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Adult Mental Health Services Follow up Report



Adult Mental Health Services – Follow up Report

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Report presented by the Auditor General for Wales to the National Assembly for Wales on 7 July 2011



Terminology and basis of comparisons used in this report

Since 2005, the NHS has undergone two reconfigurations. Initially, a number of NHS Trusts merged, before NHS trusts and the 22 Local Health Boards (LHBs) were re-organised into the current seven integrated Health Boards in October 2009. Throughout this report, we use the term 'Health Boards' to refer to the new, integrated health bodies. We use the term 'LHBs' and 'NHS Trusts' to refer to the former organisations.

We collected information from the 22 former LHBs and NHS Trusts, and local councils. In key areas we have updated with information provided by the new Health Boards. We analysed data from 2005 to the present. We have summarised and compared data at the most local level possible. This is usually either at the level of council areas (which are the same as the geographical areas covered by the former LHBs) or at former NHS Trust level. However, due to the way some services are organised, this was not always possible.

As we were interested in comparing performance between 2005 and 2010, we have not summarised data at a Health Board level, as summarisation often hides considerable variation across different parts of a Health Board area.



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Summary

- 1** Mental illness is common and disabling. Estimates of the overall prevalence of mental distress suggest that one in four British adults experience at least one diagnosable mental health problem in any one year, and one in six experiences this at any given time. Mental health problems range from common disorders of depression and anxiety, which affect between eight per cent and 12 per cent of the population in any year, to the less common psychotic illnesses such as schizophrenia¹.
- 2** A broad range of services is needed to promote good mental health and to support people who develop a mental health problem. This is particularly the case for those with more serious mental health problems, who may often need support from such services as health, social services, housing and employment. The NHS, local authorities and the voluntary sector provide services for people with a mental health problem.
- 3** In October 2005, the Auditor General published a baseline review of adult mental health services. He concluded that, although there were encouraging examples of good practice, the overall way in which adult mental health services were planned, organised and funded did not support delivery of the Welsh Government's National Service Framework². In particular, the review found:
 - a** significant gaps in key elements of service delivery were preventing the full implementation of the National Service Framework;
 - b** scope for greater integration and co-ordination of adult mental health services across different agencies and care sectors;
 - c** considerable variations in the approach to empowering and engaging service users and carers; and
 - d** planning and commissioning arrangements that did not fully support the development of whole system models of care.
- 4** In response to our baseline review and a number of other reviews³, the Welsh Government:
 - a** published in 2005 *Raising the Standard*, the revised Adult Mental Health National Service Framework, which established 44 key actions to be delivered between 2005-06 and 2012-13⁴;
 - b** announced an additional £5 million of annual funding;
 - c** ensured that action plans were produced by each of the 22 local multi-agency mental health planning groups⁵; and

¹ The Office for National Statistics, *Psychiatric Morbidity Report*, 2001.

² Welsh Government, *Adult Mental Health National Service Framework*, 2002.

³ Wales Collaboration for Mental Health, *Under Pressure*, 2004; and the Healthcare Inspectorate Wales (HIW)/Health Commission Wales (HCW), *Review of Adult Mental Health Medium Secure Units in Wales*, 2005.

⁴ Welsh Government, *Raising the Standard - The Revised Adult Mental Health National Service Framework and Action Plan for Wales*, October 2005

⁵ Membership of multi-agency mental health planning groups included local authorities, Local Health Boards, NHS Trusts, the National Probation Service, voluntary sector partners, and service user and carer representatives.

- 11** We asked Health Boards and councils to identify jointly the actions needed to address the gaps and shortfalls highlighted by our local reports, and to incorporate these into local plans and strategies. Details of local performance against Assembly Government targets and guidance are set out in [Appendix 2](#).
- 12** This report summarises the position across Wales and includes our recommendations for action at a national level. The report covers:
- a** the progress made since 2005 in improving adult mental health services in key service areas ([Part 1](#) of the report);
 - b** the extent to which the barriers to change identified in 2005 have been addressed ([Part 2](#)); and
 - c** how improvements need to be sustained into the future ([Part 3](#)).
- 13** The life span of the revised National Service Framework is coming to a close, and the Framework is to be replaced during 2011 with a revised strategy for mental health. The findings of this report should assist the Welsh Government in revising its strategy.
- 14** Our overall conclusion is that since our baseline review there has been clear progress in improving adult mental health services, although some important gaps and inequalities in the services provided remain. This reflects the mixed success that the Welsh Government, NHS bodies, and councils have had in removing key barriers to change. These organisations face new challenges in further developing services.

Since 2005, there have been important improvements in adult mental health services in many parts of Wales, although progress has been variable and some service gaps and inequalities remain

- 15** **Steps have been taken to improve primary care provision of mental health services, although issues remain with practice staff training and the support provided by specialist services.** More extensive use is being made of standardised tools to help diagnose mental health problems, other than for assessing suicide and self-harm risk. Although some progress has been made in providing mental health training to GPs and practice staff, many of these staff have not received such training in the last three years. Also, only limited progress has been made in increasing the number of GPs with specialist skills in mental health.
- 16** Since 2006, general practices have been able to choose to provide an enhanced service for those with a severe mental illness. Those doing so receive additional payments for providing the service, which seeks to help address the higher prevalence of many physical health problems in those with severe mental illness. The provision by general practices of this enhanced service is very patchy, and its impact in improving physical health has been limited.



- 17 Specialist support for primary care has been expanded in many parts of Wales. Gateway workers now cover most council areas, providing an assessment, gate keeping and signposting role. However, in some parts of Wales, gateway workers do not cover all of the council area, and, in others, support services are poorly resourced.
- 18 **There has been a shift in resources from inpatient to community services but, although many areas now have a broader range of community services in place, these do not always have adequate capacity.** Between 2005 and 2009 there has been a 23 per cent reduction in the overall number of adult mental health beds, and a 14 per cent increase in community staffing levels. However, progress across Wales has been mixed and there is no apparent rationale for the level and mix of inpatient and community resources in different areas.
- 19 Good progress has been made in establishing crisis resolution and home treatment services, which act as an alternative to hospital admission. The number of council areas covered by this service has increased from nine in 2005 to 18 by the end of 2009, and there were specific plans in place to establish these services in the remaining four council areas. However, Welsh Government guidelines on when and how these services should be provided are not being met in some parts of Wales, and only limited crisis and emergency respite accommodation is available across Wales.
- 20 Assertive outreach services, which target people with severe and enduring mental illness who do not effectively engage with mainstream mental health services, have also expanded. In 2009 these services were available in seventeen council areas, compared with six council areas in 2005.
- 21 Where they are provided, crisis resolution and home treatment services and assertive outreach services are not always available across all parts of a council area. Also, staffing levels and the composition of teams vary widely.
- 22 There has been far less progress in developing early intervention in psychosis services. Early recognition and intervention when someone first develops a psychosis can lead to a faster and more complete recovery, a decrease in the frequency and severity of relapses, and an increase in the time to the first relapse. Gwent is leading the way in Wales with early intervention in psychosis services, and a smaller service covers Carmarthenshire, Ceredigion, and Pembrokeshire, but these are the only dedicated services in Wales.
- 23 Progress in meeting the Welsh Government's policy guidance and targets for the organisation and management of community mental health teams has been mixed. In some parts of Wales, there are issues with team membership, the extent of integration between health and social care, and co-ordination with other specialist services such as drug and alcohol services, criminal justice, and housing. A common weakness was the poor quality of demand and capacity planning across community teams.
- 24 **Psychology therapy services have improved since 2005, and there has been some progress in moving towards a stepped model of care, but waiting times can still be very long.** The National Institute for Health and Clinical Excellence recommends a stepped model of care approach to psychological therapies, which can range from simple low intensity and low cost interventions through to high intensity secondary care treatment. There is a

commitment to develop a stepped model of care approach in most parts of Wales, but implementation is mostly at an early stage.

- 25** Some parts of Wales have experienced improvements in the extent of psychological therapies available in primary care, although waiting times remain too variable, with some LHBs reporting in 2009 waiting times in excess of the Welsh Government's 12-week target. The number of community mental health staff trained in psychological therapies has increased in most parts of Wales. Specialist psychologist and psychotherapist staffing levels have also increased in most parts of Wales since 2005, although long waiting times persist in many areas, and can be well in excess of 12 months.
- 26** **Despite recent improvements in care planning in some areas, service users are not being consistently supported and involved in their care.** Information provided to service users is not consistently kept up to date in some parts of Wales, and many service users did not know how to contact someone for support out of hours. Advocacy services have been expanded across Wales although the level of provision is inconsistent.
- 27** Although some Health Boards have reported recent improvements with care planning, many of the service users who responded to our survey in 2009 had not been properly involved in their care. Only one in two service users stated that they had been given a written copy of their care plan, and many did not think that they had been appropriately involved in decisions about their care and treatment.

The Welsh Government, NHS bodies and councils have had mixed success in addressing barriers to change

- 28** **Action by the Welsh Government to promote and support improvements in adult mental health services has been partly effective.** The Welsh Government has delivered many of the actions for which it was responsible under the revised National Service Framework, although not always to the planned timescales and there are some important omissions. The Welsh Government has issued policy guidance in a number of service areas outlining how these services should operate, but has not effectively monitored the implementation of the guidance.
- 29** In addition to the actions outlined in the revised National Service Framework and the annual targets set for the NHS, a number of external reviews and reports on mental health services have included recommendations for action. This has resulted in too many targets and key actions for mental health services, which have not been co-ordinated and prioritised effectively at a local level. This may have contributed to the variable progress in implementing actions that are central to the quality of care, such as planning and auditing the implementation of National Institute for Health and Clinical Excellence guidelines on mental health.



- 30** Information on which to assess the outcomes of services and their impact on service users is lacking. Variations in expenditure and service delivery across Wales can be identified, but there is a lack of comparative information on the impact of these variations. The development of more outcome-based targets for depression in hospital, first-episode psychosis, and dementia care is a positive step forward.
- 31** **Patterns of expenditure on adult mental health have been highly variable across NHS bodies and councils, and it is not clear yet whether the Welsh Government's attempts to protect NHS mental health expenditure have been successful.** Between 2005-06 and 2008-09, the proportion of expenditure that has gone on adult mental health services fell in some former LHBs and social service departments and increased in others. Expenditure on adult mental health per head of adult population is highly variable across Wales, and the variations are not explained by the differing levels of need.
- 32** In an attempt to ensure mental health is given an appropriate priority the Welsh Government has ring-fenced NHS mental health funding since 2008-09. However, these arrangements have lacked clarity, cannot be easily monitored, and may not have been complied with.
- 33** **Progress in improving local planning arrangements has been mixed.** Agreed multi agency service models for mental health services are in place in most parts of Wales, and in many areas they are being revised by Health Boards and partner organisations to ensure consistency within Health Board areas. However, success with implementing and monitoring the plans drawn up in response to our 2005 baseline review has

been mixed, and the earlier NHS trust re-organisation appears to have impeded progress in some parts of Wales. The effectiveness of local multi-agency planning groups remains variable.

- 34** National Service Framework requirements relating to service user engagement are not being universally met in areas such as involvement in planning and monitoring service quality. However, innovative methods are being used in some parts of Wales to involve service users in planning service improvements.

The new Health Boards, supported by the national programme for mental health, need to sustain improvement during a period of financial restraint

- 35** **Mental health services face some new challenges.** There is widespread support for the adoption of a recovery approach to mental health that focuses on maximising mental health and independent living, rather than an approach that focuses on treating mental ill health. However, the adoption of a recovery approach will require a fundamental change to service culture and delivery.
- 36** Adult mental health services face the challenge of sustaining and building on the improvements made in recent years during a period of financial restraint and increasing demand for services. Furthermore, there is evidence that investment in some mental health services, such as early intervention in psychosis, can deliver net savings to the NHS and the public sector as a whole. But, finding the funds to invest in such services will be a

- challenge in the current economic climate. The cessation of funding for services currently funded on a non-recurring or fixed term basis also poses a challenge for Health Boards.
- 37** The Mental Health (Wales) Measure received Royal Assent in February 2010. The Measure covers primary care support services, care planning, and advocacy services. The Measure will be implemented in stages over the next three years and will require considerable change to the way services are delivered.
- 38** **The new Health Boards provide an opportunity to drive forward change.** The most recent NHS re-organisation removes some of the barriers to whole-system development of services and provides an opportunity to drive forward change. However, there is no guarantee that mental health services will be given a high priority in the new Health Boards, and there is a risk that local authorities, the voluntary sector, and service users and carers will not be appropriately involved in planning mental health services.
- 39** The Vice Chair and an Executive Director of each Health Board have responsibility for primary, community, and mental health services. The National Assembly's Health, Wellbeing and Local Government Committee has identified a risk that primary and community services would demand most of the Vice Chairs' and Directors' attention at the expense of mental health services. The Welsh Government accepted the Committee's recommendation that the role of the Vice Chair be kept under review.
- 40** Better joint working and integration between health and social services is a Welsh Government policy objective, and different approaches to joint working and integration within mental health are being pursued across Wales. There has been no evaluation, however, of these approaches to assess the extent to which they deliver cost and service outcome benefits.
- 41** **The national programme for mental health has a key role to play in supporting the further development of mental health services, but more robust arrangements are needed to ensure Health Boards are responding appropriately to national programme advice.** To support improvement to health services the Welsh Government set up a number of national programmes, including one for mental health, in June 2010. The programmes were intended to have a fixed life and are currently being reviewed by the Welsh Government.
- 42** The mental health national programme aims to provide direction, advice, and support to Health Boards, but has no responsibility for delivery. Responsibility for delivering efficiencies and service improvements remains with Health Boards, and responsibility for performance management remains with the Welsh Government. The mental health national programme operates in a variety of ways, including leading on collaborative projects, collating and sharing information and good practice, and providing advice and guidance. The Welsh Government expects all Health Boards to adopt national programme advice or provide a justification for not doing so, referred to as 'adopt or justify'.



- 43 We have not reviewed the operation of the mental health national programme in detail, but there are indications that Health Boards do not have effective arrangements in place to monitor whether they are responding appropriately to national programme advice and outputs, such as on high impact service changes, cost saving opportunities and good practice compendiums. Also, it is not clear how the 'adopt or justify' approach will be performance managed by the Welsh Government, given the extensive range of actions that Health Boards will need to consider in responding to the 11 national programmes.

Recommendations

Developing and implementing the Welsh Government's strategy for mental health

- 1 The Welsh Government, through the revised National Service Framework and associated policy implementation guidance, has clearly outlined the range of adult mental health services that should be available across Wales. We have identified that these services are not always in place, do not always have appropriate capacity, or do not meet the required guidelines and standards. Different models of joint working and integration between health and social services exist across Wales. **We recommend that the Welsh Government:**
 - a focuses its new mental health strategy on embedding key service elements in all parts of Wales and ensuring these services have appropriate capacity and operate effectively; and
 - b reviews the impact on costs and service outcomes of the different approaches to joint working and integration between health and social care.

Adopting a recovery and outcomes-based approach to mental health

- 2 Moving away from an approach to services that is dominated by treating mental ill health and maintaining stability, to one that focuses on recovery and maximising mental health and independent living, will be challenging. Amongst other things, it will require an increased focus on the outcomes that services deliver for people who have a mental health problem. The Mental Health (Wales) Measure supports the development of a recovery and outcomes approach. The approach may need to be tailored for some groups of people, such as those with dementia, where maintaining independence for as long as possible may be a more appropriate objective than seeking recovery. **In addition we recommend that the Welsh Government:**
 - a explicitly bases its new strategy on a recovery approach to mental health, and identifies and plans for the implications of adopting this approach at a national and local level in terms of training, governance and service design;
 - b places service outcomes at the heart of the new mental health strategy, including in relation to target setting, information gathering and performance management; and
 - c in developing a recovery and outcomes based approach, works with other parts of the UK that are moving in the same direction, to share learning and assess the potential for common outcome measures.

Funding mental health services

- 3 The Welsh Government, through ring fencing, has sought to ensure that Health Boards give adult mental health services an appropriate priority. The mental health national programme has identified a range of savings opportunities within mental health, which can be used to fund service developments. In addition, there is clear evidence that investing in some mental health services can deliver, over time, greater savings both within mental health and in other parts of the NHS and the public sector. **We recommend that the Welsh Government:**
- a reviews whether ring fencing has been effective in ensuring that adult mental health services have an appropriate priority and delivering the required service elements, or whether an additional or alternative approach is required, such as the development of local and national five-year financial strategies for mental health; and
 - b examines the potential for investing in those mental health services that will deliver a net saving to the NHS and the public sector as a whole.

Taking the opportunities provided by NHS re-organisation and the mental health national programme

- 4 The creation of the larger integrated Health Boards and the mental health national programme both provide an opportunity to improve services and meet the range of challenges now faced by mental health services. We have identified a number of risks associated with these developments, and as a result **we recommend that the Welsh Government:**
- a reviews within the next 12 months the impact of the roles of the Health Board Vice Chair and Board Director with responsibility for mental health, to ensure they are delivering the desired outcomes;
 - b issues revised guidance on multi-agency local planning arrangements for mental health that takes account of the new NHS structures and the need to ensure councils, the voluntary sector and service users and carers are appropriately engaged in planning and decision making;
 - c takes steps to assure itself that Health Boards have robust governance arrangements in place to ensure they respond appropriately to national programme advice and outputs; and
 - d develops a process to performance manage the 'adopt or justify' approach by Health Boards to national programme advice.



Part 1 – Since 2005, there have been important improvements in adult mental health services in many parts of Wales, although progress has been variable and some service gaps and inequalities remain

- 1.1** This part of the report examines the progress made in a number of key service areas that the baseline review had identified as being problematic across Wales. These include:
- a** mental health services in primary care;
 - b** specialist community-based services;
 - c** psychological therapies; and
 - d** involving service users in their care.

Steps have been taken to improve primary care provision of mental health services, although issues remain with practice staff training and the support provided by specialist services

- 1.2** Most people with less severe mental health problems will receive their care entirely from within the primary care sector. Primary care also plays a significant role for people with severe mental health problems, acting as the main point of referral to specialist mental health services. Our 2005 baseline review concluded that the mental health services provided by general practices were often underdeveloped.

- 1.3** As part of our follow-up review, in the second half of 2009 we undertook a survey of service users across Wales. This revealed that service users are generally positive about the care they receive from primary care. However, a minority were dissatisfied, with 14 per cent and six per cent respectively rating the care from their GP for their mental health and psychical health as 'poor' or 'very poor'.

Standardised tools to help diagnose mental health problems are being used more extensively, other than in assessing suicide and self-harm risk, and some progress has been made in providing relevant training to GPs and practice staff

- 1.4** There has been mixed success in improving the use of standardised tools in general practices:
- a** there has been a significant improvement in the number of general practices stating that they use standardised tools to help diagnose adults with a mental health problem, up from 33 per cent in our 2005 survey of general practices to 94 per cent in 2009; but
 - b** only 30 per cent of responding practices stated that they were using a standardised tool to assess suicide and self-harm risks in 2009 compared to 26 per cent in 2005.

- 1.5** The Welsh Government set a target that, by March 2007, all LHBs were to ensure that GPs and practice staff received training to help them diagnose and manage adults with mental health problems. There have been improvements since 2005, in the number of GPs and practice nurses receiving training, and a number of national training initiatives for primary care have also been developed (**Case Study 1**). However, the Welsh Government's target on training was still not being met in 2009:
- a** eight of the 22 LHBs reported that they had not provided any training in mental health issues to GPs or practice nurses during the previous three years;
 - b** one in three practices responding to our survey stated that no GP in their practice had received mental health training during the previous three years (this was down from 42 per cent in 2005); and
 - c** two in three practices stated that none of their practice nurses had received such training (down from 82 per cent in 2005).

- 1.6** In 2005, fewer than half of council areas (10 of 22) were covered by agreed protocols for the assessment and management in primary care of adults with mental health problems. Our follow-up review identified no overall improvement by 2009, with a similar proportion of council areas being covered by such a protocol.
- 1.7** The Mental Health (Wales) Measure 2010 makes a number of changes to the current legislative arrangements relating to the assessment and treatment of people with mental health problems (**Appendix 3**). The Measure provides a new opportunity for Health Boards to develop guidelines on the links between primary care and primary care mental health support services, and on the identification, assessment and management of people with mental health problems by general practice staff.

There has been little progress in increasing the number of GPs with specialist skills in mental health

- 1.8** General Practitioners can develop specialist skills in mental health in a number of ways. They can be approved to undertake compulsory admissions of mentally ill people to hospital under Section 12 (2) of the Mental Health Act (1983). They can also be accredited as a General Practitioner with a Special Interest in mental health. General Practitioners with a Special Interest have been developed across Wales in a number of clinical areas. The term refers to a practitioner who develops an expertise in addition to their generalist skills, to enable them to practice at a higher level in a defined clinical area.

Case Study 1 – Mental Health training initiatives in primary care

The Wales Mental Health in Primary Care Network is developing a gold standard of care for primary care mental health. This is aimed at achieving consistent standards of care, whilst striving for continuous improvement in health and well-being. As part of this approach, information, training, and support tools are available to general practices.

