CARING FOR PEOPLE, KEEPING PEOPLE WELL

A PERSON'S CHANCE OF LEADING A HEALTHY LIFE IS THE SAME WHEREVER THEY LIVE AND WHOEVER THEY ARE

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INTEGRATED MEDIUM TERM PLAN 2019-22
MENTAL HEALTH CLINICAL BOARD

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Cardiff and Vale University Health Board

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INTRODUCTION

A1. BACKGROUND

Key Drivers:

- All Wales strategy 'Together for Mental Health' has a 3 year cycle of delivery plans with each delivery plan having themed priorities up until 2022. The current delivery plan reinforces the importance of current areas of Welsh Government investment in mental health services, targeting services such as **Camhs** and **First Episode Psychosis**, **EU Liaison** and **Out of Hours Services**, **Substance Misuse, Trauma Informed Care** and the delivery of **Psychological Therapies** supported through the impending MATRICS Cymru all Wales Psychological Therapies delivery framework.
- Social Services Wellbeing Act came into force in April 2016 aiming to promote independence, give greater control, provide more information and focus on prevention and early intervention.
- A Welsh Government Dementia strategy is now published to support the refresh of the Cardiff and Vale 3 year dementia plan and a revision of the commissioning and delivery arrangements for the Cardiff and Vale service collaborative. The focus of the new strategy is the '**Team around the individual'**.
- Additional funding has been seen this year and ongoing under the '**GP Sustainability'** program of work in **primary mental health liaison** services where the 'home first' and prevention agenda are key strategic aims to promote collaborative working with mild to moderate mental health conditions, preventing dependency on specialist services. The last 5 years of service plans in mental health has supported this agenda, with a record of moving inpatient resources to community service investment. This plan will continue in the forthcoming 2018/19/20 periods.
- Benchmarking results UK wide in Mental Health will influence plans for Mental Health services for **Older People's bed numbers** as well as supporting whole system community services reviews. Related objectives include reducing waiting times, simplifying access, managing demand, delivering psychological based interventions appropriately and monitoring health improvements in service users more effectively

Headline Achievements for the 17/18 period

All developments for last year as well as the forthcoming period are collaborative ones, involving one or all partners in major change. This includes other clinical boards, the Local Authority, police, ambulance and third sector agencies. This IMTP period speaks on behalf of the enthusiasm of all services to work across boundaries in the interest of service user's outcomes. To date,

through transformation, mental health is now supporting a 4 fold increase in referrals of people seeking support from their GP and a40% bed reduction in10 years with the same numbers of staff.

- Successful completion of a collaborative pilot in Cardiff East of Mental Health Practitioners working as extended specialist e support to GPs, for people with mild to moderate mental health problems. This is supported by bespoke commissioned third sector psychologically based service. The pilot has evaluated well in reducing demand and improving the quality of primary care mental health services and is now received support for all elements of the model to be scaled up across Cardiff and Vale. This is potentially a revolution in mental health support to meet ever increasing demands on GPs. This work is attracting the attention of the Welsh NHS mental health services with the Primary Care Workers being asked to attend National Conferences to explain this model.
- Following an extensive engagement exercise with the community health council and others, 2019 saw the co-location of the three Vale Community Mental Health Teams, as a step towards the establishment of health and well being centres described in Shaping Our Future and Well Being Strategy. The teams are now functioning as one with efficiencies seen in managing demand, liaising more easily with related health and other agencies and seeing professionals working differently and more focussed on service user outcomes and needs.
- The MHCB submitted successful costed plans against available Welsh Government recurrent funding in the areas of its strategic direction. Particularly in the areas of First Episode Psychosis (pre-empting the Camhs repatriation), substance misuse dual diagnosis, psychological therapies and Matrics Cymry. In addition Peer Support Workers as part of a recovery college, the enhancing of EU cover, investing in specialist support to the CRTs to enhance the 'team around the individual' described in the dementia strategy and avoid unnecessary admissions to UHB beds will all benefit from additional funding. All additional monies are focussed on the principles of 'Home First, reducing hospital delays, improving access to psychological support and adding capacity to pressured specialist teams and supporting the integration agenda..
- Another example of co-location with the Local Authority and third sector has been our tier two MHSOP day care services – October 2019 saw the move of Turnbull day unit base to Grand Avenue to refurbished premises. This is based on the understanding that once a health crisis is resolved, people have health and social care needs as part of their ongoing assessment and treatment and respite for families
- With the increased exposure of mental health in the media and society, and the growing value of Psychological Therapies in the context of delivering collaborative bio-psychosocial model care over a traditional disease model, the Welsh Government have introduced a further non-tier 1 target into UHB Mental Health services. This is a 26 week 'Referral To Treatment' target for the commencement of a psychological intervention. This is welcomed and initial submissions reveal that C&V has up to

3000 people at any one time awaiting a formal Psychological Intervention with approximately 70% of those receiving this within the 26 week waiting time. This performance compares very well to the progress in other UHBs where numbers are as low as 10s and 100s.

