; figures for 2018-19 were being finalised at time of writing
[8] See Forward Financial Plan (FFP) 2018-19

The driver for change and the objective of this plan is to make sure the Council is best placed to enable those that require a Mental Health Service to have fulfilling lives based on achievement of their personal aspirations and optimising their independence, whilst being safeguarded from harm. To do this we need to review what we do now and how we do it, to ensure we achieve best value for money so that we can appropriately meet demands within our available budget.

Changes to Service Delivery

We have already identified a number of people who are able to transition into alternative services that offer greater levels of personal independence. For example, 6 people could be offered the option to move into more community-based services, including:

- Supported living (a shared house with individual tenancy rights; people living where and with whom they want, for as long as they want, with the ongoing support to sustain that choice)
- Core and cluster (nearby houses that share care and support staff between them)
- Extra Care schemes (apartment complexes based in the community, where people have their own self-contained flat and can utilise a range of on-site communal facilities)

However, to enable this to happen we must commission a wider range of services than our current offer; this will include working with Registered Social Landlords to help develop different housing solutions.

Through training programmes, team meeting discussions, sharing good practice examples, professional supervision, screening and case allocation processes, and tactical panels (where requests for funding applications are made), we are supporting the workforce to embed outcome-focused practice.

We want to continue to improve on the progress already made with the CMHTs, ensuring all Care and Treatment Plans reflect people's changing needs as well as their wishes.

Where possible we need to engage with providers to develop provision to assist with preventative work and also develop therapeutic groups/opportunities for people to access following discharge from secondary services.

We have reviewed the way we assess and commission social care packages and findings have shown that:

- People experience better outcomes when assessments focus more on what people can or could do and how they can be integrated more into their communities to benefit from more natural support mechanisms
- Strong goal and outcome planning within assessments helps to prevent drift in care management and reduce lost opportunities to help people achieve different outcomes in their lives
- Early transition planning which focuses more on developing a person's skills and resilience results in improved opportunities for people to live in more independent care settings
- Underdeveloped succession and contingency planning to consider the implications of a breakdown of carer support can contribute to overuse of residential care
- A traditional contracting model and an underdeveloped market results in less individualised and disenabling accommodation and care support models which does not stimulate innovation or choice

These findings support the need to build on current good practice and implement a conversation approach to assessment and review practice based on strengths and recovery. It also underlines the need to take forward the procurement of a new commissioning framework for social care and housing related support so that the local market is able to offer a choice of individualised and innovative options in the local community that supports progression, rehabilitation and recovery.

Our Priorities – What we plan to do

We are an ambitious Council and there is much we want to achieve to make sure people get the best possible support and have positive life experiences.

The following section outlines the areas of priority we are planning to work on over the next 12 months and beyond in order to progress the overarching objectives, setting out our key priorities and work areas.

Priority 7 - Complex Needs: Learning Disabilities & Mental Health Services[9]

For people accessing learning disability services or mental health services, we will, in partnership with clients, carers, families and service providers remodel services and implement a 'progression' model of care.

We want to ensure that people do not become entrenched and over-dependent on services. We will work with all partners to promote individuals' strengths and independence, and ensure they receive the care they need based on the outcomes they want to achieve.

Key to this approach is embedding the ***'progression model'*** and ***'recovery model'*** of care. An example of the progression approach is the identification that a person currently living in a residential care home out of the area wants and can, with the right support and planning, return to Neath Port Talbot and live in their own home. To achieve this, first the person might take up residency in a local residential care provision for a period of time, during which the provider will work with the individual to help them acquire independent living skills. During this time they may form a friendship group with other residents and, at a later date, move to a supported shared home. Here they receive further enabling support and acquire more independent skills so that, after a period of time, all can move into homes of their own; true independence with their own front door.

Recovery acknowledges an individual's potential and capacity for growth and development and that people with mental health problems can make significant improvements by taking greater control over all parts of their lives, including becoming more independent, engaging in meaningful activities and having fulfilling and supportive relationships. The individual is supported to

[9] As taken from Social Services, Health & Housing Strategic Business Plan 2018-19

'recover' their life and work towards goals that give their life meaning again. Although they may not fully 'recover', they will be a part of the wider community and not segregated from it by being placed in residential or hospital care. This means that housing, education, employment and **participation in mainstream community and leisure activities provide the focus of the care and treatment plan. Individuals are treated in familiar settings** – as a result in-patient admissions reduce and become shorter in duration as acute and/or intensive treatment services are established within the community.

Over a number of years, it is anticipated that accommodation configuration will gradually change from being one that is mainly residential to one where the majority of individuals are living more independently, including 'core and cluster'.

As such, service providers will be commissioned and routinely monitored according to their ability and progress in promoting independence of individual clients, whilst ensuring that we continue to receive best value for money.

Case Study

"C" currently resides in a mental health residential care home. She wishes to return home and had been undertaking home leave for approximately 75% of her stay while there. There was a lack of evidence in regards to enabling her progression by the care home and they stopped her home leave. There was a risk of "C" regressing and action was required to ensure a prompt response to promoting her potential to 'move on'.

"C" will now transfer to a specialist rehabilitation care establishment for approximately 3 months in order to help her prepare and encourage her progression to return to her own home by providing a bespoke package of care. To support "C" in her own home we envisage providing ongoing community based support or a Direct Payment.

It is also estimated that this action will result in a saving of around £1,200 per week once "C" is home and community based / Direct Payment support is in place.