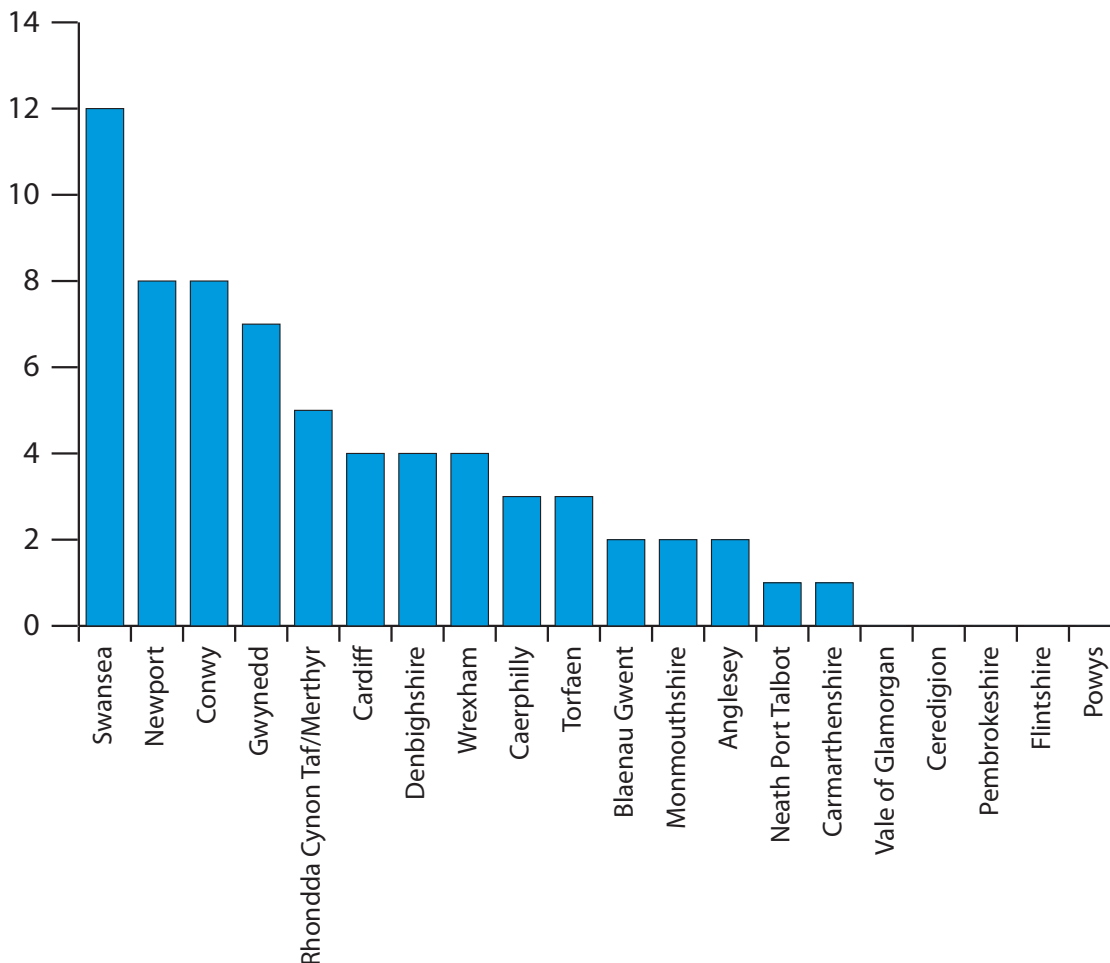
The Positive Choices project is a five-year national project led by Mind Cymru, which aims to raise awareness of suicide and provide training in early intervention skills to staff in front-line services. Over 3,000 people across Wales have received suicide intervention skills training, using an award-winning and internationally recognised training programme. Those trained include practice and community nurses, as well as some GPs.



1.9 Our 2005 baseline review found that in many parts of Wales few GPs had been approved to undertake Section 12 admissions. Our follow up review found an uneven distribution of Section 12 approved GPs across Wales, with five LHB areas not having any in place (Exhibit 1).

1.10 In 2009, Only three LHBs reported that any of their GPs had been accredited as ‘General Practitioners with a Special Interest’ in mental health. The total reported number of GPs across Wales with such accreditation was eight.

Exhibit 1 – Number of Section 12 approved GPs



Note
Bridgend LHB reported having Section 12 approved GPs but did not confirm the number of these; Rhondda Cynon Taf and Merthyr provided combined data.

Source: Wales Audit Office survey of LHBs (2009)

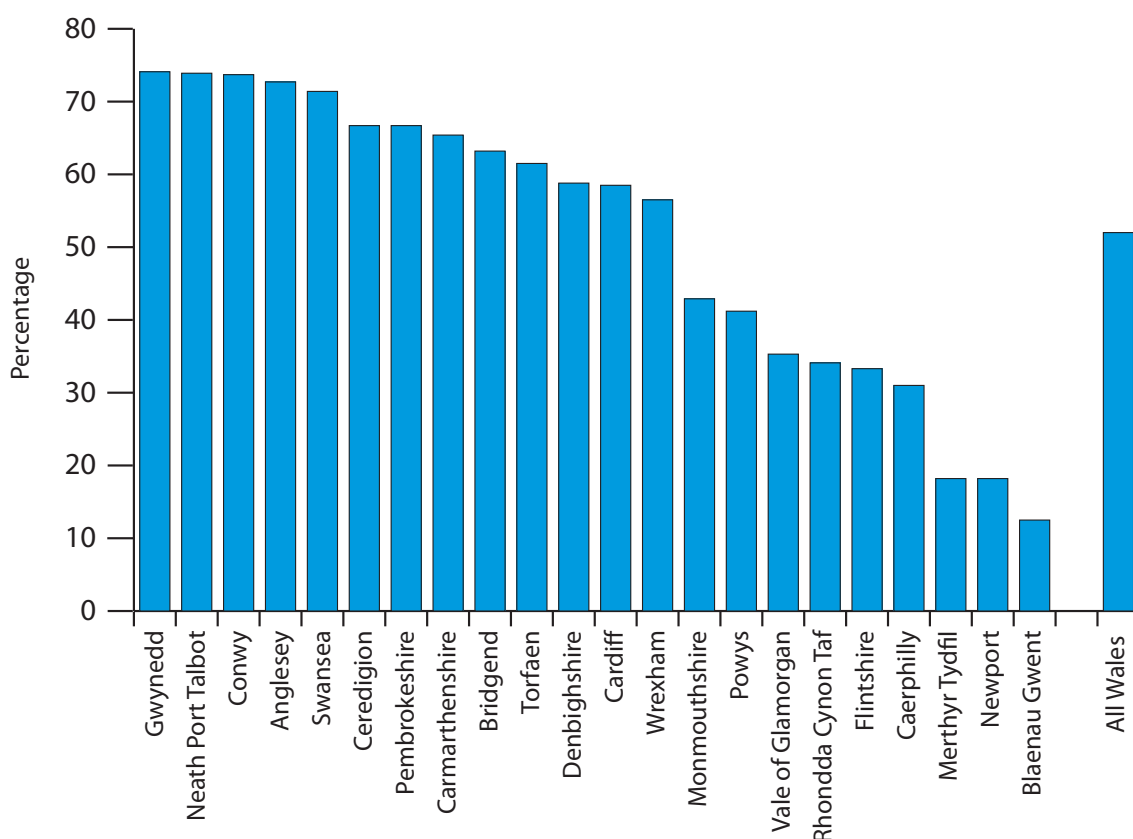
The provision by general practices of an enhanced service for people with a mental health problem is very patchy, and its impact in improving physical health has been limited

- 1.11** As part of the General Medical Services contract, general practices can now provide a range of enhanced services, for which they receive additional payments. All general practices can choose to provide enhanced services.
- 1.12** The enhanced service for mental illness was introduced in Wales in 2006 to help address the higher prevalence of many physical health problems in those with a severe mental illness

compared to the general population. It requires GPs to produce a Practice Severe Mental Illness report for patients with a severe mental illness, which is forwarded to Care Programme Approach co-ordinators or consultant psychiatrists to support care planning.

- 1.13** As at June 2010, across Wales 52 per cent of general practices had taken up this enhanced service. The take-up has been very high in some areas, but, in others, few practices have shown an interest (**Exhibit 2**). Many of the areas with low take-up have a population with a comparatively high prevalence of mental health needs.

Exhibit 2 – Percentage of practices providing an enhanced service for mental illness



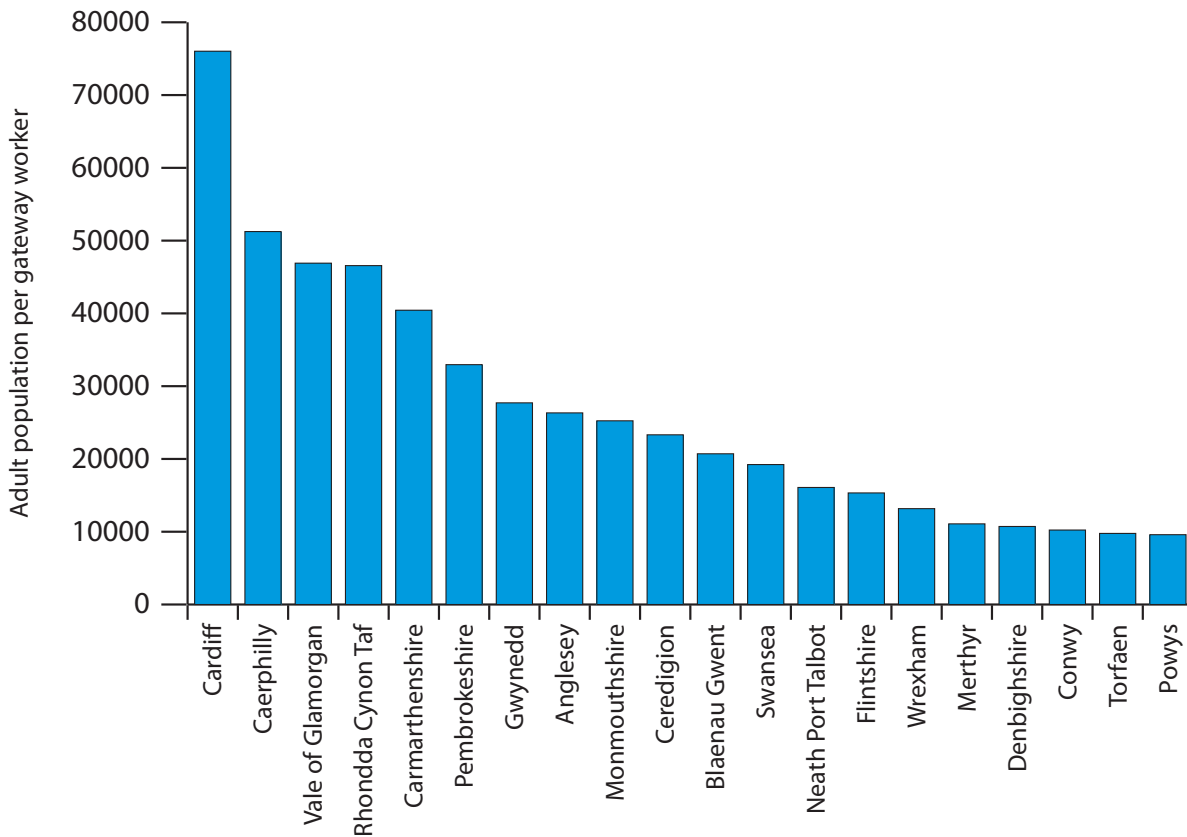
Source: Welsh Government data released in December 2010, relating to the position in June 2010



- 1.14** General Practitioners draw up the Practice Severe Mental Illness report based upon patient contacts through the year. This may or may not require an additional examination, as a face-to-face health check is not a requirement of the enhanced service.
- 1.15** In 2009, 15 of the 22 LHBs had audited the enhanced service for mental illness. Thirteen of the audits looked at whether practices were undertaking comprehensive face-to-face physical health checks on people with mental health problems. Eight of these audits found that comprehensive health checks were taking place in all or most practices, but five audits reported that this was the case in around half or less of practices that were providing an enhanced service.
- 1.16** We asked LHBs whether they believed that the enhanced service had had a significant impact on the care provided to people with a mental health problem. Five LHBs were not sure of the impact, and of the others:
- a** only one LHB stated that this was 'definitely the case';
 - b** 11 stated there had been an impact 'to some extent';
 - c** one LHB stated the impact had been very patchy; and
 - d** four stated there had been 'little or no impact'.
- 1.17** The National Public Health Service for Wales undertook a review of the mental illness enhanced service, and concluded that there had been limited evidence of the service's impact on the physical health of the population, and that it was generally perceived to be ineffective⁸. The review identified a number of weaknesses in the way the enhanced service was run, but also a consensus that a well constructed enhanced service could bring benefits to people with a mental illness.
- Specialist support for primary care has been expanded in many parts of Wales, but not all areas had gateway workers and, in some others, support services are poorly resourced**
- 1.18** In 2005, we found that specialist mental health support for primary care services was in place or emerging in a small number of council areas. Support was provided either through specialist primary care teams or through primary care liaison or link workers.
- 1.19** Subsequently, the Welsh Government set a target relating to gateway workers as part of the 2006-07 Service and Financial Framework. By March 2007, all GP practices were to be assigned a mental health 'gateway' worker to provide screening, assessment, gate keeping, and signposting to other services. This led to an expansion in specialist support to primary care in many parts of Wales.
- 1.20** By 2009, only one council area was not covered by a gateway service, although the relevant Health Board subsequently informed us that this has now been addressed. In another council area, community mental health team members ran assessment clinics as part of their routine duties as an alternative means of providing a gateway service.
- 1.21** The remaining council areas were all covered by a dedicated resource undertaking the gateway function. However, we found substantial differences in the resources dedicated to providing the gateway worker function (**Exhibit 3**). Also, the service was not available across all parts of four council

⁸ National Public Health Service for Wales, *A rapid review of the mental illness directed enhanced service in Wales*, October 2009

Exhibit 3 – Adult population per gateway worker



Source: Wales Audit Office survey of NHS Trusts (2009)

areas, and in some others the capacity of the service was a significant issue. The role undertaken by gateway workers also varied, with some providing limited interventions to service users who do not require more specialist and intensive support from mental health services.

1.22 We found that in half of council areas gateway workers were located within community mental health teams. In the other areas gateway workers were part of separate primary care support teams.

1.23 Our 2009 survey of general practices also indicates that specialist support for primary care is not effective in all areas:

- a 56 per cent of responding practices stated that they had not received any support, including telephone liaison, from a psychiatrist in the previous 12 months;
- b 29 per cent of practices stated they had not received any support from a gateway worker or Community Psychiatric Nurse in the previous year; and



- c 45 per cent of practices (compared with 79 per cent in 2005) stated that they needed more advice and support from adult mental health services, with this being rated as the joint second highest service development priority by general practices.

1.24 The Mental Health (Wales) Measure 2010 outlines requirements for primary care mental health support services in Wales. These are to undertake assessments, provide primary mental health treatment, make referrals to specialist services, and provide information and advice to primary care providers, service users, and carers. The Measure is driving the mental health agenda in primary care and provides an opportunity to develop services that are more consistent across Wales.

There has been a shift in resources from inpatient to community services but, although many areas now have a broader range of community services in place, these do not always have adequate capacity

1.25 Community-based mental health services provide an alternative to hospital admission, and support safer and more prompt hospital discharge, well being and recovery. Our baseline review in 2005 concluded that there were key gaps in community-based mental health services. Most service users who responded to our survey as part of our follow-up review expressed satisfaction with the care they receive from specialist mental health services, although nearly one in five rated their care as poor or very poor.

Although there has been an overall reduction in the number of inpatient beds and an increase in community staffing levels, progress across Wales has been mixed and there is no apparent rationale for the level and mix of resources in different areas

1.26 The Welsh Government's policy is to develop community-based services and reduce the reliance on inpatient beds. There has been clear progress across Wales in this regard since 2005. By 2009 the number of adult mental health beds had reduced by 23 per cent and health and social services mental health community staffing levels had increased by more than 14 per cent.

1.27 Overall, the number of acute adult mental health beds has reduced by 20 per cent, with a 31 per cent reduction in the number of other beds, such as for rehabilitation and continuing care. Acute bed occupancy rates have also reduced, from 92 per cent in 2005-06 to 84 per cent in 2009-10. These reductions have corresponded with a reduction in the number of inpatients, by 17 per cent between 2005-06 and 2009-10⁹.

1.28 Overall staffing levels across community-based health and social services increased between 2005 and 2009. However, the extent of change has been highly variable, with:

- a four of the 22 council areas experiencing a reduction in community staffing levels of between five per cent and 15 per cent;
- b two areas experiencing increases of less than five per cent; and
- c increases in the other 16 areas varying between seven per cent and 100 per cent.

⁹ We have used inpatient deaths and discharges to measure the change in the number of adult inpatients, as up-to-date information is available by age group. Inpatient admissions data is only available across all age groups, but this shows a similar level of decline, of 16 per cent, between 2005-06 and 2009-10.

1.29 There appears to be no clear rationale for the balance and mix of resources in different areas. We examined acute bed and community staffing numbers across Wales, taking into account the level of need as indicated by the Mental Illness Needs Index¹⁰. We would have expected to see those areas with higher needs having more resources overall, and, in those areas that have similar levels of need, low inpatient bed numbers being associated with higher community staff resources. However, there was no consistency across Wales in the relationships between these variables (**Exhibit 4**).

In some parts of Wales the development of local services has reduced the number of people placed out of area

1.30 Some NHS bodies and councils have been working successfully to repatriate people placed out of area in residential homes or specialist mental health units (**Case Study 2**). This requires the development of local services that allow more costly out-of-area placements to be brought to an end, thereby generating savings to be re-invested in other mental health services.

1.31 In contrast, some parts of Wales were reporting a continuing increase in the number of out-of-area placements and associated expenditure. Increasing financial pressures and the impetus being provided by the national programme for mental health¹¹ are now driving repatriation in those areas that have been slow to make progress.

Case Study 2 – Repatriation project in Swansea

There is an established repatriation project in Swansea. At the time the first repatriation programme was initiated there were approximately 40 people from the Swansea area that were in out-of-area or high cost placements.

Of these people 21, who were in placements costing a total of £3.4 million a year, were deemed to meet agreed criteria for possible. Following assessment and consideration of each person's needs it was decided to repatriate 14 people to more local services. This provided a cost saving in the region of £2 million a year, of which £1.3 million was earmarked for reinvestment.

The repatriation approach was helped by the development of a co-ordinated range of housing accommodation, funded by the NHS but provided by Supporting People services in Swansea.

Since 2005 psychiatry staffing levels have declined in some areas and increased in others, but there are long waiting times for a routine appointment in some parts of Wales

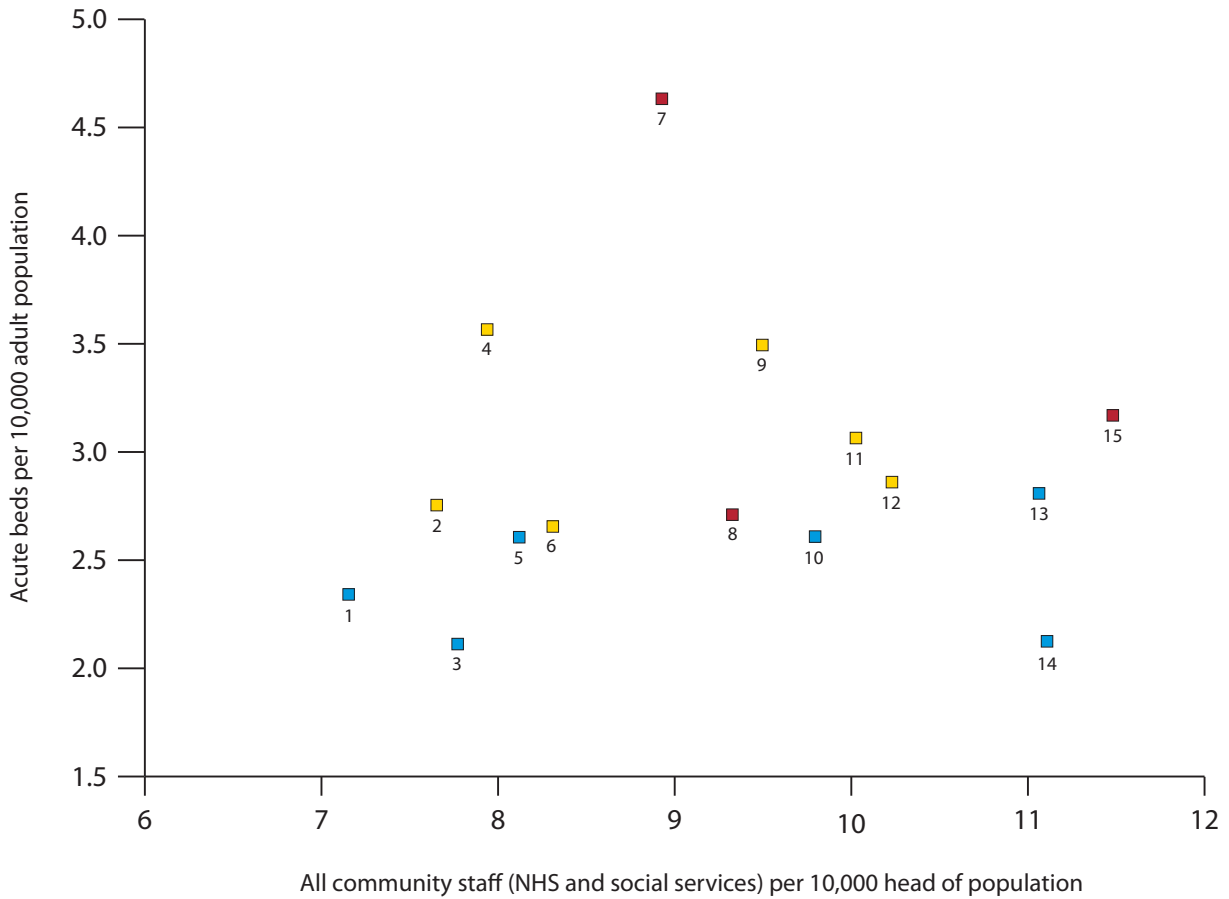
1.32 Since 2005, there has been a small increase in the level of adult psychiatry staffing across Wales. By 2009, adult general psychiatry and adult psychiatry sub-specialism staffing had increased by 3.7 whole time equivalent funded posts, an increase of 1.7 per cent. This represents an increase of 12.9 consultant whole time equivalent funded posts (an increase of 14.5 per cent), offset by a reduction in the number of senior and junior doctors.