- C&V Mental Health staff are increasingly finding themselves supporting national work streams such as outcome measures, the WCCIS All Wales electronic patient record, developing a Psychological Therapy framework and leading innovative practice. 2018 has seen a number of C&V MH staff presenting on a national stage.
- As mental health issues enjoy a higher profile, the capacity to outreach with ever diverse liaison services beyond the traditional mental health setting is expanding with recent collaborative plans with the police and ambulance service call centres coming to fruition.

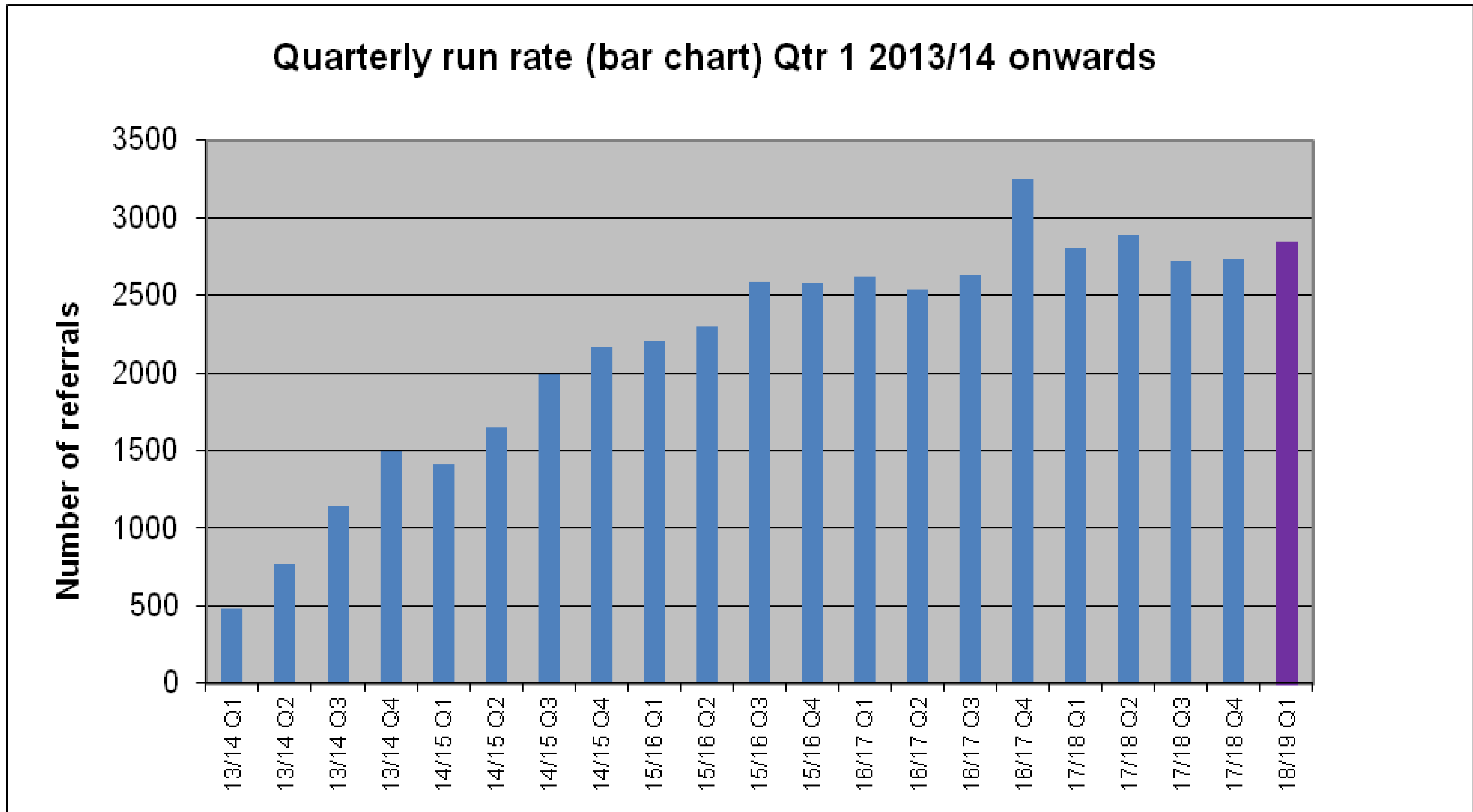
A2. CLINICAL BOARD PERFORMANCE OVERVIEW

2.1 High level - Mental Health Specific for WG Reporting see *

Key Performance Indicator – WG Reported	**Clinical Board Performance**	**Peer Benchmark**	**Planned Action – high level description**
Mental Health Measures Parts 1 to 4 *	Parts 1, 3 & 4 all compliant this year against a profile of increasing demand Part 2 Care and Treatment plans has seen a small but ongoing breach in compliance	**See fig 1 – for Part 1 popularity increased awareness to seek help for MH issues** CTP quality a typical picture across Wales.	Draft Action Plan against the Delivery Unit (DU) report prepared and reporting into the MHLC for progress and monitoring. To undertake internal re-audits using the DU assessment tool with their permission. Compliance gradually improving but recognised that care coordination by medical staff requires further thought for service users who do not meet 'relevant patient' status. This will improve compliance further and add to both quality and new ways of working.
First Episode Psychosis per 100,000 pop *	Referrals - 27 , Caseloads – 24 Contacts – 15	Mean – 80 Mean – 66 Mean – 34	Investment from WG 370K to increase the capacity and MDT function of the team – anticipated to meet mean average performance across all measures by the end of 2019

	Staff – 2.4	Mean - 7.2	