Commissioning and Social Care Intentions

Consideration for the commissioning of services will only occur where a service can demonstrate that it can achieve the biggest impact and maximum benefit for people with mental ill health. To achieve this, our plans include:

- A systematic asset-based and outcome-focused review of all people with mental ill health in receipt of a care and treatment package to ensure it takes a proportionate approach to risk and delivers the outcomes that matter to people
- Encouraging an asset based approach so that people with mental ill health utilise community based prevention and well-being services, for example through our Local Area Coordinators or Direct Payments
- Work with those in receipt of services, their families and existing providers to identify who could either be supported differently or move to more enabling forms of accommodation and support
- Promote development of core and cluster, supported living and other housing accommodation options with new and existing partners to enable the 'move-on' of people where appropriate
- A 'Transition Team' to jointly work on complex care cases and facilitate their smooth transfer between Children's and Adult Services
- Recommissioning our service delivery model through a new framework which also encourages providers to be more innovative, moving away from over dependence on residential care

Outcomes

As a result of changes to the way we assess and review care needs and commission services, we expect to see a number of positive outcomes as the new model embeds, for example:

- Better mental health is achieved and sustained through the availability of a range of personalised service options
- Care and treatment planning will be person centred as well as recovery and reablement based
- People with mental ill health are enabled to achieve their personal goals and be active members of their local communities and, by extension, feel less stigma by making use of community facilities and resources

- Increased emphasis on working towards a person's personal outcomes using a targeted approach so that people are able to live the lives they want to live
- Enable Social Workers to plan pathways of care based on individual need, rather than service availability so that people receive the right type and levels of support as they are enabled to achieve greater levels of independence
- Enable providers to develop business strategies based on projected needs so that we have a robust and sustainable market that is able to meet local needs and demands
- A more dynamic, flexible and diverse range of accommodation and service options available to those who need it so that people have greater choice and control
- Sustainability of high quality provision that is also good value for money so that we can meet demands within budget
- Carers are supported to continue in their caring role

Conclusion

Mental Health Services is a priority area for Neath Port Talbot CBC but a new approach is required to ensure services are sustainable and more tailored to individuals. We believe that this Plan's model of delivering services locally in community settings, with a focus on progression, intervention, rehabilitation and recovery will meet the aspirations of people with mental ill health and their carers. We look forward to the continued advice and support of the Cabinet Member for Adult Services and to the development and implementation of a Mental Health Members' Interest Group.

Action Plan for Mental Health Services (April 2018 – March 2019)

Our commitments will be to:

1. **Take forward outcome focussed assessments and review the commissioning arrangements for complex care. This will involve reviewing individual care packages of people with complex needs and work with providers to create a range of support and accommodation options.**

   This will be achieved by:
   a) Giving people more choice and a louder voice to take greater control over decisions about the way they want to live their lives and the services they need to support them to do this
   b) Embedding quality assurance and performance management to ensure best outcomes are achieved for those accessing services, and promote a culture of continuous improvement
   c) All staff completing a three-day outcome focused training course
   d) Undertaking regular reviews of commissioned services
   e) Ensuring that safeguarding is central to all of the above actions

2. **Implement an outcome focussed approach to promote greater levels of independence.**

   This will be achieved by:
   a) Reviewing each care package to ensure placements for people with complex needs are effective, outcome based and appropriate
   b) Ensuring residential providers are progression, recovery and rehabilitation focused
   c) Embed CMHT Operational Policy
   d) Continue to improve processes and outcomes in line with CMHT supportive review recommendations

e) Maintain and continue to stabilise the Teams through period of change

3. **Carry out a review of Mental Health service provision to develop a rehabilitation and community based model for the future.**

   This will be achieved by:

   a) Engaging with the market to draw together innovative models that support the Council's agenda of independence, choice and control and to commission appropriate models of support in accordance with individual needs
   b) Develop modern response services with a recovery philosophy led by care coordinators

4. **Create clear pathway models for complex care services to enable people to achieve optimum independence. This will include working with providers to develop a wider range of care, support and accommodation options which promote greater independence.**

This will be achieved by:

a) Utilisation of the 'progression model' of care programme, which ensures that care packages are tailored to the needs of the individual, whilst placing emphasis on progression, across Mental Health Services
b) Reviewing the provision of community support to ensure that Supporting People Programme Grant funding is making an optimal contribution to the development of an accommodation and support service pathway for people with mental ill health that has clear and streamlined access arrangements
c) Improving transition planning so that support is available and accessed in a timely manner

d) Providing information and guidance to individuals on alternative community based provision, including by working with Local Area Co-ordinators

5. **Work with providers to develop 'core and cluster' housing models; these consist of separate accommodation near each other to allow for shared support across a number of properties.**

This will be achieved by:

a) Engaging with providers to develop innovative core and cluster accommodation models that can support the Council's agenda for independence, choice and control
b) Commence implementation of the agreed optimum model for adult mental health services, as outlined in the Western Bay Strategic Framework for Adults with Mental Health problems

6. **Improve the availability of services that promote rehabilitation and recovery for those experiencing mental ill health.**

This will be achieved by:

a) Seeking to develop sanctuary-type provision to offer short term therapeutic support for people experiencing crisis
b) Working with Health partners to remodel acute mental health services which are more community based and in line with the Western Bay Area Plan for Care and Support Needs 2018-2023
c) Building up the community infrastructure to better support people with mental health needs

7. **Work with Health colleagues to foster a joint approach for reablement models and for the delivery of complex care services. Seek opportunities to drive forward integration between the Council and Health Board teams, in terms of the social work and commissioning arrangements for mental health and complex care services.**

   This will be achieved by:

   a) Strengthening existing partnership arrangements to identify opportunities for further integration and joint working
   b) Complete CMHT Action Plan review in line with recommendations
   c) Engaging with Health colleagues regarding future models of care and support