¹⁰ The Mental Health Needs Index estimates the level of need for mental health services using various population characteristics, and is useful in predicting the prevalence of both severe and common mental health disorders at an area level.

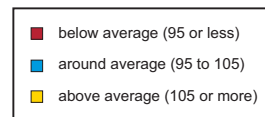
¹¹ The Welsh Government has set up 11 national programmes, including one for mental health, to provide direction, advice, and support to Health Boards in improving services and delivering efficiencies.



Exhibit 4 – Acute beds and community staffing



- | | | | |
|---|------------------------|----|---|
| 1 | Caerphilly | 9 | Cardiff and Vale of Glamorgan |
| 2 | Newport | 10 | Conwy and Denbighshire |
| 3 | Bridgend | 11 | Rhondda Cynon Taf |
| 4 | Swansea | 12 | Neath Port Talbot |
| 5 | Torfaen | 13 | Carmarthenshire, Pembrokeshire and Ceredigion |
| 6 | Blaenau Gwent | 14 | Anglesey and Gwynedd |
| 7 | Powys | 15 | Monmouthshire |
| 8 | Flintshire and Wrexham | | |



Note

Areas with a below-average level of need are indicated in red, those with around average in blue, and those with an above-average level of need in yellow. Some services are organised across council areas, and as a result, the graph shows 15 rather than 22 data points.

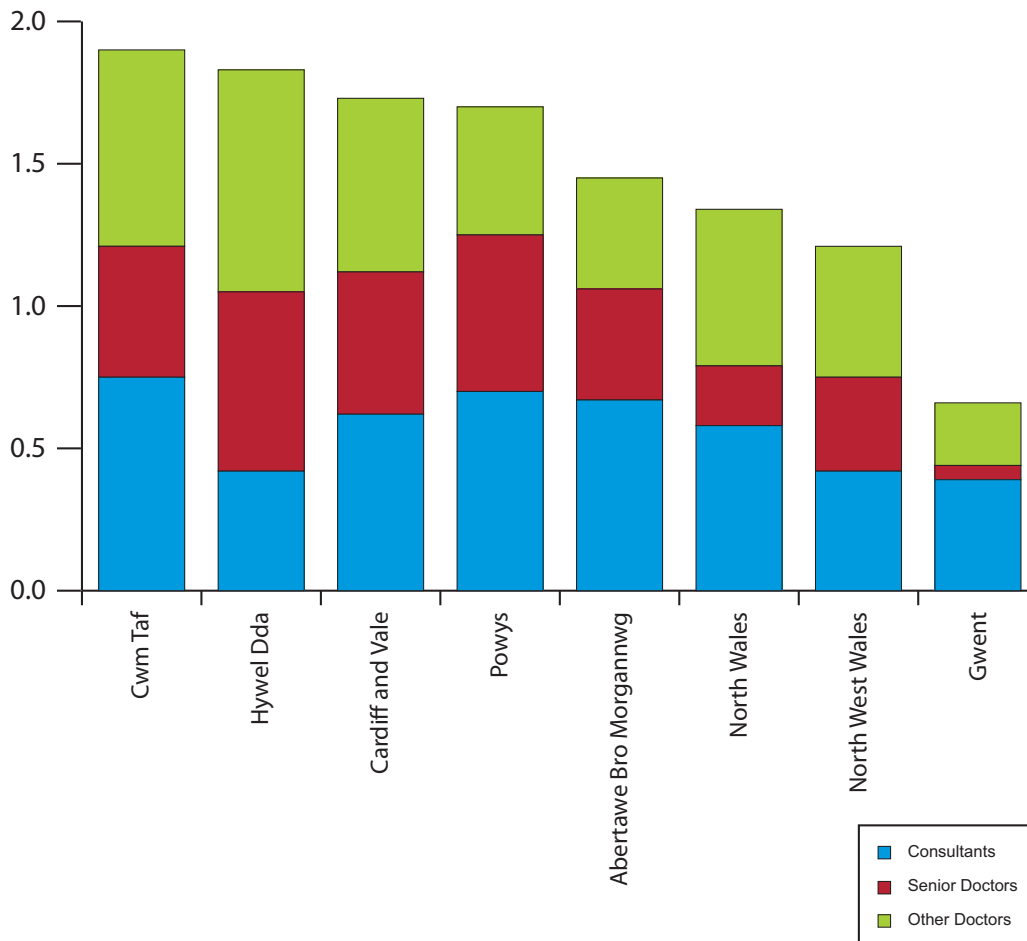
Source: Wales Audit Office survey of NHS Trusts and community teams (2009)

- 1.33** In most NHS Trusts, adult psychiatry staffing levels had not changed substantially between 2005 and 2009. However, across Gwent staffing numbers reduced by more than 17 whole time equivalents, although consultant numbers stayed broadly the same. In contrast, staffing levels across the Abertawe Bro Morgannwg NHS Trust increased by more than 14 whole time equivalents, including increases to the number of consultants and senior doctors. These reflect the development of local services funded through patient re-patriations from out of area placements, and the development of links with Swansea University. There remains a wide variation in adult psychiatry staffing levels across Wales ([Exhibit 5](#)).
- 1.34** There are no specific targets relating to waiting times for an appointment with a psychiatrist. Our survey of NHS Trusts in 2009 showed that average waiting times for a routine assessment with a psychiatrist in community or outpatient clinics varied between four weeks and 12 weeks. Urgent appointments were reported to be seen on average within one or two weeks. Emergency referrals were reported as being seen the same day or within 24 hours, with the exception of Powys, which reported that it was taking 48 hours on average to see an emergency referral.
- 1.35** Nearly two in every five service users who responded to our survey had had their appointments with a psychiatrist cancelled or changed to a later date within the preceding 12 months. Of the 98 service users who reported having an appointment cancelled, this occurred:
- a** once in 59 per cent of cases;
 - b** on two or three occasions in 35 per cent of cases; and
 - c** on four or more occasions in five per cent of cases.
- 1.36** Most service users who responded to our survey stated that they had had enough time with their psychiatrist to discuss their condition, with 48 per cent stating this was definitely the case, and 29 per cent saying that this was the case to some extent. However, this still left nearly one in four service users who considered that they did not have enough time with their psychiatrist.
- Although good progress has been made in establishing crisis resolution and home treatment services, staffing levels are variable and only limited crisis and emergency respite accommodation is available**
- 1.37** As an alternative to hospital admission, crisis resolution and home treatment services offer a rapid response in the form of assessment and, where appropriate, support and treatment for a limited period to adults who are experiencing a mental health crisis. They offer people experiencing severe mental health difficulties the opportunity to be treated in an environment less restrictive than a hospital, with increased choice in the management of their mental health problems.
- 1.38** In 2005, crisis resolution and home treatment services were in place or were being set up that covered just nine of the 22 council areas. Subsequently, the Welsh Government set the target that all parts of Wales were to be covered by these services by March 2006. The Welsh Government also issued policy implementation guidance that outlined the functions and operational requirements of these services¹².

¹² Welsh Government, *Policy Implementation Guidance on the development of Crisis Resolution/Home Treatment Services in Wales*, Welsh Health Circular (2005) 48, May 2005.



Exhibit 5 – Adult Psychiatry Established Funded Posts per 10,000 adult population

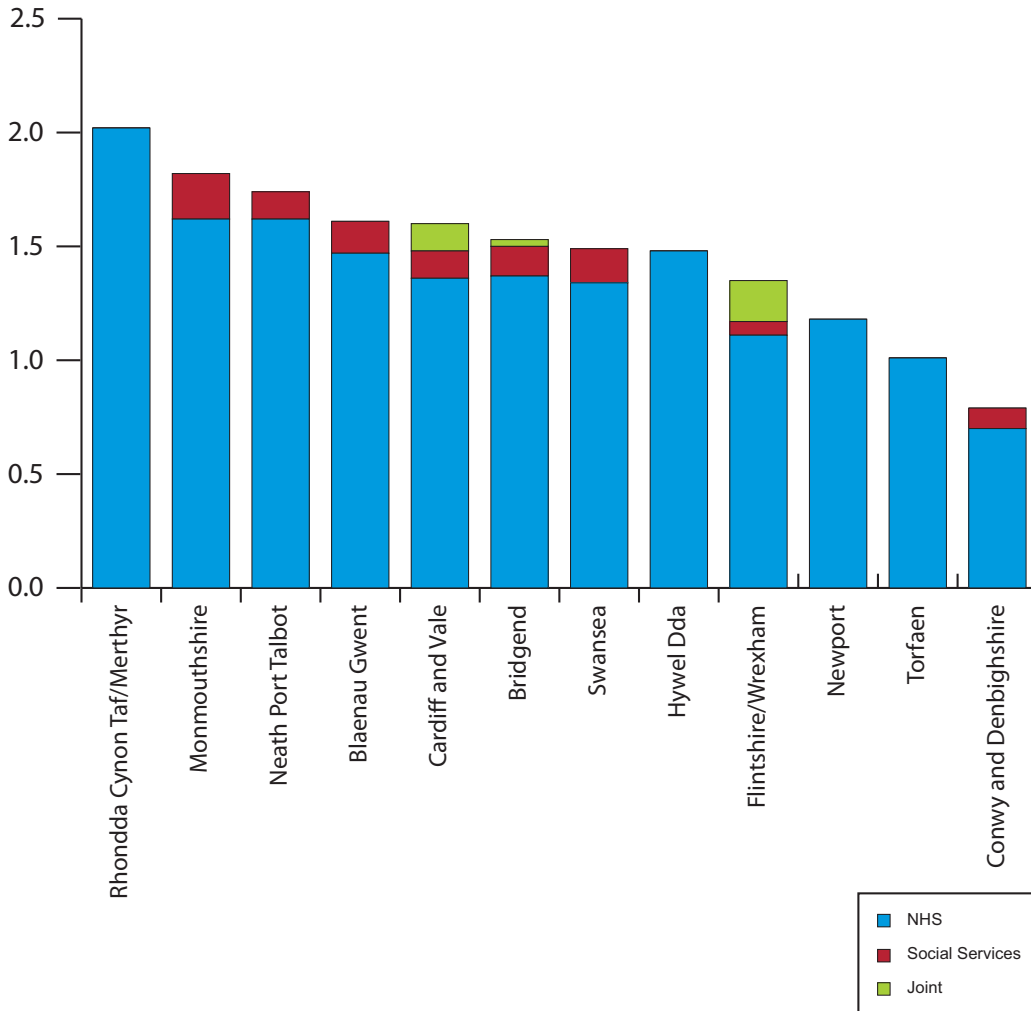


Source: Wales Audit Office survey of NHS Trusts (2009); data covers adult general psychiatry and sub-specialisms

1.39 There has been substantial progress since 2005 in developing crisis resolution and home treatment services. By the end of 2009, only four council areas (Caerphilly, Anglesey, Gwynedd and Powys) did not have these services available, and, in each of these, there were specific plans in place to establish services. However, in Bridgend the service is partly reliant upon a non-recurring funding stream, although discussions are taking place locally to secure recurrent funding.

1.40 Crisis resolution and home treatment teams did not cover the whole of the adult population living within three council areas (Conwy, Denbighshire, and Flintshire). We also found problems with some teams closing caseloads or operating restrictive referral arrangements. There are also considerable variations in the staffing levels of different teams ([Exhibit 6](#)).

Exhibit 6 – Crisis resolution and home treatment staff per 10,000 adult population



Note
 Crisis resolution and home treatment services are often provided across more than one council area and can cover part of some council areas. In total, there are 16 teams covering the 12 areas shown above.
 Source: Wales Audit Office survey of NHS Trusts (2009)

1.41 We found that many crisis resolution and home treatment teams were not complying fully with the policy guidelines issued by the Welsh Government on how they should operate, with:

- a three of 16 teams carrying out routine assessments on hospital sites rather than in service users’ homes;

- b six teams not providing services during all of the core hours of 9 am to 9 pm, seven days a week; and
- c important variations in team membership, with social services staff, occupational therapists, clinical psychologists and healthcare assistants being absent from many teams.



1.42 There is limited availability of crisis accommodation in Wales that can provide a viable alternative to hospital admission. Only two NHS Trusts reported any provision of crisis accommodation: there was adequate provision in one area (**Case Study 3**) but, in the other, the accommodation was not sufficient to meet identified needs. However, emergency respite accommodation is more widely available: half of NHS Trusts reported having this available, although in most areas it was not sufficient to meet assessed needs.

Case Study 3 – Crisis accommodation

In Cardiff, there is a crisis house staffed by Gofal Cymru, which the crisis resolution and home treatment team visit. The house has four beds with a maximum stay of eight days. The house is also used for emergency respite.

Assertive outreach services have been expanded since 2005, but not all areas have these services and, where they exist, staffing levels and team membership are variable

1.43 Assertive outreach services target individuals with a severe and enduring mental illness who do not effectively engage with mainstream mental health services. A recent Kings Fund report into avoiding hospital admissions highlighted that adopting an assertive case management approach using multidisciplinary teams has the potential to reduce mental health admissions¹³.

1.44 The assertive outreach approach is characterised by flexibility around the service users' particular needs, with services being provided in the users' own environment. Assertive outreach services are aimed at those individuals who have:

- a** a severe and persistent mental disorder associated with a high level of disability;
- b** a history of frequent admissions or use of intensive home-based care;
- c** difficulty in maintaining contact with services; and
- d** multiple and complex needs.

1.45 In 2005, assertive outreach teams were in place in only six council areas. One of these areas had a very small team that providers saw only as a starting point for the development of an adequate service. In many areas, health and social services had identified the need to develop assertive outreach services but had not secured any funding to enable development.

1.46 As part of the Service and Financial Framework targets for 2008-09, the Welsh Government set a target for all health communities to establish an assertive outreach service. These were to be in place by March 2009.

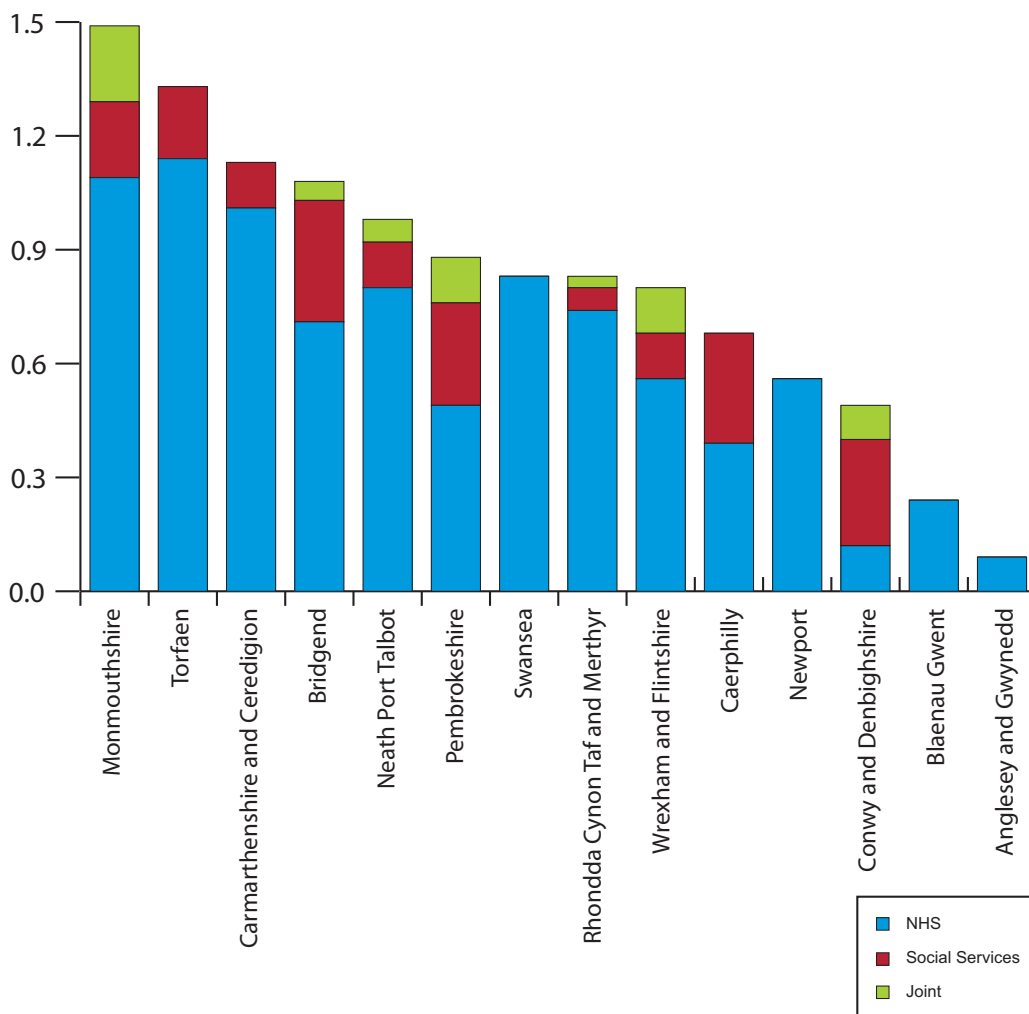
1.47 By the end of 2009, seventeen council areas had an assertive outreach service, although in four areas the service did not cover the whole adult population. In two areas (Swansea and Blaenau Gwent), the service was provided by ring fenced or dedicated staff under the umbrella of community mental health teams, and in the remainder by assertive outreach teams.

¹³ Kings Fund, *Avoiding Hospital Admissions, What does the research evidence say?* December 2010

1.48 However, there was only an embryonic assertive outreach service covering Anglesey and Gwynedd, and there was no assertive outreach service in Powys, Cardiff, and the Vale of Glamorgan. Recurrent funding has recently been confirmed for an assertive outreach service for Cardiff and the Vale of Glamorgan, and Powys is working with its three mental health providers to develop a service model that is appropriate to its rural nature.

1.49 Where assertive outreach services were provided in 2009, staffing levels were very variable (**Exhibit 7**). The composition of teams also varied, with only a minority employing healthcare assistants, social services support workers, clinical psychologists and occupational therapists. Some services, such as the embryonic service in Anglesey and Gwynedd (one worker covering an adult population of more than 108,000 adults), and in Blaenau Gwent (one worker covering an adult population of more than 40,000 adults), lacked adequate capacity.

Exhibit 7 – Assertive outreach staff per 10,000 adult population



Note
 Assertive outreach service can cover more than one council area.
 Source: Wales Audit Office survey of NHS Trusts (2009)



1.50 The availability of assertive outreach services also varied across Wales. In eight of the 17 council areas that had a service, it was only available Monday to Friday; in two areas, the service was available six days a week; and in seven areas the service was available seven days a week. One team, (covering two areas), worked between 9 am and 7 pm on weekdays and between 9 am to 5 pm on weekends. However, the remaining teams all worked between 9 am and 5 pm; although some teams reported providing a service on weekends and evenings if the needs of the service user required it.

1.51 In Swansea, the assertive outreach service consists of a ring-fenced resource of 11.2 whole time equivalent staff, operating as a single service under the umbrella of the three separate community mental health teams. The service, managed by one of the community mental health team managers, is provided seven days a week with flexible hours to meet the needs of service users. At the time of our review, we found few of the Swansea assertive outreach staff had been trained in psychological therapies, in contrast to the staff of many of the other assertive outreach services in Wales.

Gwent is leading the way in Wales with early intervention in psychosis services, but in many other areas these services are absent

1.52 Of those who experience psychotic symptoms, most will experience them for the first time between the ages of 15 and 30. Research shows that the earlier psychosis is recognised and treated, the better the outcome. Early intervention in psychosis services can lead to a faster and more complete recovery, a decrease in the frequency and severity of relapses, and an increase in the time to first relapse. The

Sainsbury Centre for Mental Health has found that existing generalist mental health services, such as community mental health teams, may not have the operational capacity, the appropriate philosophy of care, or the necessary skill mix to offer the specialised interventions needed by young people with early psychosis.