MHSOP Bed Numbers per 100,000 of the population	83.3 - 3rd highest reported in UK and 2nd highest reported in Wales	Mean average 42.4	Whole system re-design, planned and currently awaiting the appointment of a project/clinical lead to look at all aspects of MHSOP patient flow with a view to reducing bed numbers further to within benchmark upper parameters.
MHSOP ALOS both excluding and including leave	130 days excluding and including leave	Mean average 74 days excluding leave and 78.2 days including leave	Of particular concern considering the existence of a crisis and home treatment resource locally. Again awaiting project/clinical lead post to review all aspects of patient flow with a view to reducing ALOS to within upper quartile parameters over 18 months and subsequent bed closures – 78 bed days excluding leave
Incidents of Physical Violence against Staff per 100,000 occupied bed days and community contacts	361 – highest reported in Wales	Mean average 207	C&V currently the only MH service in Wales to undertake face up restraint as per best practice with a positive approach to high reporting culture. De-escalation breakaway training available to all in patient and community staff To review hotspots and themes from staff aggression incidents to assess areas requiring more development if required Compare C&V with other inner city organizations for greater benchmarking relevance
Serious Incidents per 100,000 occupied bed days and community contacts	46	Mean average 24	See suicide and self harm action plan (Number 4 in service change proposals) Complete local thematic review of serious incidents following identification the importance of post discharge contact within an identified period of time Continue to promote high reporting culture Compare C&V with other inner city services for greater benchmarking relevance
Complaints per 100,000 occupied bed days	89	Mean average - 64	Compare C&V with other inner city services for greater benchmarking relevance Continue to promote high reporting culture Continue with thematic reviews periodically with a plan to promote and provide training on the themes of complaints emerging – staff attitude being one theme.