1.53 In 2005, very few areas had early intervention in psychosis services. A number of community mental health teams reported that they included early intervention as part of their remit, and in one area the community mental health team had identified and trained a limited number of staff to provide an early intervention service. However, we found that the early intervention services provided from within a community mental health team were unprotected and risked being 'squeezed out' by the need to focus on supporting people in crisis.

1.54 As part of the 2008-09 Service and Financial Framework, the Welsh Government set a target for all health communities to offer early intervention for clients with a first episode of psychosis, allowing for the commencement of treatment within three weeks of referral to the early intervention service. This was to be achieved by March 2009. However, there was some confusion and debate about how the service should be delivered, and only limited progress has been made in developing early intervention in psychosis services across Wales.

1.55 Most progress has been made in Gwent, which has an early intervention service covering all five council areas. The service focuses on the early identification and self-management of psychosis, and reports that it is minimising hospital admissions for those on its caseload. There is only one other

dedicated early intervention psychosis team in Wales, which covers Carmarthenshire, Ceredigion and Pembrokeshire. This team has a far lower level of staffing per head of population than the Gwent-wide service.

Progress in meeting the Welsh Government's targets and policy guidance on the organisation and management of community mental health teams has been mixed

- 1.56** In 2005, all community mental health teams comprised some form of integration between health and social services. However, the extent of integration and the skill mix of teams were highly variable. We also found considerable scope in many parts of Wales to improve co-ordination between specialist mental health and other services.
- 1.57** The revised National Service Framework for Adult Mental Health included a range of targets relating to the organisation and management of community mental health teams. In July 2010, the Welsh Government built upon these targets by issuing interim policy implementation guidance and standards for community mental health teams¹⁴. There has been some progress against the revised National Service Framework targets, but Health Boards and councils are not yet fully compliant with all targets and standards.
- 1.58** We found that the majority of community mental health teams are based around primary care groupings and have health and social services staff co-located. Guidelines on referring from primary to secondary care are generally in place, as are a range of protocols outlining how services will operate. In 2009, we received 57 returns from our survey of community mental health teams and these identified that teams routinely comprised

social care, nursing and psychiatry staff as core members. However, two in five teams did not have either a clinical psychologist or a psychological therapist as a core member, and just over one in 10 did not have an occupational therapist as a core member.

- 1.59** We also found poor quality demand and capacity planning for community mental health teams in NHS Trusts. In addition, three NHS Trusts reported in 2009 that they had not reviewed skill mix within their community mental health teams, and only one reported having a joint workforce plan covering health and social services staff in community mental health teams.
- 1.60** The revised National Service Framework targets and Welsh Government guidance promote the integration of health and social services within community mental health teams. However, in many teams we found only limited integration of line management and information recording systems. For example, medical notes were not being included in shared case files in some areas, and we found constraints on health and social services staff being able to access each other's IT systems.
- 1.61** Where crisis resolution and home treatment services, assertive outreach services and early intervention services are delivered by discrete teams, mutually agreed and documented responsibilities, liaison procedures and case transfer procedures should be in place. In some areas, our follow up review found a lack of clarity over the respective roles and functions of the community mental health team and the other components of mental health services, in particular crisis resolution and home treatment teams. This was resulting in unclear and disjointed service provision.

¹⁴ Welsh Government, *The role of community mental health teams in delivering community mental health services, Interim Policy Implementation Guidance and Standards* (July 2010).



1.62 We also found that co-ordination and liaison between mental health and other services is not always in line with the targets and guidance. The majority of community mental health teams did not have effective liaison arrangements with other specialist services, such as drug and alcohol services, criminal justice services or housing services.

1.63 A number of revised National Service Framework targets relate to the liaison that should be taking place between psychiatrists and mental health nurses and general ward and Accident and Emergency staff. In 2009, the majority of NHS trusts were meeting these targets, but in two trusts liaison arrangements did not cover all District General Hospital wards, two trusts did not have mental health liaison nurses for District General Hospital wards, and one trust did not have Accident and Emergency mental health liaison nurses in place.

Psychology therapy services have improved since 2005 and there has been some progress in moving towards a stepped model of care, but waiting times can still be very long

1.64 In 2005, our baseline review established that psychology therapy services were very variable and that primary care counselling services were not always available. Long waiting times were also very common.

1.65 The service users who responded to our survey in 2009 wanted more counselling services. In total 169 service users stated that they had not had counselling in the previous 12 months and, of these, 46 per cent stated

that they would have liked this intervention. A minority of respondents also wanted improved relationships with psychologists and counsellors.

1.66 Only one NHS trust reported that it did not have a psychological therapies management committee. In the others, the committee generally had appropriate representation and an appropriate range of responsibilities.

There is a commitment to develop a stepped model of care approach to psychological therapies in most parts of Wales, but implementation is mostly at an early stage

1.67 The Welsh Government set a target for each area in Wales to have a plan by March 2007 for the establishment of a range of psychological therapies. The National Institute for Health and Clinical Excellence recommends a stepped model of care approach to psychological therapies.

1.68 Stepped care provides patients with a greater choice of interventions. If appropriate, patients are first offered simple, low intensity and low cost interventions. High intensity, secondary care treatment is only offered to those who are at risk to themselves or others, who have a previous history of treatment failure or who do not improve as a result of the initial intervention.

1.69 We found widespread support for implementing psychological therapies based on a stepped model of care approach, with only Powys LHB stating that it did not intend pursuing this model. Nevertheless, progress in implementing the approach has been slow and by 2009 only three NHS trusts had a plan for the development of the approach that covered both primary and secondary care.

Some parts of Wales have experienced improvements in the extent of psychological therapies in primary care, although waiting times are too variable

- 1.70** A range of staff working in primary care, including gateway workers and counsellors, can provide psychological therapies, and the revised National Service Framework included targets relating to psychological therapies in primary care. By 2007, all GP practices were to have access to psychological therapy services, either within or available to the primary care base, with a maximum waiting time of 12 weeks. In addition, structured counselling was to be available in primary care by the end of March 2009.
- 1.71** In 2009, the majority of LHBs reported to us that there had been an increase in the availability of psychological therapies, although five LHBs reported that they had experienced little or no increase since 2005. Twelve LHBs told us that structured counselling was available in all general practices, but one LHB stated this was not available in any practices, and the remaining LHBs reported various levels of coverage. In our survey of general practices, the provision of psychological therapy services including counselling was the most frequently identified service development priority.
- 1.72** Eight LHBs stated that they did not routinely monitor waiting times for a first counselling appointment in primary care. Although the remaining LHBs stated that they monitored waiting times, five were not able to provide us with the relevant data. Of the nine LHBs reporting data, waiting times varied between three and 36 weeks and the maximum waiting times for four were longer than the 12-week target.

- 1.73** Our survey of general practices indicates an improvement in waiting times. In 2009, only one of 97 general practices (one per cent) reported a waiting time of more than six months, compared to 14 of 223 (six per cent) in 2005. Even so, seven per cent of responding practices reported waiting times in excess of the 12-week target.

The number of community mental health staff trained in psychological therapies has expanded in most parts of Wales

- 1.74** Staff working within community mental health services, such as nurses, occupational therapists and social workers, can play an important part in delivering psychological therapies. However, they need appropriate training and supervision, and need to have the capacity to deliver the therapies. In 2009, five of the eight NHS Trusts reported to us that the numbers of staff providing general mental health care who have had specific training in psychological therapies had increased since 2005.
- 1.75** We gathered information from each community mental health team, crisis resolution and home treatment team, and assertive outreach team about the staff who had been trained in psychological therapies. This showed that in 2009, 70 per cent of all teams had at least one person trained in psychological therapies. The majority (78 per cent) of community mental health teams, 50 per cent of crisis resolution and home treatment teams and 38 per cent of assertive outreach teams had someone trained in psychological therapies. We also found that:
- a** the extent of training varied greatly across Wales, with some NHS Trusts having a clear approach to expanding these skills and a high proportion of trained staff (**Case Study 4**);



- b** some teams had a range of staff trained including nurses, social workers and occupational therapists, whereas others limited the training to nursing staff;
- c** in some parts of Wales staff had been trained in different approaches, whilst in others training was limited to one psychological therapy, often Cognitive Behavioural Therapy;
- d** in some parts of Wales a mix of external and internal training was provided, whilst others relied on in-house and 'on-the-job' training; and
- e** many of the staff trained in psychological therapies did not have the provision of psychological therapies included in their job descriptions.

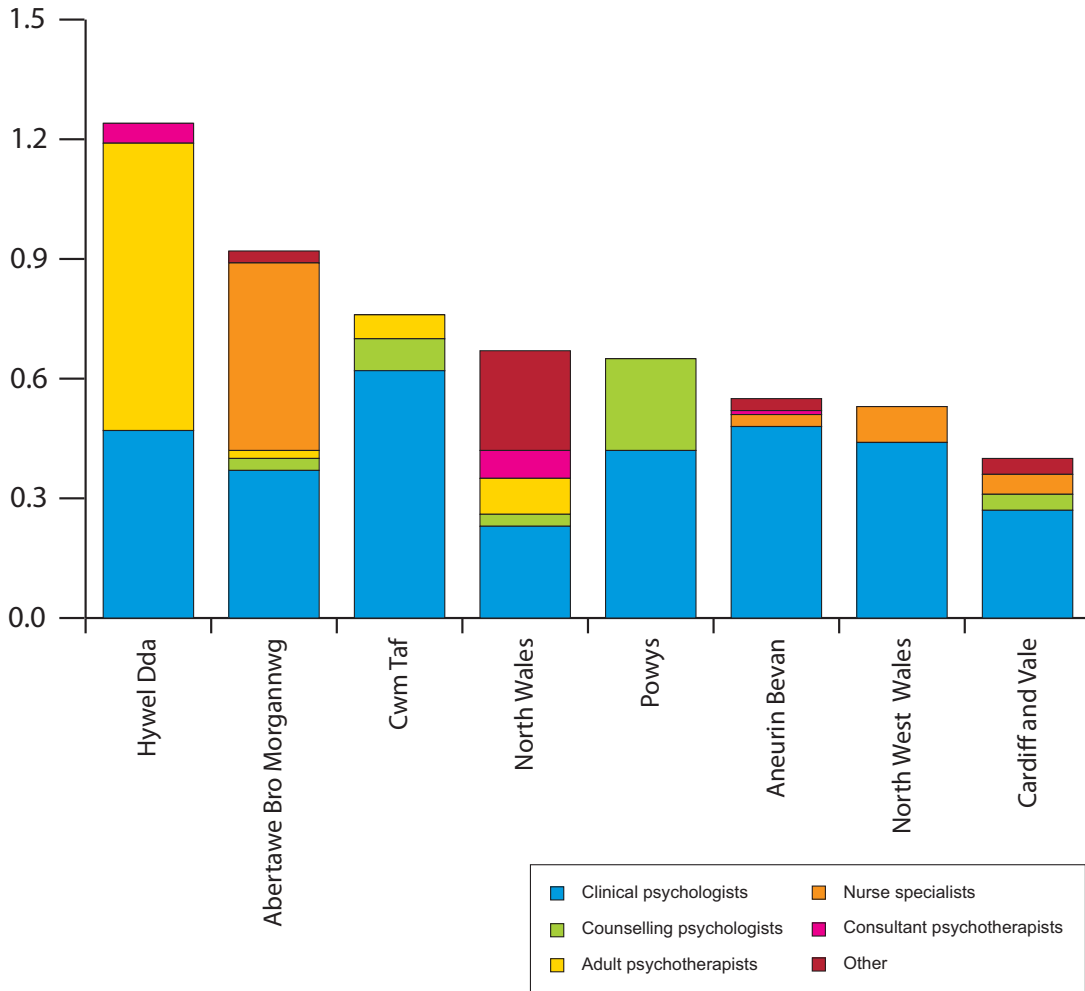
Case Study 4 – Training community mental health team staff in psychological therapies

The community mental health team in Blaenau Gwent has trained its community psychiatric nurses in a range of interventions (cognitive behavioural therapy, eating disorders, counselling and psycho-social interventions). There is also a nurse specialist providing cognitive behavioural therapy, and a social worker and a support worker providing counselling. Staff have a range of qualifications, and the provision of psychological therapies is written into their job descriptions.

Specialist psychologist and psychotherapist staffing levels have increased in most parts of Wales since 2005, although long waiting times persist in many areas

- 1.76** Five NHS Trusts stated that the numbers of psychologists and therapists providing therapy services in secondary care settings to adults with mental health problems had increased between 2005 and 2009. Two NHS Trusts reported that there had been no increase, and one NHS Trust did not provide the relevant information.
- 1.77** In those NHS Trusts reporting an increase, there has been a significant expansion in some areas, but in other areas the increases in staffing have been far more limited. Despite overall increases, psychological therapy staffing levels remain variable across Wales (**Exhibit 8**), and these variations do not appear to be explained by differing levels of need. For example, Hywel Dda is the best resourced in Wales, but the three areas it covers have average or below average mental health needs. By contrast, the poorest staffed area includes Cardiff, which has one of the highest levels of mental health needs.
- 1.78** The revised National Service Framework included the target that, by March 2007, all patients subject to the Care Programme Approach who were assessed as requiring access to psychological therapies were to start therapy within three months of the assessment. As part of our survey of NHS Trusts in 2009, we requested data on waiting times to compare against this target. Two Trusts did not provide the information. Of the remaining six Trusts, two reported waiting times that were routinely within the target, and four reported very variable waiting times that included some outside the target. In one Trust, waiting times ranged from between six and 12 months, and in another between 34 and 48 months.

Exhibit 8 – Psychological therapy staff per 10,000 adult population



Note

To ensure an accurate comparison between areas, the data excludes primary care counsellors as these can be part of psychological therapy staffing or part of primary care support teams.

Source: Wales Audit Office survey of NHS Trusts (2009)



Despite recent improvements in care planning in some areas, service users are not being consistently supported and involved in their care

1.79 In 2005, we found that the extent to which health and social care services were engaging with service users was too variable. The follow-up review focussed upon the information provided to service users, advocacy services, and the involvement of service users in their care.

Information provided to service users is not consistently kept up to date in some parts of Wales, and many service users did not know how to contact someone for support out of hours

1.80 The revised National Service Framework included targets relating to information for service users. By March 2006, bilingual, locally accessible service directories were to be in place, which included arrangements for access out of hours and provision in the voluntary sector. By March 2009, mental health information was to be available in minority languages and Braille. We found that progress has been very mixed, with service directories that:

- a** were out of date in nine council areas;
- b** did not cover all services, with out-of-hours services and services in primary care not being included in five and eight council areas respectively; and
- c** were available in minority languages in just five council areas and in Braille in just three council areas.

1.81 Our survey of service users in 2009 showed that only 45 per cent of respondents were aware of the free phone mental health helpline for Wales. Our survey also identified that just 34 per cent of service users had a number for someone from the local mental health service that they could contact out-of-office hours.

Advocacy services have been expanded although the level of provision is inconsistent

1.82 The Mental Capacity Act 2005 introduced the role of Independent Mental Capacity Advocate for people who lack the capacity to make specific important decisions. The Act covers a range of people, including those with mental ill health. Independent Mental Health Advocacy (under an amendment to the Mental Health Act 1983) commenced in Wales in November 2008, and it was required that independent advocacy was to be available to people detained in hospital and to people subject to a community treatment order. The Mental Health (Wales) Measure 2010 extends the availability of advocacy to all patients admitted with a mental health problem, including those on short-term or emergency sections.

1.83 The Welsh Government set a number of targets relating to advocacy services in the revised National Service Framework. By March 2007, statutory advocacy (for those people compulsorily admitted to hospital) was to be available across Wales. For non-statutory advocacy, services were to be available in all inpatient facilities by March 2009 and across the community by March 2010.

- 1.84** All NHS Trusts reported in 2009 that statutory advocacy was available on all wards. However, progress with non-statutory advocacy on inpatient wards has been more variable. Five NHS Trusts had non-statutory advocacy across all wards, two NHS Trusts did not have any provision and one NHS Trust had partial provision on some wards.
- 1.85** Less progress had been made with the provision of advocacy in the community, with many NHS Trusts not having any provision. Two NHS Trusts (Hywel Dda and North West Wales) reported having community advocacy across the whole catchment area, although not necessarily at a level to meet demand, and a further two (Gwent and Abertawe Bro Morgannwg) stated that community advocacy was available in parts of its area (Case Study 5). Given that the focus of the relevant legislation is on the provision of advocacy in inpatient settings, there is a risk that little progress will be made by Health Boards in addressing weaknesses with advocacy in the community.

Case Study 5 – Community mental health advocacy service in Bridgend

This service was for anyone with mental health issues who feels that they are excluded, unfairly treated or simply not getting the help they think they need. The service has been running for six years and employs 1.5 full time equivalent advocacy workers, who give information on, and help people access, services, help with filling in forms and writing letters, and attend appointments with health, social services, and housing staff. The service supported 76 people during 2009-10, at least 40 per cent of whom were not currently receiving mental health services.

Although recent improvements with care planning have been reported by some Health Boards, many of the service users who responded to our survey have not been properly involved in their care

- 1.86** The revised National Service Framework included a number of targets relating to the involvement of service users in care planning. By March 2006, a service user subject to the standard or enhanced Care Programme Approach was to be involved in drawing up his or her care plan, and was to receive a copy of the care plan. By March 2010, all service users on the enhanced Care Programme Approach and 90 per cent of all service users on the standard Care Programme Approach were to have an agreed care plan. The later target requires a greater degree of involvement by service users in their care planning.
- 1.87** Some of the service users who responded to our 2009 survey considered that they had not been appropriately involved in care planning and decisions about their care. This suggests that Health Boards would struggle to consistently meet the Welsh Government's targets as:
- a** 58 per cent of service users knew who their care co-ordinator was;
 - b** 51 per cent of service users were given or were offered a copy of their care plan;
 - c** 51 per cent of service users said they 'definitely' understood what was in their care plan, and 28 per cent that they understood 'to some extent'; and
 - d** 43 per cent of service users said they were 'definitely' involved in deciding what was in their care plan, and 33 per cent that they were involved 'to some extent'.



- 1.88** The experiences of service users with care planning reviews were also very mixed, with 42 per cent of respondents reporting that they had not been involved in a care plan review during the previous 12 months. Of those that had had been involved in a care plan review, 51 per cent stated that they 'definitely' found the care review helpful.
- 1.89** The extent of communication with and involvement of service users in their care was also variable, with:
- a** 36 per cent of service users stating that they 'definitely' have enough say in decisions about their care and treatment; and
 - b** 35 per cent of service users stating that their diagnosis had 'definitely' been discussed with them.
- 1.90** The engagement of service users in decisions about their medication was also limited. Nineteen per cent of service users stated that they did not have any say in decisions about medication. For those service users having new medication prescribed during the previous 12 months, 14 per cent stated that the purpose of the medication was not explained to them, and 42 per cent stated that they were not told about possible side effects.
- 1.91** Some Health Boards told us of recent improvement in the extent of compliance with the Care Programme Approach. Progress is being made against the relevant Welsh Government targets, and the NHS Wales Annual Quality Framework for 2011-12 includes a target of full compliance with the Care Programme. In addition, in July 2010 the Welsh Government issued interim policy implementation guidance for the Care Programme Approach, which outlines the principles, focus and way in which care planning should be delivered¹⁵.
- 1.92** To support implementation of the Care Programme Approach, the Welsh Government's Delivery and Support Unit and the National Leadership and Innovation Agency for Healthcare are undertaking a national follow up review. The review includes a caseload audit of every clinician and practitioner working in community mental health services. A national report will be available later in 2011.

¹⁵ Welsh Government, *Delivering the Care Programme Approach in Wales*, Interim Policy Implementation Guidance, July 2010.

Part 2 – The Welsh Government, NHS bodies and councils have had mixed success in addressing barriers to change

2.1 Our 2005 baseline review identified some barriers that were restricting improvement in mental health services. We found that the effectiveness of local multi-agency planning varied across Wales. We also found that mental health services were not always seen as a local priority, and that the way in which mental health services were funded did not facilitate effective long-term service planning and development. Finally, there were very variable arrangements for involving service users in planning and monitoring. This part of the report examines the extent to which the barriers to change identified in 2005 have been addressed.

Action by the Welsh Government to promote and support improvements in adult mental health services has been partly effective

2.2 Following our 2005 baseline review of services, the Welsh Government published a revised National Service Framework. The revised framework included a detailed action plan, which set out the steps that the Welsh Government, NHS bodies and councils were to take covering the period up to 2012-13. The Welsh Government has supported the delivery of the action plan through issuing policy guidance and setting annual targets for the NHS.

The Welsh Government has delivered many of the actions for which it was responsible under the revised National Service Framework, although not always to planned timescales and there are some important omissions

2.3 The revised National Service Framework included 17 actions to be delivered by the Welsh Government. Although some actions were overtaken by subsequent events, such as the requirements of the Mental Health (Wales) Measure 2010, the majority have been delivered, although on occasion delivery was considerably later than had been planned. For example, the Welsh Government committed to producing guidance on suicide prevention by March 2006, but did not publish the final guidance until 2008.

2.4 Some important actions have not been delivered. In particular:

- a** although a mental health promotion action plan was issued for consultation in October 2006, the final action plan, covering both health promotion and addressing stigma and discrimination, will not be available until later in 2011;
- b** policy implementation guidance has not been issued on how to ensure the environments in which mental health services are provided are fit for purpose, including how they will deliver dignity, privacy, and appropriate space and resources for purposeful activity; and



- c a minimum data set for adult mental health has not been developed, although there have been attempts to progress this and the Welsh Government told us that it is considering addressing mental health service information requirements through its Informing Healthcare programme¹⁶.

The Welsh Government has issued policy guidance in a number of key service areas, but has not effectively monitored the implementation of guidance

- 2.5 Since 2005, the Welsh Government has issued a range of policy implementation guidance, including in relation to adult mental health services in primary care settings, crisis resolution and home treatment services, the role of community mental health teams, and assertive outreach services. The policy guidance generally provides clear advice on how services should be set up and run, and has provided a good benchmark for assessing services as part of the follow-up review.
- 2.6 The Welsh Government does not have a robust means for monitoring how effectively its policy guidance has been implemented locally. The Welsh Government's performance management has focussed on a limited number of Annual Operating Framework targets and on ensuring services are in place, rather than on whether services have been developed and implemented in accordance with the relevant guidance.

There are too many targets and key actions for mental health services, which have not been effectively co-ordinated and prioritised at a local level and have sometimes led to unintended consequences

- 2.7 The revised National Service Framework included 44 key actions for the Welsh Government, NHS bodies and councils to deliver. The Framework set out performance targets against each key action. The Welsh Government also sets the NHS annual performance targets through the former Service and Financial Framework process and its replacement, the Annual Operating Framework process.
- 2.8 Performance management by the Welsh Government has focussed on the annual targets, and these have received most attention by NHS bodies. For example, Trust and LHB boards received routine updates on performance against the annual targets, but not against National Service Framework targets. This remains the case with Health Boards.
- 2.9 A mapping exercise undertaken in June 2010 by the national programme for mental health established that there were 29 current action plans for mental health relating to the NHS arising from various reviews and reports in recent years. These plans contain 425 high level actions for the NHS. The national programme for mental health has attempted to distil these actions into a more coherent and manageable number of high impact changes. The exercise is to be extended to cover local authorities, which will involve yet more actions.

¹⁶ Informing Healthcare is a Welsh Government programme set up to improve health services in Wales by introducing new ways of accessing, using and storing information.

- 2.10** The National Service Framework targets and the annual targets have clear timescales for delivery and set clear and consistent priorities. However, the substantial number of other actions required of the NHS, and the absence of a clear priority between them and with the National Service Framework and annual targets, may have contributed to the variable progress being made across Wales in implementing actions that are central to the quality of care.
- 2.11** For example, under the revised National Service Framework, LHBs and NHS Trusts were required to undertake, by March 2007, a systematic review of the guidelines and technical appraisals issued by the National Institute of Clinical Excellence and to develop local incremental implementation plans. Currently there are 23 National Institute of Clinical Excellence guidelines covering mental health and behavioural conditions. These evidence-based guidelines weigh up the costs and benefits of different treatments and interventions. However, our survey of NHS Trusts in 2009 found that:
- a** only one NHS Trust had audited all the relevant guidelines and technical appraisals to determine if they had been fully implemented, with most other trusts stating that they had reviewed the guidelines in only some areas; and
 - b** only two NHS Trusts had draft plans in place for the incremental implementation of the Institute's guidelines, although the plans had not been agreed and implementation had not started.
- 2.12** We found evidence that the targets relating to crisis resolution and home treatment were leading to some unintended consequences. The Annual Operating Framework for 2009-10 included a target that 95 per cent of service users admitted to a psychiatric hospital between the hours of 9 am and 9 pm should have received a gate-keeping assessment by the crisis resolution and home treatment service prior to admission. Local Health Boards routinely reported against this target to the Welsh Government.
- 2.13** In 2009, three crisis resolution and home treatment teams in Wales were undertaking mainly hospital, rather than community-based, assessments. This made the Annual Operating Framework target easier to achieve, since undertaking assessments within or on the same site as the inpatient beds allows easier control and gate keeping of beds. These three teams were located in the only NHS Trusts to meet consistently the Annual Operating Framework target between June and October 2009.
- 2.14** However, undertaking largely hospital-based assessments is clearly contrary to policy guidance, which states that crisis teams should routinely undertake assessments in a service user's home. Undertaking assessments on hospital sites is likely to lead to significant inconvenience to people who are very vulnerable and unwell. In addition, hospital-based assessments may encourage higher levels of admissions, given the proximity and ease of access to an inpatient bed.
- 2.15** Key targets can also be met by simply putting services in place, such as having a gateway or assertive outreach service. However, we found that in some parts of Wales the capacity of these services was wholly inadequate.



A clear focus on the expected outcomes of services and information on which to assess whether these are being delivered is lacking, although the development of ‘intelligent targets’ within mental health is a positive step forward

- 2.16** In the past, Welsh Government policy and target setting have focussed on the provision of specific service elements, and on performance standards for these services. The focus has been on service inputs rather than on outcomes for service users. In the revised National Service Framework, the outcomes that services are expected to deliver are not generally made explicit, and the outcomes achieved have not been measured in subsequent years.
- 2.17** Our follow-up review has highlighted the need to develop readily available, comparable information on which to assess the outcomes of services and their impact on service users. Whereas we are able to describe in detail the variations in expenditure and service delivery across Wales, there is a lack of information on which to assess the impact on outcomes for service users.
- 2.18** In England, an NHS outcomes framework¹⁷ and an outcome-based mental health strategy¹⁸ have been developed recently. This is the start of a process to develop comprehensive outcome measures in the coming years (**Case Study 6**).
- 2.19** There needs to be a clear link between outcome measures and care planning, which should set out at an individual level the outcomes expected from the interventions and support to be provided. Separate assessments by service users and practitioners of the extent to which desired outcomes are being achieved, perhaps as

Case Study 6 – Approach to service outcomes in England

The Department of Health has developed a new mental health outcomes strategy, under the umbrella of an NHS Outcomes Framework covering all NHS services. Outcome frameworks for public health and for adult social care are in the process of being finalised. The new strategy for mental health identifies six high level outcome-based objectives:

- a** more people will have good mental health;
- b** more people with mental health problems will recover;
- c** more people with mental health problems will have good physical health;
- d** more people will have a positive experience of care and support;
- e** fewer people will suffer avoidable harm; and
- f** fewer people will experience stigma and discrimination

For each objective, a number of initial outcome measures have been agreed, and further potential measures identified that in time should provide a more definitive and robust set of outcome measures for mental health. The strategy and NHS Outcomes Framework include specific outcome measures relating to mental health, including:

- a** under-75 mortality rate in people with serious mental illness;
- b** the proportion of adults in contact with secondary mental health services who are in employment;
- c** emergency readmissions within 28 days of discharge from hospital;
- d** health-related quality of life for carers (using a standardised tool); and
- e** patient experience of community mental health services (using an annual survey).

The proposed outcome measures for public health and adult social care include the:

- a** smoking rate of people with serious mental illness;
- b** suicide rate; and
- c** proportion of people with mental illness and/or disability in settled accommodation.

¹⁷ Department of Health, *The NHS Outcomes Framework 2011/12*, December 2010.

¹⁸ Department of Health, *No Health without Mental Health, a cross Government mental health outcomes strategy for people of all ages*, February 2011.

part of the annual care plan review, could provide a valuable source of information on service outcomes achieved. However, we did not find any established process in any part of Wales to produce, collate and report such information.

2.20 The Welsh Government, through the National Leadership and Innovation Agency for Healthcare, is developing 'intelligent targets' for the NHS. This approach focuses on the consistent delivery of evidenced-based interventions or 'care bundles' that are known to deliver improved outcomes for service users. Clinicians and practitioners are actively involved in developing these targets. The approach often involves a combination of interventions that, when provided together, deliver better outcomes for service users. The Centre for Mental Health Services Development at the National Leadership and Innovation Agency for Healthcare, working with service professionals and service users, is developing mental health intelligent targets for depression in hospital settings, first episode psychosis, and dementia care. An intelligent target for eating disorders is also in the initial stages of development.

2.21 Based on clinical evidence, the target for depression aims to improve the rate of detection and appropriate treatment for NHS inpatients with depression to help them achieve their optimal level of functional recovery. It encourages effective screening for depression in hospital settings and early intervention.

2.22 The target for first episode psychosis aims to improve the clinical and social/functional outcomes for people with a first episode psychosis. In particular, it aims to reduce the duration of untreated psychosis to three months. To begin with, the National Leadership and Innovation Agency for Healthcare, working with service professionals, focussed on establishing the baseline duration of untreated psychosis for each Health Board in 2010-11.

2.23 The intelligent target for dementia care aims to improve the quality of life and care for people with dementia and their carers. It includes a range of measures and interventions that have been identified as key drivers for improving outcomes across memory clinics, community services, and general hospital and psychiatric inpatient wards.

2.24 It is too soon to assess the success of this approach. Nevertheless, it appears to be a positive step towards increasing the focus on service outcomes.



Patterns of expenditure on adult mental health have been highly variable across NHS bodies and councils, and it is not clear yet whether the Welsh Government's attempts to protect NHS mental health expenditure have been successful

Real terms expenditure on adult mental health has fallen in some NHS bodies and councils and risen in others

- 2.25** We compared mental health expenditure by LHBs, Health Commission Wales, NHS trusts, and social services departments between 2005-06 and 2008-09. A detailed analysis of expenditure patterns is available in [Appendix 4](#). We have examined actual expenditure figures and calculated expenditure in real terms accounting for inflation, as measured by the retail price index.
- 2.26** Local Health Board expenditure on mental health covers primary care prescribing costs, secondary care services including those provided by NHS trusts, and continuing NHS healthcare costs. Local Health Board expenditure is reported for children and adolescents, adults, and older people. However, up to 20 per cent of LHB mental health expenditure is not assigned to a specific age group. As a result, we have analysed total LHB expenditure on mental health rather than just expenditure on adult mental health.
- 2.27** Mental health expenditure by Health Commission Wales covers specialised services, such as placements into secure facilities, and typically this involves relatively low volume but high cost cases. We have examined expenditure patterns in total for Wales, but have excluded Health Commission Wales expenditure from our analysis of LHBs that follows.
- 2.28** NHS trusts reported their expenditure on adult mental health services, and, although this expenditure is included in the overall LHB mental health expenditure figures, we also examined these expenditure patterns as they provide a further level of detail. Social services data relates to net expenditure on adult mental health services; as a result, we have not combined this with LHB expenditure, which covers all age groups.
- 2.29** Across Wales, we found that between 2005-06 and 2008-09 expenditure by Health Commission Wales on mental health has fallen each year, and has reduced overall by 11.2 per cent and by 24.6 per cent in real terms. In contrast to expenditure on specialised services, during the same period:
- a** LHB expenditure on all mental health services increased by 23.1 per cent, and by 10.1 per cent in real terms;
 - b** NHS Trust expenditure on adult mental health increased by 9.2 per cent, but decreased by 1.4 per cent in real terms; and
 - c** social services expenditure on adult mental health increased by 20.5 per cent, and by 8.2 per cent in real terms.

2.30 However, there has been significant variation in expenditure patterns between LHBs, NHS trusts and social services in Wales. We found that between 2005-06 and 2008-09:

- a** LHB expenditure on all mental health services fell in one LHB, but in real terms it fell in five LHBs;
- b** expenditure on adult mental health services fell in one NHS Trust, but in real terms it fell in six of the 11 NHS Trusts; and
- c** social services expenditure on adult mental health services fell in four councils, but in real terms it fell in seven councils.

The proportion of expenditure that has gone on adult mental health services has fallen in some areas and increased in others

2.31 We examined how mental health expenditure patterns compare to overall expenditure patterns in LHBs (excluding Health Commission Wales), NHS Trusts and social service departments between 2005-06 and 2008-09. Across Wales, the proportion of total expenditure that has gone on mental health increased in LHBs, from 11.7 per cent to 12.2 per cent, and in councils, from 4.6 per cent to 4.8 per cent. However, the proportion of NHS Trust expenditure that has gone on adult mental health has fallen from 6.7 per cent to 6.4 per cent.

2.32 The pattern across Wales varied. We found that:

- a** eight of the 22 LHBs experienced a reduction in the proportion of expenditure spent on mental health services;
- b** nine of the 11 NHS trusts experienced a reduction in the proportion of expenditure spent on adult mental health services; and
- c** nine of the 22 councils experienced a reduction in the proportion of social services expenditure spent on adult mental health services.

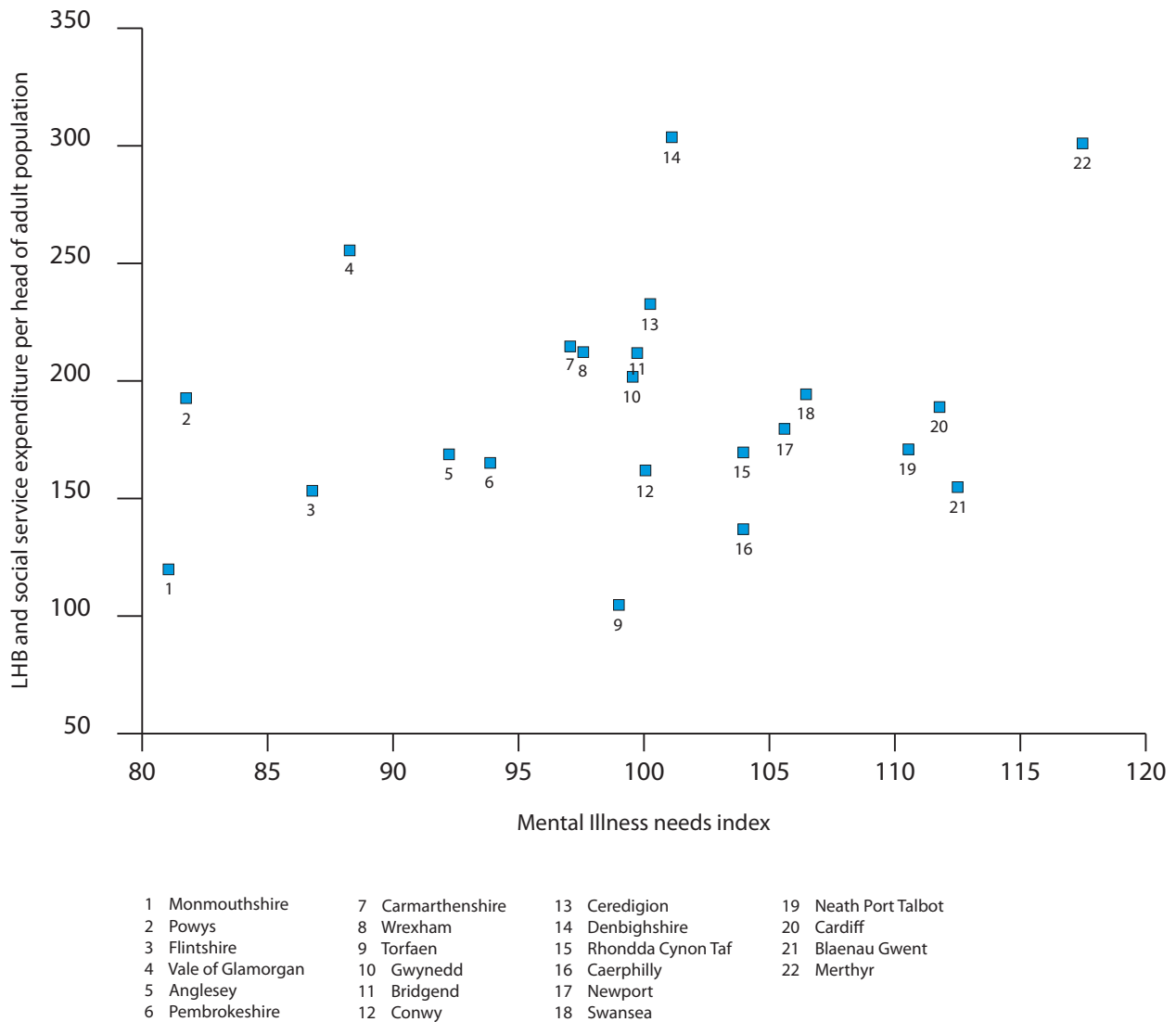
Variations in expenditure on adult mental health services are not explained by variations in need

2.33 We examined expenditure on adult mental health services by LHBs and social service departments across Wales. We found that the amount spent per head of adult population in 2008-09 varied from £82 to £236 by LHBs and from £22 to £68 by social service departments. The combined expenditure on adult mental health ranged from £105 to £304 per head.

2.34 These variations do not reflect the different level of need in each area. As the level of need, as measured by the Mental Illness Needs Index, increases across Wales you would expect to see expenditure per head rising, but this pattern is not evident in many areas ([Exhibit 9](#)).



Exhibit 9 – LHB and social services adult mental health expenditure per head



Source: NHS programme budget data, Stats Wales and Local Government Finance Statistics, Welsh Government

The Welsh Government has ring-fenced NHS mental health funding, but these arrangements lack clarity, cannot be easily monitored and may not have been complied with

2.35 Mental health has been a long-standing priority for the Welsh Government. Most recently in *One Wales, A progressive agenda for the government of Wales*¹⁹, the Welsh Government placed a new priority on providing mental health services. However, our baseline review identified that the extent to which NHS Trusts and LHBs shared this priority varied, and this was reflected in local budgetary decisions. Also, in 2007 the Report of the All Wales Review of Mental Health Services concluded that mental health was often not a priority at a local level, and that mental health services lost out when compared to acute services²⁰.

2.36 To address these issues the Welsh Government has ring-fenced mental health expenditure across all age groups since 2008-09. Initially covering only NHS Trust core services, in 2010-11 ring fencing was extended to include primary care expenditure and mental health Continuing NHS Healthcare expenditure. Ring fencing is to continue into 2011-12.

2.37 Ring fencing was intended to protect mental health expenditure and facilitate investment in services. The Welsh Government has made it clear that the ring-fenced funds form a floor, below which the relevant expenditure must not fall. It has also encouraged NHS bodies to exceed the ring-fenced expenditure, to reflect mental health as a priority spending area. In addition, the Welsh Government made it clear

that any efficiency savings from adult mental health services were to be re-invested within those services²¹.

2.38 There are a number of issues with the way the ring fencing of mental health expenditure has operated. Despite the guidance issued by the Welsh Government, some LHBs and their successor Health Boards have been unclear about what was to be included within the ring-fence and how it was to operate. Most recently, at the request of the Health Board Vice Chairs for primary, community and mental health services, the national programme for mental health issued a briefing paper explaining the ring fence arrangements.

2.39 There is some inconsistency between the Welsh Government's policy on ring fencing and its *Five-Year Service, Workforce and Financial Strategic Framework for the NHS*²². This 2010 document provides the framework for strategic developments within the NHS, and includes an analysis of likely funding gaps and how they can be met through savings. The Framework includes savings targets for mental health of up to £15 million in 2010-11, and estimates potential recurrent savings opportunities of between £30 million and £50 million a year for mental health by 2014-15. The clear implication is that these savings will help address future NHS funding shortfalls, and the Framework document makes no reference to ring fencing or to savings being retained within mental health.

2.40 For 2008-09 and 2009-10, the ring-fence was limited to LHB expenditure on NHS trust services. The amount to be ring-fenced was originally calculated from programme budget

¹⁹ Welsh Government, *One Wales, A progressive agenda for the government of Wales, an agreement between the Labour and Plaid Cymru Groups in the National Assembly Government*, June 2007.

²⁰ Mary Burrow and Stewart Greenwell, *The other end of the telescope – A refocusing of mental health and well being for service users and carers, Report of the All Wales Review of Mental Health Services*, December 2007.

²¹ Welsh Government, *2008-09 Local Health Board and Health Commission Wales Revenue Allocations*, Welsh Health Circular (2008) 006, February 2008.

²² Welsh Government, *Delivering a Five-Year service, Workforce and Financial strategic Framework for NHS Wales*, June 2010.



analysis undertaken by NHS Trusts. This allocated expenditure from financial systems across different service or 'programme' areas. The amount has then been uplifted each year. The monitoring of the ring-fenced expenditure has been based on annual LHB programme budget data, but this is not sufficiently detailed to allow expenditure on NHS Trust mental health services to be identified. Local Health Board expenditure on secondary care is reported but this can include other areas of expenditure in addition to NHS Trust services. As a result, financial monitoring information to determine the extent of compliance with ring fencing is not available for the first two years of its operation.

- 2.41** From 2010-11 the ring-fence has been expanded to cover all areas of Health Board expenditure on mental health, and, as a result, monitoring data will be available in time to assess the extent of compliance. However, there is an issue with the timeliness of the monitoring data. The generation of annual programme budget expenditure is complex and time consuming, and only starts once Health Board accounts are finalised for the relevant financial year. Based on current practices, programme budget returns for 2010-11, will not be available before April 2012.
- 2.42** There is some evidence to indicate that not all health bodies have complied fully with ring fencing requirements over the years. During our fieldwork, Finance Directors in LHBs and NHS trusts expressed varying levels of commitment to adhering to the ring fencing guidance. More recently, clinical leaders for mental health in some Health Boards report that mental health services are being required

to contribute cost improvements to cover Health Board deficits, rather than reinvesting any savings in mental health services, as required by the ring fencing guidance.