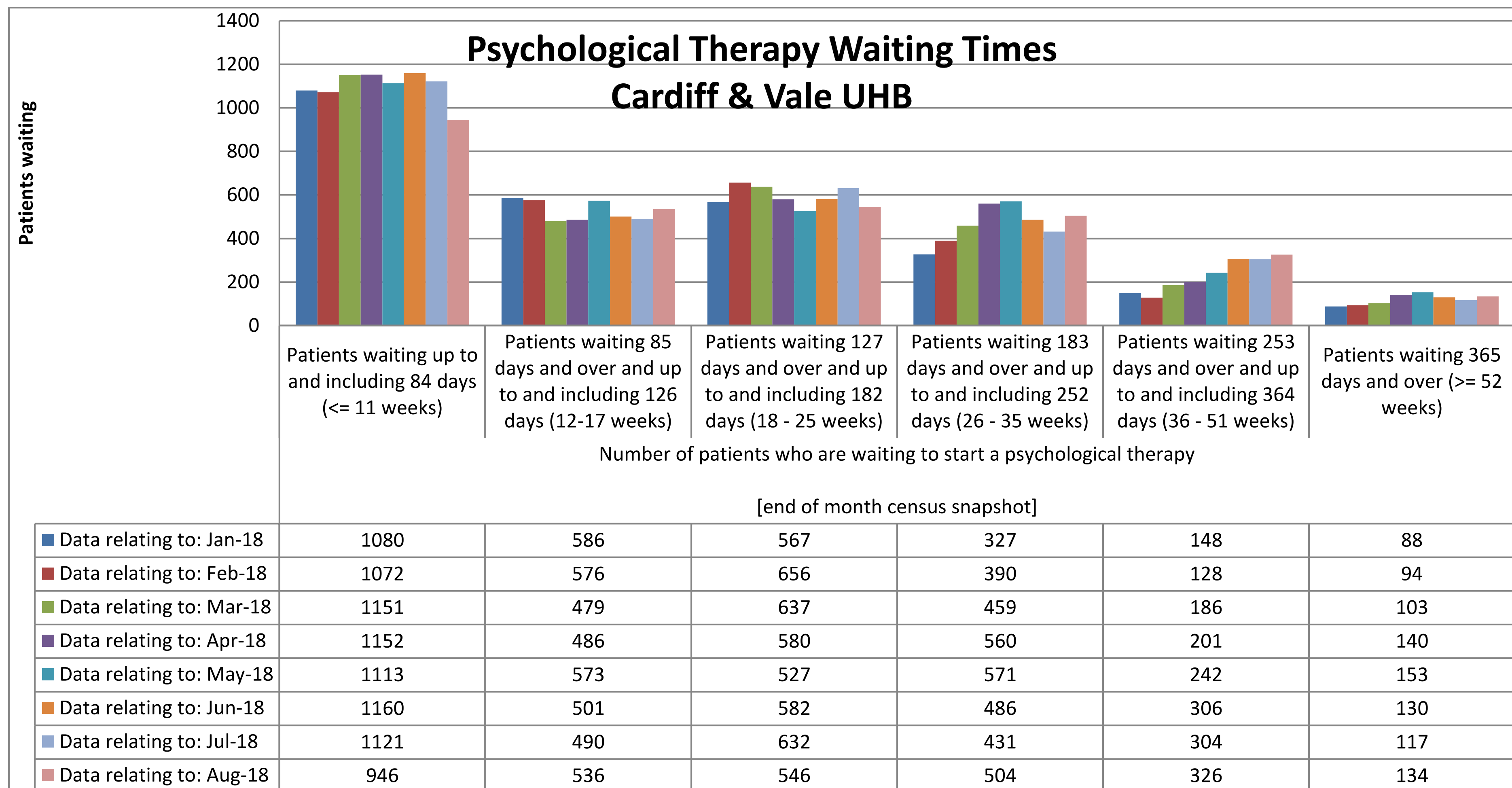
Fig 1 – Increase in PMHSS Referrals since commencement



2.2 High level clinical and service efficiency

Key Performance Indicator – WG Reported*	**Clinical Board Performance**	**Peer Benchmark**	**Planned Action- high level description**
Access to Psychological interventions *	New RTT **– See figure 2** for commencement of a recognised psychological therapy of 26 weeks this year for MH services.	**Shared information across Wales indicates C&V is very productive** with Circa 3000 waiting and approx 70% receiving within the 26 weeks.	C&V is offering double the number of its nearest UHB with more investment due. Investment as part of the 2019/20 WG innovation fund will be targeted at long waiting lists, increasing the capacity of the PTs hub and offering additional psychology support to mother and baby services, eating disorders and MHSOP. The service anticipates compliance by May/June 2019
Crisis Resolution and Home Treatment * Requires 90% of all service users referred as an emergency to be assessed within 4 hours or 24 hours if admitted.	90%+	Various Models across Wales – C&V has a 24 hour model with integrity to the evidence base	Continue with the service delivery – implement actions from a review of MHSOP crisis team
Adult Community Contacts per 100,000 population	21,745 contacts	Mean – 31,139	Community services review attempting to drive down caseloads and increase the delivery of structured psycho-social interventions which may reduce the number but increase the quality of contacts – therefore the appropriateness of a quantitative target is being further considered.
Vacancies	5% Vacancies in Cardiff and Vale	17% Mean average across UK and 3rd best in Wales	C&V Mental Health services continue to attract staff with its diversity of services and specialities as a city and ADP course.
Sickness	5% sickness compared to % last year	Mean average 6% - but aspiring to best practice services of maintaining sickness 5 %	Various initiatives to improve compliance with sickess reductions including: • Easing staffing levels through MHSOP redesign • Improving Ward Manager release time to comply with sickness standards & a bespoke support service for staff