- 2.43** In addition, some clinical leaders for mental health consider that local non-compliance with the requirement to retain mental health savings within the service is causing a perverse incentive. Rather than supporting the development of new models of community-based care, concerns that funds will be withdrawn from mental health if beds are closed may be resulting in the continuation of existing bed levels.
- 2.44** We also compared secondary care programme budget expenditure on mental health to the ring-fenced sums for 2008-09. Secondary care expenditure, given that it can include more than NHS trust services, should at least match the ring-fenced budget. However, for 2008-09 we found that secondary care expenditure was lower than the ring-fence sum in three LHBs (Caerphilly, Monmouthshire and Newport).

Progress in improving local planning arrangements has been mixed

- 2.45** Our 2005 baseline review found that the effectiveness of local multi-agency planning groups varied across Wales. Explicit multi-agency visions of mental health services were generally not in place and some areas lacked comprehensive action plans for the local development of mental health services.

Agreed multi-agency service models for mental health services are in place in most parts of Wales, and in many areas they are being revised by Health Boards and partner organisations to ensure consistency within Health Board areas

2.46 In 2009, we found that service models for adult mental health services were in place across most parts of Wales. These service models and subsequent strategies and plans were usually based on council areas.

2.47 The new Health Boards inherited a number of service models and strategies for mental health services and there were often inconsistencies and variations between council areas. Most Health Boards are now seeking to develop with their partners coherent service models and strategies to address inequalities and ensure more consistent service provision across their areas. However, the pace of progress appears to be very mixed, with little headway being made in some parts of Wales.

There has been mixed success with implementing and monitoring the plans drawn up in response to our 2005 baseline review, and NHS re-organisation appears to have slowed progress in some part of Wales

2.48 To ensure a co-ordinated approach to service development, the original National Service Framework had set out a requirement that each council area should have a local multi-agency planning group. This requirement has been met, although both our baseline and follow-up reviews have identified that the effectiveness of the planning groups is highly variable. We found some good examples of well organised planning groups, supported by task and finish groups, that were setting the direction for local service

improvement. However, we also came across some planning groups that were considered locally to be little more than ‘talking shops’, and some where local partner organisations were experiencing difficulties in working together.

2.49 Following our baseline review in 2005, the Welsh Government required all areas to produce local multi-agency action plans. Action plans were produced across Wales, and reviewed centrally by the Welsh Government. We found that in some parts of Wales the action plans have been the driver for change: they have been updated regularly and their implementation has been monitored closely. However, in other parts of Wales we found a range of problems.

2.50 In five council areas, the action plans had not been kept up to date and progress in their implementation had not been monitored effectively. In two council areas, a number of different action plans had been developed, and it was not clear what steps were needed to improve services. In some areas action plans were not costed, and in two council areas the plans did not clearly identify priorities.

2.51 Since the 2005 baseline review, there have been a number of NHS trust mergers, affecting 12 of the 22 council areas. These mergers required revised planning and management arrangements within the NHS, and new relationships with partners to be developed. A number of the areas that experienced NHS trust re-organisation reported to us that this had significantly slowed down the pace of improvement in mental health services. At the time of our fieldwork, it was too early to assess fully the impact of the establishment of the new Health Boards.



Although National Service Framework requirements relating to service user engagement are not being universally met, innovative methods are being used in some parts of Wales to involve service users in planning service improvements

2.52 As part of our 2009 survey of service users, we asked whether mental health services had ever sought their views on local services, either through a questionnaire, a consultation exercise, at meetings or through other means. Sixty-one per cent of service users who responded stated that their views had not been sought. We asked those people who had been consulted whether they considered that their views had been acted upon, and found that:

- a** 54 per cent felt that this was definitely or to some extent the case;
- b** 35 per cent felt that this was not really or definitely not the case; and
- c** 11 per cent of service users were not sure or did not know.

2.53 As part of the revised National Service Framework the Welsh Government had set a number of key targets relating to service user involvement in planning services. Although our follow up review found some innovative examples of how service users are being involved in service planning and review (case studies 7 to 9), the Welsh Government's targets were not being met consistently across Wales:

- a** service users were not represented on all the relevant multi agency planning groups in six council areas;
- b** nine LHBs had not undertaken an audit of service user involvement using 'Stronger in Partnership', the Welsh Government's

guide to involving mental health service users and carers in all aspects of planning, delivering and monitoring services;

- c** five LHBs did not have service users on appointment panels for mental health staff;
- d** service users were not involved in monitoring service quality in seven council areas; and
- e** three council areas did not have service user and carer development workers in place.

Case Study 7 – Involving service users in developing a service charter

The Cardiff and Vale Mental Health Development Project supports voluntary sector, service user and carer involvement in the planning and delivery of services. The Project is co-ordinating a multi-stakeholder steering group to support service users and carers in leading the development of a Recovery Charter for Cardiff and the Vale of Glamorgan. The Charter is intended to set the framework for recovery-based services and what this means for service users, carers, staff and organisations.

Case Study 8 – Involving service users in establishing a crisis resolution and home treatment service

Aneurin Bevan Health Board involved service users and carers in establishing the way ahead on crisis resolution and home treatment services across Gwent. The process involved service users and carers sitting on a panel and undertaking a formal option appraisal exercise to determine the preferred option.

Case Study 9 – Service user interviews

In North Powys, service users have interviewed other service users to map out their journey through services. A total of 28 interviews were carried out during 2009, with the aim of enhancing understanding of service user perspectives and needs.

Part 3 – The new Health Boards, supported by the national programme for mental health, need to sustain improvement during a period of financial restraint

Mental health services face some new challenges

3.1 Since our 2005 baseline review, new challenges have emerged. In particular, there is widespread support for the adoption of a different approach to delivering mental health services; there has been a change from a period of investment in services to one of financial restraint; and new legislation on mental health services in Wales has been enacted.

There is widespread support for the adoption of a recovery approach to mental health that focuses on maximising mental health and independent living, but this will require a fundamental change to service culture and delivery

3.2 Traditionally, mental health services have focussed on a medical dominated model that focuses on treating mental ill health. A recovery-based model focuses upon the individual's potential for recovery, is far more holistic, and offers a more positive approach to mental health and wellbeing. Recovery in the context of mental health services means regaining mental health to the maximum extent possible and achieving a better quality of life lived as independently as possible. It is an outcome-based approach, which has the partnership between the service and the individual service user at its core.

3.3 There is widespread support from service users and service providers for the recovery approach to mental health. This was evident during our fieldwork, and in the evidence provided by various organisations and groups to the Health Wellbeing and Local Government Committee inquiry into community mental health services. In its report²³, the Committee recommended that the Welsh Government adopt the recovery approach to mental health in Wales and incorporate it into its strategic mental health policies and the National Service Framework.

3.4 The Welsh Government has agreed that future policy development will be in line with the principles underpinning the recovery approach. However, adopting a recovery-based approach will involve a fundamental change to the way services are delivered. A report on the recovery model by the Royal College of Psychiatrists, the Care Services Improvement Partnership and the Social Care Institute for Excellence concluded that the approach carries far-reaching implications for training, supervision, governance and service design²⁴. Evidence from our follow-up review also indicates that adoption of a recovery approach will require significant changes to service culture and delivery. We have highlighted earlier in the report the lack of adequate involvement of many service users in decision-making and care planning. In addition, we found that:

²³ Health, Wellbeing and Local Government Committee, *Inquiry into Community Mental Health Services*, September 2009.

²⁴ Care Services Improvement Partnership, Royal College of Psychiatrists, Social Care Institute for Excellence, *A Common Purpose – Recovery in Future Mental Health Services*, June 2007.



- a** four NHS trusts had not implemented a therapeutic model of care across all inpatient wards, despite this being a Welsh Government target under the National Service Framework that was to be delivered by March 2006;
 - b** 13 per cent of service users stated that they had not received help in finding employment, although they would have liked help;
 - c** 24 per cent of service users stated that they would have liked, but had not received, help in obtaining social security benefits; and
 - d** 26 per cent of service users stated that they had not received enough support with their housing and accommodation needs during the previous 12 months.
- 3.5** Our survey of service users also identified that relationships with service professionals were an issue for some service users. We asked service users about their experiences with psychiatrists, community psychiatric nurses, social workers, support workers, psychologists and counsellors. We found that:
 - a** the number of service users who believed they were not carefully listened to varied between 13 per cent and 29 per cent across these different professions;
 - b** between 15 per cent and 32 per cent stated they did not have trust and confidence in these staff; and
 - c** between 11 per cent and 25 per cent stated that the various professionals did not treat them with respect and dignity.

Continued improvement is needed during a period of financial restraint and increasing demand for services

- 3.6** Adult mental health services face the challenge of sustaining and building on the improvements to services made in recent years at a time of financial restraint and increasing demand. The economic downturn has resulted in additional pressure being placed on health and social service budgets. Even though mental health expenditure is ring-fenced, Health Boards will still need to make efficiency savings to maintain existing services. This is because ring-fenced sums include an uplift each year, but this does not fully cover inflationary costs. Efficiency savings are also needed to fund new or expanded services.
- 3.7** Furthermore, it is likely that there will be an increase in demand for mental health services in the coming years as a direct result of the economic downturn. A recession can have a damaging effect on psychological health and not just for those made unemployed. A report to NHS Health Scotland²⁵ concluded that: 'In the short to medium term, the impact of the recession on health and social services is likely to be considerable. An upturn in demand is probable, particularly in relation to anxiety, depression, and homelessness'.
- 3.8** The national programme for mental health has identified a range of efficiency saving opportunities for Health Boards, including:
 - a** reducing the costs of placing people in secure units by decreasing reliance on expensive services from outside Wales and/or outside the NHS;

²⁵ NHS Health Scotland, *The potential impact of the recession on health in Scotland and the implications for NHS Health Scotland*, HS paper 2/09, January 2009.

- b remodelling bed capacity, for example by maximising the impact of crisis resolution and home treatment services in reducing admissions and lengths of stay; and
 - c reducing prescribing costs.
- 3.9** In addition, Health Boards have requested that the national programme for mental health undertakes, on their behalf, a collaborative procurement exercise to drive up quality and achieve value for money from independent sector providers.
- Investing in mental health services can deliver greater savings to the NHS and other parts of the public sector**
- 3.10** A report by the Department of Health in England²⁶ examined the economic case for a number of evidence-based mental health interventions. The report concluded that it makes financial sense to invest in building and maintaining good mental health, and in intervening as soon as mental illness arises. It identified that effective intervention can generate savings in health and in many other areas of public sector expenditure, and in the economy as a whole. The interventions covered in the report include:
- a early identification and intervention – such as parenting interventions for children with a conduct disorder, early detection of and intervention in psychosis, and early diagnosis and treatment of depression at work;
 - b promotion of positive mental health and prevention of mental disorder – such as school-based violence prevention programmes, work-based mental health promotion, and suicide prevention; and
 - c addressing the social determinants and consequences of mental health problems – such as debt advice, targeted employment support for those recovering from mental health problems, and housing support services.
- 3.11** The potential savings are considerable. The report estimates, for example, that if comprehensive early detection of psychosis services were in place across England, net savings of around £330 million to the NHS over a 10-year period would result, together with around £140 million of savings to the wider public sector, increasing to £1.7 billion if wider costs are taken into account. However, finding the funds to invest in such services will be a challenge in the current economic climate.
- 3.12** The cessation of funding for services currently funded on a non-recurring or fixed term basis also poses a challenge for Health Boards. For example, the Big Lottery Fund has provided a total of £15 million to support 18 mental health projects across Wales, each of which will run for five years. The impact of individual projects will be evaluated and, where projects demonstrate cost effectiveness and/or improved outcomes, the relevant Health Boards will need to find funding for those they wish to sustain. Similarly, the replication of successful projects in other parts of Wales will require other Health Boards to find the necessary funding.

²⁶ Department of Health, *No Health without mental health: A cross-Government mental health outcomes strategy for people of all ages, Supporting document – The economic case for improving efficiency and quality in mental health*, February 2011.



Considerable changes will be needed to implement the Mental Health (Wales) Measure successfully

3.13 The Mental Health (Wales) Measure received Royal Assent in February 2010. Under the Measure:

- a** there is a legal requirement for Health Boards and local authorities to deliver primary care mental health support services that offer assessment of an individual's mental health and provide advice and/or treatment of an individual's mental disorder within primary care;
- b** all individuals accepted into secondary mental health services for treatment will have a care and treatment plan prepared and regularly reviewed by a care co-ordinator, that is based on the expected outcomes of services, and that is drawn up in consultation with the service user;
- c** individuals who have been discharged from secondary mental health services, but who subsequently believe that their mental health is deteriorating to such a point as to require specialist intervention again, are able to refer themselves back to secondary services directly, without necessarily needing to first go to their general practitioner or elsewhere for a referral; and
- d** statutory independent mental health advocacy is expanded to all inpatients, whether admitted under compulsion or not.

3.14 Different elements of the Measure will come into force at different times, with full implementation expected to take three years. The Welsh Government has allocated £5 million to support implementation. Evidence from this follow-up review indicates that considerable changes to the way services are delivered are needed to meet the requirements of the Measure ([Appendix 3](#)).

3.15 The National Assembly for Wales Finance Committee has reported on the financial implications of implementing the Measure²⁷. While noting that a detailed analysis had identified that implementing the Measure will cost £5 million a year, it concluded that accurate forecasting of these costs was extremely difficult. This is because:

- a** it is not possible to assess the level of unmet need for primary mental health support services, and there could be a large latent demand which could in turn lead to a significant unexpected funding requirement; and
- b** there are uncertainties arising directly from the fact that the Measure will fundamentally change the way in which services are provided, and it is not always possible to predict how quickly changes and savings from elsewhere will be achieved.

²⁷ National Assembly for Wales Finance Committee, Report on the Financial Implications of the Proposed Mental Health (Wales) Measure, July 2010.

The new Health Boards provide an opportunity to drive forward change

3.16 On 1 October 2009, the 22 LHBs and seven NHS Trusts were replaced with seven integrated Health Boards responsible for all health care services in their areas. This has provided some key opportunities but also some new risks.

The most recent NHS re-organisation removes some barriers to whole-system service development and provides an opportunity to drive forward change

3.17 In our 2005 baseline review, we concluded that whole system service development was being undermined by fragmented commissioning arrangements. Responsibility for commissioning various elements of mental health services was spread between 22 LHBs, 22 local authorities, and Health Commission Wales, which was responsible for specialised and tertiary services.

3.18 The reorganisation of the NHS in 2009 has simplified NHS planning and delivery arrangements and has brought together within the seven integrated Health Boards responsibility for funding and providing all NHS mental health services in an area, with:

- a** primary and secondary care services no longer provided by separate organisations; and
- b** the transfer to Health Boards of budgetary responsibility for specialised and tertiary services.

3.19 Giving Health Boards control over all areas of NHS mental health expenditure has removed some of the previous disincentives for change. For example, under the previous arrangement a placement into a secure unit would have been the financial responsibility of Health Commission Wales. However, there was a disincentive for LHBs and NHS Trusts to provide step-down services as financial responsibility would then pass to them. A similar disincentive occurred with Continuing NHS Healthcare. The costs of Continuing NHS Healthcare were borne by the LHB, and this did not provide an incentive for NHS trusts to work with service users and, where appropriate, move them back out of Continuing NHS Healthcare.

3.20 The larger geographic areas now covered by Health Boards also provide opportunities for improving services. Some mental health services require a large population base to be cost effective, and in the past this required co-ordination and agreement between two or more LHBs. The new larger Health Boards should make the provision of such services easier.

3.21 Inequalities in service provision are also now more evident in the larger Health Boards. We have identified encouraging signs in some Health Boards that they are now addressing long-standing inequalities in service provision between the council areas that they cover.



Risks remain that mental health services will not be given appropriate priority by the new Health Boards

3.22 As part of the NHS reforms, the Vice Chair and an Executive Director of each Health Board have responsibility for primary, community and mental health services. We have not reviewed the extent to which Vice Chairs have a good understanding about mental health services in their areas and the key issues they face. However, the Health, Wellbeing and Local Government Committee's inquiry into community mental health services raised a concern that primary and community services would demand most of the Vice Chairs' and Directors' attention at the expense of mental health services. The Committee recommended that the role of the Vice Chair be kept under review subject to evidence of mental health services being given appropriate priority²⁸. The Welsh Government accepted this recommendation.

3.23 With one exception, Health Boards have a mental health sub-committee, but the sub-committees seem to be developing in different ways. In the majority of Health Boards, the role of the sub-committee is limited to monitoring compliance with the Mental Health Act (1983), but In Aneurin Bevan Health Board the remit of the sub-committee is far broader and includes planning and performance monitoring of all mental health services. Cwm Taf Health Board does not have a mental health sub-committee, with the main board monitoring compliance with the Mental Health Act.

3.24 Given their size and the range of services for which they are now responsible, there is a risk that mental health may not feature appropriately on the agenda of Health Boards. The ability of the Vice Chair and Director to influence the Board agenda is critical. Although it is too soon to assess their impact, the Boards do appear to be receiving appropriate information on mental health. We reviewed three sets of board papers from each Health Board covering the period between August and November 2010. We found that:

- a** mental health was routinely included in the performance and financial reports provided to boards;
- b** boards were routinely provided with updates from sub-committees that included mental health services within their remit; and
- c** a number of Boards were presented with mental health strategies or plans.

There is a risk that local authorities will not be appropriately involved in planning mental health services and the different approaches to joint working and integration have not been evaluated

3.25 It is particularly important that all relevant service providers are engaged in planning service developments, including health services, social services, housing services and the voluntary sector. One of the conclusions from our review of housing services for adults with mental health needs was that joint planning, involving all relevant local agencies, was not always effective²⁹. This was also the case for other aspects of mental health service planning.

²⁸ Health, Wellbeing and Local Government Committee, *Inquiry into Community Mental Health Services*, September 2009.

²⁹ Wales Audit Office, *Housing Services for Adults with Mental Health Needs*, November 2010.

- 3.26** Between 2005 and 2009, the planning of adult mental health services was based around the 22 council areas, and different models of joint working emerged across Wales. In some areas, agencies relied upon traditional partnership working arrangements, with multi-agency planning groups and forums. In other areas, a more integrated approach was adopted. For example, in 2005 Conwy and Denbighshire NHS Trust, Conwy County Borough Council and Denbighshire County Council established the Conwy and Denbighshire Adult Mental Health and Social Care Partnership, using the joint flexibilities arrangements in the Health Act 1999. These arrangements allowed funding to be pooled between health bodies and health-related local authority services, and resources and management structures to be integrated. The parties drew up a legal partnership agreement, using Section 31 of the 1999 Act. In other areas, joint working was pursued by health and social services appointing joint directors and commissioning managers.
- 3.27** The new Health Boards and their partners are revising the joint working arrangements that they inherited, and in some areas the model of future joint working and the extent of integration between health and social services are under review.
- 3.28** The 2009 NHS reorganisation has provided a new challenge for agencies in ensuring effective local planning arrangements are in place. There are potential tensions between Health Boards, whose focus is likely to be on addressing inequalities and providing a consistent level of services across their areas, and the agenda of different councils, which are likely to focus on the priorities for their smaller geographic areas. There is a risk that councils will not fully engage with joint

planning if they perceive that they are junior partners and have little influence.

- 3.29** Better joint working and integration between health and social services is a Welsh Government policy objective. However, we found no evidence of any formal evaluation having been undertaken of the relative benefits that the different models of joint working and integration within mental health have delivered in terms of efficiencies or service outcomes. Evaluation would help inform Health Boards and councils across Wales in their considerations of the different models of joint working and integration.

The national programme for mental health has a key role to play in supporting the further development of mental health services, but more robust arrangements are needed to ensure that Health Boards are responding appropriately to national programme advice

The national programme for mental health has a key role to play in supporting Health Boards deliver efficiencies and service improvements

- 3.30** The Welsh Government's Service, Workforce and Financial Strategic Framework sets out the process to achieve transformational change in the delivery of health services in Wales over the next five years³⁰. To support the Framework, in June 2010 the Welsh Government established 11 national programmes, including one for mental health services.

³⁰ Welsh Government, *Delivering a Five-Year service, Workforce and Financial strategic Framework for NHS Wales*, June 2010.



- 3.31** The national programmes aim to support service improvements and identify potential areas in which efficiencies can be made. They provide direction, advice, and support, but they are not responsible for delivery. Responsibility for service improvements rests with individual Health Boards, and responsibility for performance management remains with the Welsh Government. The national programmes were intended to have a fixed life, and the Welsh Government is currently reviewing the operation of all national programmes.
- 3.32** National programmes are chaired by Health Board Chief Executives, have programme directors, and report to a Chief Executives' Board. The mental health national programme is unique in that it has co-chairs, one from a Health Board and one representing the Association of Directors of Social Services. This reinforces the multi-agency nature of mental health.
- 3.33** The stated purpose of the mental health national programme is to provide leadership and direction to help ensure that high quality and best value for money mental health services are delivered, and to promote and protect the mental health and well-being of citizens. The national programme uses a variety of approaches, including leading on collaborative projects, collating and sharing information, and providing advice, guidance and good practice compendiums. The national programme's priorities for 2011 are:
- a** a collaborative procurement project focussing on Continuing NHS Health Care packages with independent providers to drive up quality, safety and value for money;
 - b** improving the management of high risk patients, focussing on enhancing medium secure services and expanding community support; and
 - c** improving hospital-based care by focussing on reducing variation, harm and waste, through for example examining bed numbers, rates of admission and length of stay.
- 3.34** The national programme is already reporting that it is achieving results. For example, it has commissioned work on behalf of the Health Boards to reduce the cost of placements and improve the quality of placements in the private sector. The national programme reports that this initiative has already secured £1.4 million of annual savings from two independent providers. The national programme has also produced various reports and outputs for Health Boards, such as 15 high impact areas for service change in mental health, and a good practice mental health services compendium is being finalised.
- More robust arrangements are needed to ensure Health Boards are responding appropriately to national programme advice and outputs**
- 3.35** The national programmes are a relatively recent development, and we have not reviewed their operation in detail. However, there are indications that arrangements in Health Boards for monitoring the adequacy of their responses to national programme advice, and the Welsh Government's arrangements for managing the performance of Health Boards in responding to national programmes, may need to be strengthened.

3.36 The mental health national programme reports to the Chief Executives' Board and all Health Boards have identified a lead mental health manager to link with the programme. The Welsh Government expects all Health Boards to adopt national programme advice or provide a justification for not doing so, referred to as 'adopt or justify'. It is therefore important that there are effective arrangements to monitor whether Health Boards are responding appropriately to national programme advice and outputs, such as on high impact service changes and good practice compendiums. However:

- a** governance arrangements within Health Boards to oversee the response to and implementation of national programme advice and outputs do not appear to be well developed; and
- b** it is not clear how the 'adopt or justify' approach will be performance managed by the Welsh Government, given the extensive range of actions that Health Boards will need to take in responding to the 11 national programmes.



Appendix 1 – Study methods

In carrying out our work, we used the following methods.

Survey of service users

- 1** We widely advertised and made available a user survey through the media, and statutory and voluntary sector service providers. Service users could complete the survey, which ran from July to October 2009, on-line or in hard copy. In total, we received 310 responses from across Wales. We had a variable response across former LHB areas, which ranged from 41 service users in Rhondda Cynon Taff, down to just three in Anglesey.
- 2** We used the former Healthcare Commission community survey as a basis for developing our user survey. We expanded the scope of questions beyond specialist mental health and social care to include a broader range of services, such as primary care, housing, and support with obtaining employment and benefits. Comparison between the two sets of results is problematic, as the surveys were distributed differently in Wales and England. However, it should be noted that the same broad patterns and themes emerge from both surveys. A summary of the results from the Wales Audit Office survey can be found on our website.

Survey of General Practices

- 3** We issued a questionnaire to all General Practices in Wales. This repeated a number of questions that we asked as part of a survey undertaken for the baseline review, allowing comparison between 2005 and 2009. The survey covered: practice staff training in mental health; use of standardised tools to assist in diagnosing and managing patients; the services available in primary care; the support available from specialist staff; and general practices' priorities for service development. Across Wales 97 practices responded, a 20 per cent response rate. The response rate varied between LHB areas from 50 per cent of general practices in Anglesey to none in Caerphilly.

Survey of Local Health Boards and NHS Trusts

- 4** All 22 LHBs completed a survey in September 2009, providing information and data on various aspects of primary care, supporting and engaging service users, and local planning arrangements.
- 5** We requested a range of information and data from NHS Trusts and their partners. All NHS Trusts completed a questionnaire, which gathered information on the range of specialist services provided in primary and secondary care settings, waiting times, staffing arrangements, inpatient bed provision, the support provided to service users and carers, and local workforce and service planning.

- 6 All NHS Trusts provided staffing data for adult psychiatry and psychology. Every community team completed a questionnaire covering staffing levels, management arrangements, staff training in psychological therapies, and operating practices. These teams included primary care support, community mental health, crisis intervention and home treatment, assertive outreach and early intervention in psychosis teams. In total, we received 106 returns from the various community teams. Most NHS Trusts and community teams met the deadline of September 2009, but it took until early 2010 to gather in fully completed returns from all areas.
- 7 Much of the information and data we gathered from NHS Trusts and community teams in 2009 repeated earlier information gathering as part of the baseline review, allowing comparison of inpatient bed numbers and staffing levels with 2005.

Semi-structured interviews and focus groups

- 8 We undertook fieldwork visits to all LHBs, NHS Trusts, and councils in Wales during the first half of 2009. As part of these visits, we undertook extensive interviews with senior managers, service managers, and lead practitioners from health, social services, and housing. We held focus groups with staff involved in providing adult mental health services, such as community psychiatric nurses, occupational therapists and social workers. We also ran focus groups for voluntary sector organisations in every area.
- 9 Nationally, we interviewed officials from the Welsh Government who have responsibility for mental health and members of the mental health programme board.

Review of documentation and data

- 10 We reviewed a range of local and national plans and documents relating to adult mental health services. At a local level, these included the multi-agency action plans and monitoring reports, health social care and wellbeing strategies, minutes from planning group meetings and Health Board meetings, council improvement plans, local housing strategies and supporting people operational plans.
- 11 We also gathered and reviewed a range of data. This included inpatient bed occupancy, inpatient admissions and length of stay. We also collated and analysed NHS Trust financial returns, and analysed LHB and social services financial data relating to adult mental health services between 2005-06 and 2008-09.
- 12 At a national level, we reviewed Welsh Government policy documents and guidelines relating to mental health, overarching strategic policies, such as the five-year service, workforce, and financial framework, recent reports on mental health services in Wales, and researched the latest policy developments in other parts of the UK.



Appendix 2 – Performance against Welsh Government Targets and policy guidance

This summary of performance is based upon information provided to the Wales Audit Office by the former LHBs and NHS Trusts.

Target	Summary of performance
<p>All LHBs were to ensure GPs and practice staff received training to help them diagnose and manage adults with mental health problems. Local Health Boards were to achieve this by March 2007 (2006-07 Service and Financial Framework target).</p>	<p>Although there appears to have been an improvement in the numbers of GPs and practice nurses receiving such training the target has not been uniformly met:</p> <ul style="list-style-type: none"> the majority of LHBs stated that they have provided training in the last three years to GPs to help them diagnose and manage adults with a mental health problem (14 of 22), and to practice nurses (13 of 22) to help them identify and support adults with a mental health problem; eight LHBs reported that they had not provided training to GPs (Cardiff, Ceredigion, Flintshire, Gwynedd, Anglesey, Pembrokeshire, Powys, Vale of Glamorgan), and eight reported not providing training to practice nurses (Bridgend, Cardiff, Ceredigion, Flintshire, Gwynedd, Anglesey, Pembrokeshire, Vale of Glamorgan); the proportion of general practices responding to our survey who stated that no GPs had received any post graduate training in mental health in the last three years fell from 45 per cent in 2005 to 35 per cent in 2009; and the proportion of general practices responding to our survey who stated that no practice nurses had received any training in mental health in the last three years fell from 88 per cent to 69 per cent.
<p>By March 2007, all LHBs were to ensure that all GP practices had a 'gateway' worker providing screening, assessment, gate keeping, and signposting to other services (2006-07 Service and Financial Framework target).</p>	<p>One LHB area (Bridgend) does not have gateway workers in place. In Newport, there are no dedicated staff providing the gateway worker function, but community mental health team staff run assessment clinics as an alternative to this service. In some other parts of Wales (Rhondda Cynon Taf, Carmarthenshire, Cardiff and the Vale), gateway workers are in place but do not cover all parts of the area. The capacity of the gateway service across the rest of Wales varies considerably, but there are some well-developed primary care liaison teams in place.</p>

Target	Summary of performance
<p>By March 2006 all LHBs should have a crisis resolution and home treatment service in place (National Service Framework Key Action 23, and 2005-06 Service and Financial Framework target).</p> <p>In addition, in May 2005 the Welsh Government also issued policy implementation guidance that outlined the functions and operational requirements of crisis resolution and home treatment services.</p>	<p>By the end of 2009 only four former LHB areas did not have these services, although there are specific actions being taken to establish these, as follows:</p> <ul style="list-style-type: none"> • In Caerphilly, Anglesey, and Gwynedd, crisis resolution and home treatment services are to be set up and funded through a reduction in beds; and • In Powys, following the transfer of mental health services to three neighbouring providers, the Health Board has approved a modernisation plan that will support the development of these services for Powys. <p>However, in three areas (Conwy, Denbighshire, and Flintshire) whilst crisis resolution and home treatment teams have been developed they do not cover the whole of the adult population living within the county.</p> <p>We found that few areas were fully compliant with the policy guidelines for crisis resolution and home treatment services issued by the Welsh Government. Assessments should be undertaken in the service user's home whenever possible, but we found that in Rhondda Cynon Taf, Merthyr, and Bridgend this was not routinely the case, with assessments taking place on hospital sites. The extent to which assessments take place in the community also varies across Gwent. Undertaking assessments within or on the same site as the inpatient beds, allows easier control and gate keeping of beds. However, this may lead to higher levels of admissions or significant inconvenience to people who are very vulnerable and unwell.</p> <p>The Welsh Government guidance also states that a core service should be provided as a minimum from 9 am to 9 pm, seven days a week, with an on-call service available throughout the night. These core hours are not being achieved in many areas (three teams in Gwent, one team in Cwm Taf, and two teams in North Wales). In some areas, core services are available seven days a week but not up to 9 pm, in others the service is not available on weekends.</p> <p>Finally, there are important variations in crisis resolution and home treatment team membership, with:</p> <ul style="list-style-type: none"> • of the 18 former LHB areas covered by a crisis resolution and home treatment team seven do not have social services staff as members; • occupational therapists are members of only five crisis resolution and home treatment teams; • four crisis resolution and home treatment teams have a clinical psychologist as a member; and • two teams do not have Healthcare Assistants as members.



Target	Summary of performance
<p>All health communities were to establish an assertive outreach service, which provided intensive support and has the capacity to meet the needs of clients who have or are at risk of disengaging with services. This was to be achieved by March 2009 (2008-09 Service and Financial Framework target).</p>	<p>There are 13 former LHB areas that are fully covered by an assertive outreach service (Bridgend, Neath Port Talbot, Swansea, Blaenau Gwent, Monmouthshire, Newport, Torfaen, Carmarthenshire, Pembrokeshire, Ceredigion, Flintshire, Wrexham, and Merthyr). A further four areas have an assertive outreach service but this does not cover the whole adult population of the county (Rhondda Cynon Taf, Caerphilly, Conwy and Denbighshire).</p> <p>There is an embryonic service in Anglesey and in Gwynedd provided through one individual who is very over committed. There is no assertive outreach service in the remaining areas (Powys, Cardiff, and Vale of Glamorgan), although recurring funding for a service covering Cardiff and the Vale has recently been secured. The majority of assertive outreach services are provided through dedicated teams.</p> <p>There are some issues with the assertive outreach teams. Some of these teams can be very small and lack capacity, and opening times are often restricted, with:</p> <ul style="list-style-type: none"> • eight former LHB areas having a service Monday to Friday (Caerphilly, Torfaen, Newport, Monmouthshire, Blaenau Gwent, Carmarthenshire, Pembrokeshire, Ceredigion); • two areas have a service six days a week (Conwy and Denbighshire); • seven areas having a service seven days a week (Merthyr, Rhondda Cynon Taf, Bridgend, Neath Port Talbot, Swansea, Flintshire, Wrexham); and • with the exception of one team (covering Wrexham and Flintshire who work 9 am to 7 pm on weekdays), the remaining teams work either 9 am to 5 pm or have flexible hours to meet service user needs. <p>Different professionals are part of assertive outreach teams in different parts of Wales, for example:</p> <ul style="list-style-type: none"> • two of the 13 dedicated teams do not have any social service staff as members, and only five employ social service support workers; • six teams do not have any healthcare assistants as members; • only three have a clinical psychologist as a member and another two teams have a psychological therapist; and • six teams do not have an occupational therapist as a member. <p>In Swansea, the service is provided through a ring-fenced resource under the umbrella of the community mental health teams. This staff resource (11.2 whole time equivalent) is dedicated to providing a seven-day a week assertive outreach service, with flexible hours as required. At the time of our review we found few of the assertive outreach staff in Swansea had been trained in psychological therapies – this was far greater in stand alone assertive outreach teams.</p> <p>In Blaenau Gwent, the service is provided by one dedicated Community Psychiatric Nurse, covering a population of over 40,000 adults.</p>

Target	Summary of performance
<p>The Welsh Government set a target for all health communities to offer early intervention to clients with a first episode of psychosis allowing for the commencement of treatment within three weeks of referral to the early intervention service. This was to be achieved by March 2009 (2008-09 Service and Financial Framework target).</p>	<p>There has been only limited progress with developing early intervention in psychosis services. There has been most progress in Gwent, which has an early intervention service covering all five former LHB areas. The service focuses on early identification, empowerment and self-management, and looks at the whole needs of a person. The service reports that it is minimising hospital admissions for those on its caseload.</p> <p>There is only one other dedicated early intervention in psychosis team in Wales, this covers Carmarthenshire, Ceredigion and Pembrokeshire. This team has far lower staffing per head of population than the Pan Gwent service.</p>
<p>The revised National Service Framework set a range of targets relating to the organisation and management of community mental health teams (Key Actions 13, 20, 22, 25, 41).</p> <p>In addition, in July 2010, the Welsh Government issued interim policy implementation guidance and standards for community mental health teams, which further clarified expectations.</p>	<p>The National Service Framework set a target for community mental health teams to be based around primary care groupings. We found that the majority of community mental health teams were based around primary care groupings, but in two NHS Trusts, this was only the case for some of their community mental health teams.</p> <p>Access criteria to community mental health team services should be made clear through multi-agency protocols and referral guidelines. We found that:</p> <ul style="list-style-type: none"> • only one NHS Trust reported having a care pathway for adults with a mental health problem that covered all agencies and care settings; • referral guidelines between primary and secondary care were generally in place, but two NHS Trusts reported that these did not cover all LHB areas within its catchment area; and • referral guidelines in two NHS Trusts did not cover arrangements for referring back to a GP from the community mental health team, and in four did not cover access to services out of hours. <p>The July 2010 guidance states that community mental health teams should undertake a demand and capacity assessment to help inform workforce requirements. We found that in NHS Trusts, approaches to demand and capacity planning in community mental health teams were generally poorly developed.</p> <p>In addition, three NHS Trusts reported that they had not reviewed skill mix in community mental health teams. Where skill mix had been reviewed this was limited to NHS Trust staff in two parts of Wales, and in no area had this covered both health and social care staff from all councils within the NHS Trust catchment. Only one NHS Trust reported having a joint workforce plan covering health and social services staff.</p> <p>Community mental health teams should have a core staff base that includes social care, nursing, psychiatry, psychology, and occupational therapy. Our survey of community mental health teams found that social care, nursing, and psychiatry staff are routinely part of these teams across Wales.</p> <p>However, 42 per cent of community mental health teams did not have either a clinical psychologist or psychological therapist as core members. This often reflected the way local services were organised with a separate psychology service, to which community mental health teams referred. We also found that 12 per cent of community mental health teams did not have occupational therapists as core members.</p>



Target	Summary of performance
Continued...	<p>Psychiatrists are integrated into community mental health teams across Wales, with the exception of part of one NHS Trust. However, in only four NHS Trusts were all psychiatrists co-located with the community mental health team. Three NHS Trusts reported that some but not all psychiatrists were co-located.</p> <p>There should be integration of health and social services within community mental health teams. We found there is scope in many teams to improve integration, with:</p> <ul style="list-style-type: none"> • just over one in three community mental health teams having single integrated line management, the rest having separate managers for health and social care; • just under two in five community mental health teams reporting having single, integrated information recording systems; and • although the majority of community mental health teams (80 per cent) use shared case files, medical notes are not included in shared case files in one in three teams. <p>NHS Trusts were to establish discharge and follow-up protocols for use in primary and secondary care services including within crisis resolution and home treatment teams by March 2007. We found this had not always been achieved, with:</p> <ul style="list-style-type: none"> • discharge and follow-up protocols fully in place for primary and secondary care services in five of eight NHS Trusts; and • with one exception, the NHS Trusts with crisis resolution and home treatment teams had discharge and follow-up protocols in all of their teams. <p>The Welsh Government set a target that by March 2007 all community mental health teams were to establish liaison workers with other specialist services. Our survey of community mental health teams found that these are generally not in place, with:</p> <ul style="list-style-type: none"> • 19 per cent of community mental health teams in Wales having a designated lead or link worker for drug and alcohol services; • 12 per cent having these for criminal justice services; • 10 per cent having these for housing; and • only one community mental health team having designated leads or link workers for each of these service areas. <p>It should be noted that the recent Welsh Government guidance on community mental health teams reinforces the need for effective links and liaison between specialist services and other agencies, but does not now prescribe how this should be achieved.</p> <p>Effective liaison psychiatry services were to be in place at all district general hospitals by March 2009. We found that five NHS Trusts had psychiatric liaison in place at all district general hospitals, with two NHS Trusts having this in place for some of their district general hospitals.</p> <p>We also found that mental health liaison nurses for district general hospital wards were in place in five NHS Trusts, but there were no mental health liaison nurses in place for community hospital wards. With the exception of one NHS Trust, Accident and Emergency mental health liaison nurses were in place across Wales.</p>

Target	Summary of performance
<p>The Welsh Government set a target for each area in Wales to have a plan for the establishment of a range of psychological therapies. This was to be in place by March 2007 (National Service Framework Key Action 26).</p> <p>The National Institute for Health and Clinical Excellence recommends a stepped model of care approach to psychological therapies, as this has significant benefits for service users and delivers better value for money. NICE defines stepped care as: <i>'A sequence of treatment options to offer simpler and less expensive interventions first and more complex and expensive interventions if the patient has not benefited, based on locally agreed protocols.'</i></p>	<p>We found that only three NHS Trusts had a plan for the development of psychological therapies that covered primary and secondary care and that was based on a stepped model of care. There is however, widespread support for implementing a stepped model of care, although progress is slow with:</p> <ul style="list-style-type: none"> • Powys having no immediate plans to pursue a stepped model; • three NHS Trusts reporting that they were committed to developing a stepped model of care but were at the planning stage; • four NHS Trusts reporting that implementation was underway; and • no NHS Trust stating that they had fully implemented the model. <p>One NHS Trust also reported that it did not have a psychological therapies management committee, but in other NHS Trusts, the committee generally had an appropriate range of responsibilities and representatives.</p>
<p>By 2007, all GP practices were to have access to psychological therapy services, either within or available to the primary care base, with a maximum waiting time of 12 weeks (2006-07 Service and Financial Framework target). Structured counselling was to be available in primary care by the end of March 2009 (National Service Framework Key Action 26).</p>	<p>Only 12 LHBs confirmed that structured counselling was available in all general practices.</p> <p>Eight LHBs stated that they did not routinely monitor the maximum waiting time for a first counselling appointment in primary care. Although the remaining LHBs stated that they monitored waiting times, four did not provide us with waiting times data. Of the nine LHBs reporting data to us, five stated that their maximum waiting times were within the 12-week target, and waiting times varied between three and 36 weeks across LHBs.</p>
<p>By March 2007, all patients subject to the Care Programme Approach who were assessed as requiring access to psychological therapies were to have therapy commenced within three months of the assessment (2006-07 Service and Financial Framework target).</p>	<p>The waiting times for the commencement of psychological therapy for a patient subject to the Care Programme Approach assessed as requiring these, were reported by NHS Trusts to be very variable. In some areas, the waiting times for a first appointment can exceed two years, and are normally outside the target time. NHS Trusts also often reported very variable waiting times depending upon which part of the Trust area the person lived in.</p>