Fig 2 – Psychological Therapy Waiting Times RTT – Demonstrated C&V most productive UHB offering more than double structured PTs than other UHBs



	Patients waiting up to and including 84 days (<= 11 weeks)	Patients waiting 85 days and over and up to and including 126 days (12-17 weeks)	Patients waiting 127 days and over and up to and including 182 days (18 - 25 weeks)	Patients waiting 183 days and over and up to and including 252 days (26 - 35 weeks)	Patients waiting 253 days and over and up to and including 364 days (36 - 51 weeks)	Patients waiting 365 days and over (>= 52 weeks)
Data relating to: Jan-18	1080	586	567	327	148	88
Data relating to: Feb-18	1072	576	656	390	128	94
Data relating to: Mar-18	1151	479	637	459	186	103
Data relating to: Apr-18	1152	486	580	560	201	140
Data relating to: May-18	1113	573	527	571	242	153
Data relating to: Jun-18	1160	501	582	486	306	130
Data relating to: Jul-18	1121	490	632	431	304	117
Data relating to: Aug-18	946	536	546	504	326	134

2.3 High level cost indicators

Key Performance Indicator	Clinical Board Performance	Peer Benchmark	Planned Action - high level description
Adult acute cost per bed	£115,543k	£140,082k mean	Upper quartile performance – maintain
Older adult cost per bed	£129,004k	£140,135k mean	Upper quartile performance – maintain
CMHT cost per patient on caseload	£2,571k	£3,349k mean	Upper quartile performance - continue trajectory
Adult acute bank and agency spend as % of total staff spend	12%	22%	Upper quartile performance - maintain
Continuing Health Care average cost per placement	£94k	£64k (2017/18 national finance agreement assessment)	Further urgent work required to understand differences in service models

A3. Risks and Opportunities

This Plan is dependent on the following:

- Support from the Community Health Council for ongoing Adult Community service change recommendations
- Availability of accommodation for adult community locality model development in the Cardiff localities under shaping our future and well being
- PCIC cluster support for joint investment in primary care based mental health services
- 2017 Local Authority cost saving program and collaboration with community integration plans

In addition to these dependencies, there are a number of risks to the delivery of our plan. These include:

Risk Description	Risk Score	Action to Manage or Mitigate
MHCB Capacity to deliver an MHSOP and Adult services in patient redesign and ongoing	10	Collaborate with Planning and streamline consultation process with agreement of Community Health Council On-going support to the CHC in understanding the Home First community

stakeholder engagement to roll out community locality model for adult services		model Develop project management and clinical leadership support where required for main streams of work
Service User and Carer engagement with the above due to the protracted process	10	Ensure Service Users and Carers, particularly those receiving community based services are kept fully informed of the process for engagement and consultation through local meetings with the clinical board
Local Authority Cost reduction program in 2017 and impact on integrated arrangements and core community functions	10	Accelerate where possible the integrated arrangements within particularly community services to afford the combined resource a degree of protection.
The current investment into Mental health liaison services as well as WG investment is draining the inpatient and core community services of experienced staff, particularly nurses. This is posing both recruitment and experience shortages.	10	Limit internal recruitment to a safe degree and attempt to recruit externally. C&V MHCB current has low vacancies and sickness which will help as a staff baseline.

A4.SUMMARY OF KEY PRIORITIES FOR 2019-22

Clinical Board ambition for 2019/22 is to continue the improvement trajectory we have achieved in 2018/19. Our key deliverables for the year are set in the main document with an outline of key actions in 2019/20 and 2020/21 as appropriate. The high level headlines are summarised in this section.

B.1 POPULATION HEALTH IMPROVEMENTS

Local Mental Health and Wellbeing Needs Analysis

Population Size

The population of Cardiff and Vale of Glamorgan is growing rapidly. Currently, around 493,400 people live in this area and between 2007 and 2017, the number of people increased by 8.9%, more than twice the Wales average of 4.0%. The number of people aged over 85 years has increased by 21.2% between 2007 and 2017[1].