Target	Summary of performance
<p>By March 2006, bilingual locally accessible service directories were to be in place, which included arrangements for access out of hours and provision in the voluntary sector (National Service Framework Key Action 5).</p> <p>By March 2009, mental health information was to be available in minority languages and Braille, and arrangements were to be in place to ensure regular updates (National Service Framework Key Action 5).</p>	<p>We found that progress has been very mixed, with service directories. These were out of date in nine LHB areas (Ceredigion, Flintshire, Wrexham, Caerphilly, Monmouthshire, Torfaen, Neath Port Talbot, Rhondda Cynon Taf, and Merthyr).</p> <p>We identified issues with what was included in service directories in seven LHB areas (Ceredigion, Pembrokeshire, Anglesey, Conwy, Neath Port Talbot, Rhondda Cynon Taf, and Merthyr). The most frequent omissions (in five LHB areas) were out-of-hours services and services in primary care. There were also omissions relating to social services (one LHB) and housing (one LHB).</p> <p>Service directories were only available in minority languages in five LHB areas (Newport, Torfaen, Swansea, Conwy, and Denbighshire). Only three LHBs reported having the service directory available in Braille (Swansea, Conwy, and Denbighshire).</p>
<p>By March 2007, statutory advocacy was to be available across Wales. For non-statutory advocacy, services were to be available across all inpatient facilities by March 2009 and across the community by March 2010 (National Service Framework Key Action 6).</p>	<p>All NHS Trusts reported in 2009 that statutory advocacy was available on all wards. However, progress with non-statutory advocacy on wards has been more variable. Two NHS Trusts did not have any provision, and one NHS Trust had partial provision across some wards. The remaining five NHS Trusts had non-statutory advocacy across all wards.</p> <p>There has been least progress with the provision of advocacy in the community, with the majority of NHS Trusts not having any provision. Two NHS Trusts reported having community advocacy across the whole catchment area, and one Trust stated this was available in parts of its area. There is a risk that there will be little progress with advocacy in the community as the focus of legislation is on inpatient settings.</p>
<p>By March 2006, service users subject to a standard or enhanced Care Programme Approach were to be involved in drawing up their care plan, and were to receive a copy of the care plan (National Service Framework Key Action 32). By March 2010, all service users on an enhanced Care Programme Approach and 90 per cent of all service users on a standard Care Programme Approach were to have an agreed care plan (2009-10 Annual Operating Framework target).</p>	<p>Some of the service users who responded to our survey have not been appropriately involved in care planning and decisions about their care; and our survey indicates that Health Boards are not consistently meeting the Welsh Government targets, with:</p> <ul style="list-style-type: none"> • 58 per cent of service users being told who their care co-ordinator was; • 51 per cent of service users being given or offered a written or printed copy of their care plan; • 51 per cent of service users saying they 'definitely' understood what was in their care plan; and • 23 per cent of service users saying they were not involved in deciding what was in their care plan.
<p>By March 2007, local authorities and LHBs were to produce local whole system models (National Service Framework Key Action 17).</p>	<p>Four LHBs (Gwynedd, Monmouthshire, Newport, and Powys) stated that they had not agreed a whole system service model.</p>
<p>By October 2006, local authorities and LHBs were to develop local plans in response to the national action plan (National Service Framework Key Action 16).</p>	<p>All LHBs produced local plans and these were reviewed by the Welsh Government.</p>

Target	Summary of performance
<p>By March 2007, LHBs/NHS Trusts were to undertake a systematic review of the National Institute of Clinical Excellence's guidelines and technical appraisals and develop a local incremental implementation plan (National Service Framework Key Action 33).</p>	<p>Our survey of NHS Trusts revealed that:</p> <ul style="list-style-type: none"> only one NHS Trust had audited all the relevant guidelines and technical appraisals to determine if they had been fully implemented, with most other trusts stating that they had reviewed the guidelines in only some areas; and only two NHS Trusts had draft plans in place for the incremental implementation of the Institute's guidelines, although the plans had not been agreed and implementation had not started.
<p>By March 2008, local authorities and LHBs were to have detailed mental health workforce strategies and plans (National Service Framework Key Action 42).</p>	<p>Only 12 LHBs reported to us having a mental health workforce strategy and plan.</p>
<p>By March 2006, local authorities and LHBs were to include service user and carer representatives on all relevant local strategic planning groups (National Service Framework Key Action 7).</p>	<p>Six LHBs reported to us that service users were not on all strategic planning groups, and seven that carers were not on all strategic planning groups.</p>
<p>By March 2007, local authorities and LHBs were to undertake local audits using 'Stronger in Partnership' (National Service Framework Key Action 7).</p>	<p>Only 11 LHBs confirmed that they had undertaken an audit using 'Stronger in Partnership'.</p>
<p>By March 2008, local authorities and LHBs were to include service users in staff recruitment and service quality monitoring (National Service Framework Key Action 7).</p>	<p>Eighteen LHBs confirmed that service users were included in staff recruitment processes, and 15 that service users were involved in monitoring the quality of services.</p>
<p>By March 2008, local authorities and LHBs were to have service user and carer development workers or equivalent in place (National Service Framework Key Action 7).</p>	<p>Four LHBs (Blaenau Gwent, Caerphilly, Powys, and Torfaen) reported not having a service user and carer development worker or equivalent in place.</p>
<p>Services, whether inpatient or community based, need to provide therapeutic care. To improve therapeutic outcomes on mental health wards, the Tidal or Re-focusing model of care (or other model if specifically approved by the Welsh Government) was to be implemented by March 2006. (National Service Framework Key Action 21, and 2005-06 Service and Financial Framework target.)</p>	<p>Four NHS trusts confirmed that the Tidal or Re-focusing model of care covered all inpatient wards, but a further four NHS trusts (Abertawe Bro Morgannwg University, Cardiff and Vale, Cwm Taf, and Powys) stated that only some wards or units had implemented such a model of care.</p>



Appendix 3 – Mental Health (Wales) Measure 2010

Against each objective in the Mental Health (Wales) Measure 2010, we have summarised the current position within adult mental health services, giving an indication of what will need to change to ensure full implementation.

Objective in the Measure	Summary of current position
<p>To provide assessment of an individual's mental health and, where appropriate, provide treatment of an individual's mental disorder within primary care, by establishing a duty for Health Boards and local authorities to deliver primary mental health support services across Wales.</p>	<p>Undertaking assessment within primary care – all areas now report having gateway workers or a similar service in place for undertaking assessments, however in four LHB areas this service did not cover the whole adult population, and in others the service is poorly resourced.</p> <p>Providing short-term interventions and treatment – one NHS trust stated that gateway workers did not provide short-term interventions. Four NHS trusts stated that all gateway workers provided counselling/talking therapies, and three that some gateway workers provided these interventions. Structured counselling was reported by LHBs to be available in all GP practices in 12 areas, in 'most' practices in three areas, in 'some' practices in five areas, in a few practices in one area, and not available in the final area.</p> <p>Provision of information – information for service users, such as service directories, are not consistently kept up to date in some parts of Wales (11 LHBs reported that their service directory was out of date).</p> <p>Support and advice to GPs and other primary care workers – in our survey of general practices 45 per cent of practices stated that they needed more advice and support from adult mental health services, with this being rated as the joint second highest service development priority by general practices.</p>
<p>To institute statutory requirements around care and treatment planning and care co-ordination within secondary mental health services.</p>	<p>All service users assessed as requiring care and treatment within secondary mental health services will have a care and treatment plan – our survey of service users (all of whom were receiving secondary mental health services) identified that only 51 per cent had been given or offered a written care plan.</p> <p>Each care and treatment plan will be developed by a care coordinator in consultation with the service user and mental health service providers – only 58 per cent of service users knew who their care co-ordinator was, and 23 per cent of service users said they were not involved in deciding what was in their care plan.</p> <p>Each care and treatment plan will be kept under review and may be updated to reflect any changes in the type of care and treatment which may be required by the service user over time – 42 per cent of service users reported that that they had not been involved in a care plan review in the previous 12 months.</p>

Objective in the Measure	Summary of current position
<p>To require that secondary mental health services have in place arrangements to ensure the provision of timely access to assessment for previous service users</p>	<p>This is a new arrangement, currently there are variable waiting times for assessment, and there is no process to ensure timely assessment and intervention for someone who has previously been discharged from caseloads.</p>
<p>To extend the group of 'qualifying patients' under the Mental Health Act 1983 entitled to receive support from an Independent Mental Health Advocate (IMHA), so that all patients subject to the formal powers of that Act are able to receive IMHA support if required; and to enable all patients receiving care and treatment for mental disorder in hospital to have access to independent and professional specialist mental health advocacy.</p>	<p>All NHS Trusts reported in 2009 that statutory advocacy was available on all wards. However, there has been more variable progress with non-statutory advocacy on wards. Two NHS Trusts did not have any provision, and one NHS Trust had partial provision across some wards. The remaining five NHS Trusts had non-statutory advocacy across all wards.</p>

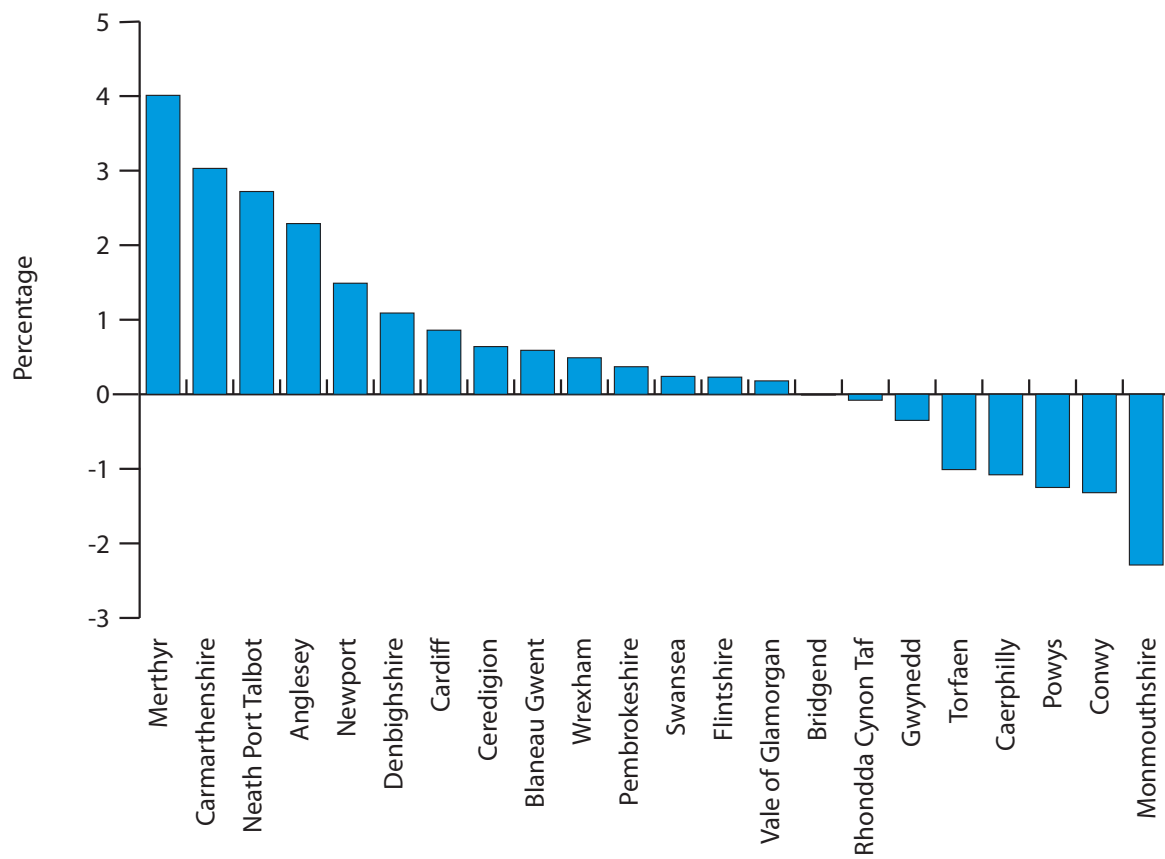


Appendix 4 – Mental health expenditure patterns

Local Health Board expenditure

- 1 We compared programme budget data on LHB and Health Commission Wales expenditure on mental health between 2005-06 and 2008-09. Programme budget data summarises expenditure into a range of service or 'programme' areas.
- 2 LHB mental health programme expenditure covers primary care prescribing costs, secondary care services including those provided by NHS trusts, and continuing NHS healthcare costs. The data is categorised by age group, covering children and adolescents, adults, and older people. As up to 20 per cent of expenditure has not been allocated to an age group, but categorised as 'other mental health services' we have analysed the total expenditure on mental health services across all age categories.
- 3 Mental health expenditure by Health Commission Wales covers specialised services, such as placements into secure facilities, and typically this involves relatively low volume but high cost cases. As part of the programme budget data, Health Commission Wales expenditure is summarised by LHB area.
- 4 We found that between 2005-06 and 2008-09 total mental health expenditure across LHBs and Health Commission Wales increased in cash terms by 18.6 per cent, and by 6.7 per cent when taking account of inflation.
- 5 Over this period, expenditure by LHBs on mental health across Wales increased in cash terms by 23.1 per cent, and by 10.1 per cent when taking account of inflation. The following analysis relates to LHB expenditure alone, and excludes Health Commission Wales spend.
- 6 There has been significant variation between LHBs, with expenditure in cash terms falling in one area and real terms expenditure falling in five LHBs. Increases in cash expenditure across the remaining 20 LHBs varied between 2.3 per cent and 57.8 per cent.
- 7 In some LHBs, expenditure on mental health services has not increased to the same extent as expenditure on some other service areas. Across Wales, the proportion of LHB programme budget expenditure that has gone on mental health services has shown an increase from 11.7 per cent in 2005-06 to 12.2 per cent in 2008-09. However, there is significant variation between areas, with eight of the 22 LHBs experiencing a reduction (Table 1).

Table 1 – Change in LHB mental health expenditure as a percentage of total programme budget expenditure (2005-06 to 2008-09)



Source: NHS programme budget data, Stats Wales



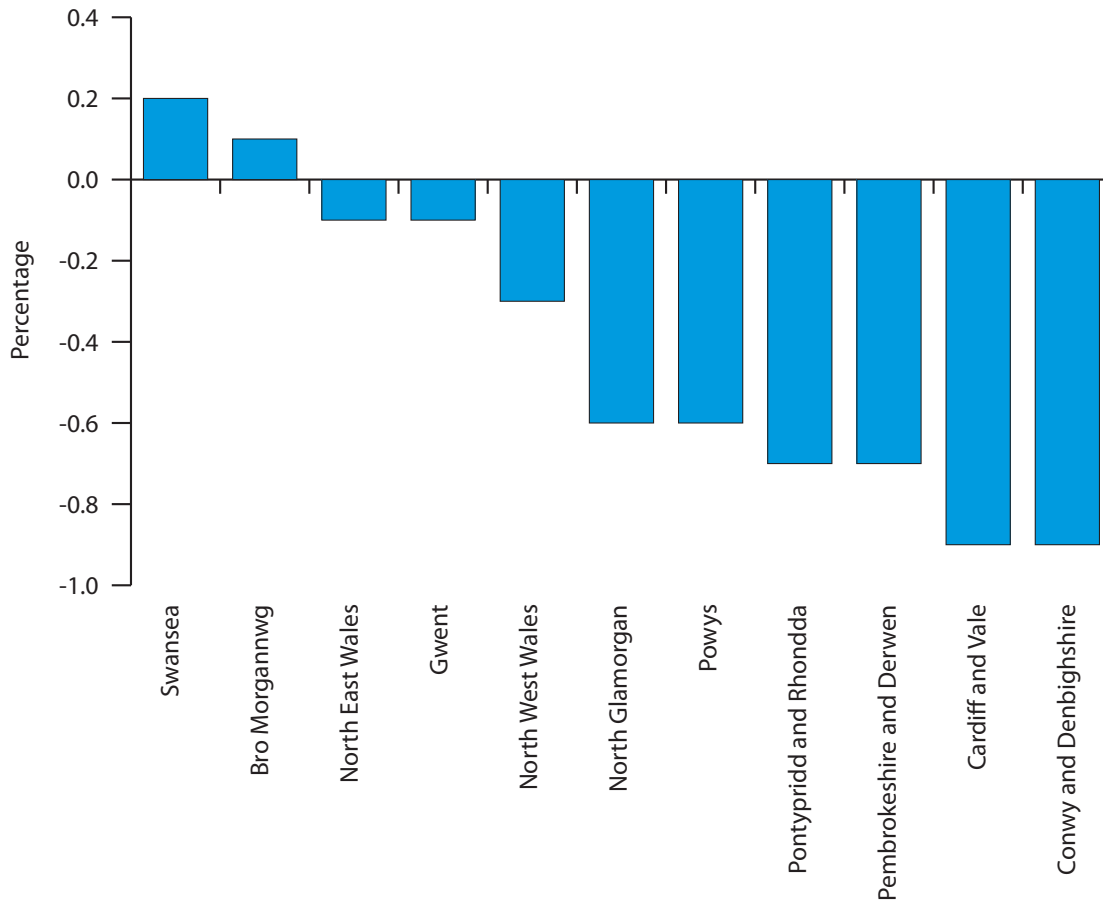
NHS Trust expenditure

- 8 We also examined NHS Trust expenditure on adult mental health. This covers a narrower range of services and excludes primary care and Continuing NHS Healthcare costs. We found that across Wales, expenditure in cash terms increased by 9.2 per cent between 2005-06 and 2008-09, but decreased by 1.4 per cent when taking inflation into account. Again, we found a lot of variation between areas, with cash expenditure falling in one NHS Trust and with real terms expenditure falling by between one per cent and 13.6 per cent in six of the 11 NHS Trusts. The increase in cash expenditure in the remaining NHS trusts varied between 3.5 per cent and 20.8 per cent.
- 9 In many parts of Wales, NHS Trust expenditure on adult mental health services does not appear to have increased to the same extent as expenditure on some other service areas. Across Wales, adult mental health expenditure as a proportion of total NHS Trust expenditure has fallen from 6.7 per cent in 2005-06 to 6.4 per cent in 2008-09.
- 10 There has also been a decline in the proportion of NHS Trust expenditure spent on all mental health services (ie, covering children, adults, and older people), from 11.6 per cent in 2005-06, to 11.2 per cent in 2008-09. Nine of the 11 NHS Trusts experienced a fall in adult mental health expenditure as a proportion of total NHS Trust expenditure (Table 2).

Social service expenditure

- 11 Changes to social service net expenditure on adult mental health have also been highly variable. Between 2005-06 and 2008-09, net expenditure on adult mental health by social services across Wales increased by 20.5 per cent in cash terms, and by 8.2 per cent in real terms. However, net expenditure on adult mental health decreased in four councils, and in real terms decreased in seven councils. In the remaining council areas cash expenditure increased by between 8.8 per cent and 104.8 per cent.
- 12 Across Wales, social service net expenditure on adult mental health services as a proportion of total social service expenditure has increased from 4.6 per cent in 2005-06 to 4.8 per cent in 2008-09. However, over the period the proportion fell in nine of the 22 councils (Table 3).

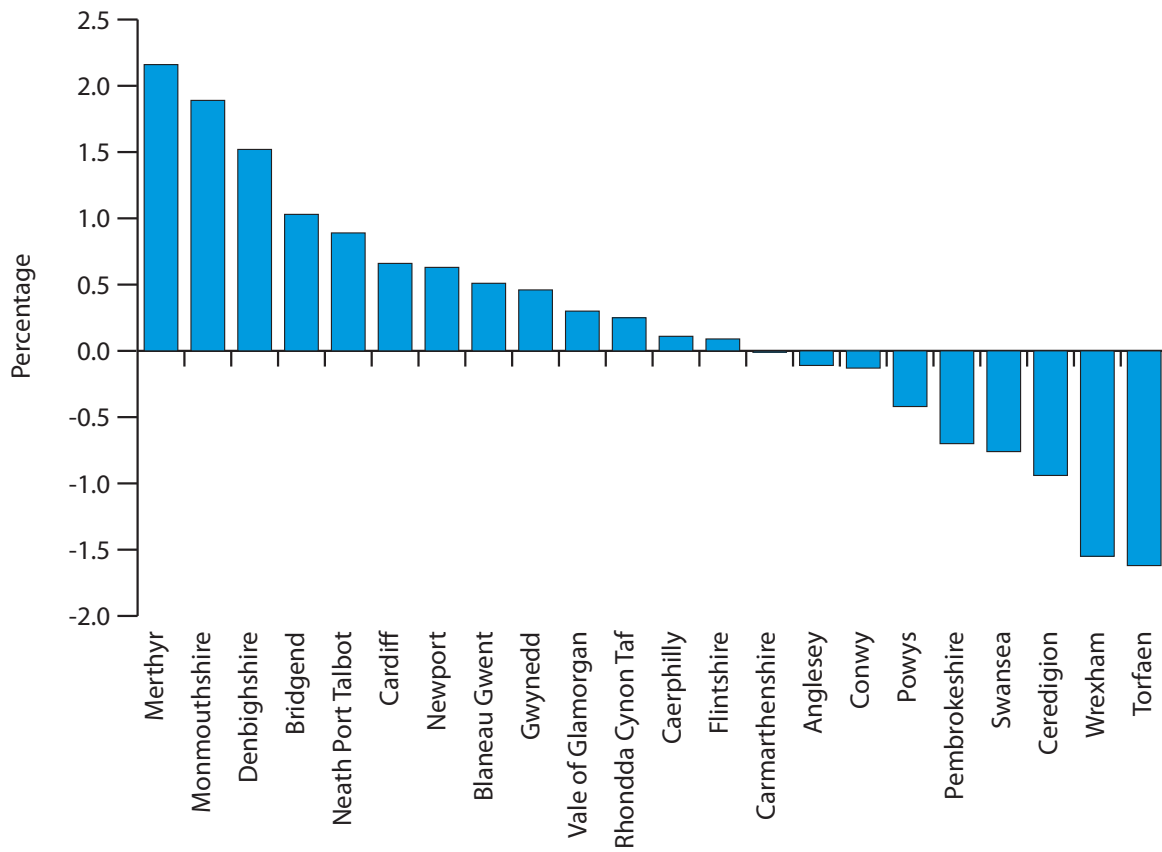
Table 2 – Change in adult mental health expenditure as a percentage of total Trust expenditure (2005-06 to 2008-09)



Source: NHS Trust financial returns 2005-06 to 2008-09



Table 3 – Change in social service net adult mental health expenditure as a percentage of total expenditure (2005-06 to 2008-09)



Source: Local Government Finance Statistics, Welsh Government