Age and Gender

The city of Cardiff has a skewed population compared to the Vale of Glamorgan because of the large numbers of students and disproportionately fewer older people. In 2017, approximately 18.1% of Cardiff's population was aged 15-24. As a higher proportion of mental disorders develop between the ages of 14 to 20, Cardiff has greater incidence of mental illness. In contrast a fifth of the Vale's population was aged 65+ in 2017, with its greater proportion of older people, the population of the Vale is likely to comprise a higher overall percentage of people with dementia than Cardiff.

Ethnicity

The proportion of people from the black and ethnic minority (BME) community[2] in the Vale of Glamorgan is 4% and is similar to the Wales average at 6%. In Cardiff, however, the proportion stands at 16%[3].

Research shows that the incidence of psychosis is higher in the African Caribbean and Black African populations[4].

Educational Attainment

The percentage of Year 11 school leavers who were known to be not in education, employment or training (NEET) in 2017 in Wales was 7.4%, results are not available at local authority level[5].

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[1] Office of National Statistics (ONS) mid-year population estimates (MYEs), 2007 and 2017

[2] BME defined as all non-white ethnic groups aggregated from KS201EW table (ONS, Census 2011)

[3] Office of National Statistics (ONS) Census 2011, KS201EW.

[4] Morgan et al, First episode psychosis and ethnicity: initial findings from the AESOP study, World Psychiatry, 2006, 5:1, 40-46.

[5] PHOF, 2017

Unemployment

Recent data for the year ending 30th June 2018 suggests 2.8% of Vale of Glamorgan residents and 6.7% of Cardiff residents are classed as unemployed, as compared to the Wales level of 4.8%[6]. Unemployment is linked to poorer mental health.

Housing and Homelessness

The number of households in Cardiff who were deemed to be eligible, unintentionally homeless and in priority need was 669 in 2017/18. In the Vale of Glamorgan this was 120[7]. Statistically, you are more likely to have a mental health condition if you are homeless: 43% of those accessing homelessness projects in England were suffering from a mental illness. There were 92 rough sleepers in Cardiff and zero in the Vale of Glamorgan during 2017/18 [7].

Diagnosis of Mental Illness

According to the GP registers in Cardiff and the Vale as at March 2018, there were 4,622 people with a diagnosis of a serious mental illness.

There were also 3,256 people with a diagnosis of dementia. However, according to the Alzheimer's Society 2014 report, GP data represents only a fraction of people with dementia in the community[8]; therefore under-diagnosis is an issue, despite Cardiff and Vale having the best detection rate in Wales.

Deprivation

Deprivation is associated with poorer mental health outcomes and those with a poorer level of income are more likely to have a common mental illness. Deprivation in the Vale of Glamorgan is largely clustered around Barry and 5.2% of the Vale areas fall into the 10% most deprived areas of Wales. In contrast, areas of deprivation in Cardiff are mainly in the southern arc of the city and

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[6] Annual Population Survey / Local Labour Force Survey: Summary of economic activity, ONS 2018

[7] Info base Cymru, 2017/18. Available from: http://www.infobasecymru.net/IAS/themes/people,communitiesandequalities/housing/tabular?viewId=26&geoId=1&subsetId=

[8] Alzheimer's Society, http://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=1666

17.7% of Cardiff's areas fall into the 10% most deprived in Wales[9]. Cardiff includes some of the least deprived areas of Wales (e.g. in Cyncoed) and some of the most deprived (e.g. in Splott).

Prevalence

According to the National Survey for Wales 2016/17, 7.7% of people in Cardiff and 8.4% in the Vale of Glamorgan reported having a mental illness[10].

This is likely to be an underestimate of the people who have a mental illness as surveys suggest that in England 16% of people have a common mental illness.

In terms of a diagnosis of a serious mental illness (schizophrenia, bipolar disorder and other psychoses), there are 4,622 people on primary care registers with these conditions, which is 0.9% of the total GP list size[11].

A prediction tool, PsyMaptic has calculated that, in Cardiff and the Vale, we would expect to find 61 new cases of psychosis per annum, between the ages of 16-64[12].

In 2018, there are 3,256 people with a diagnosis of dementia on GP registers in Cardiff and Vale.

Service usage

Benchmarking data shows that the Adult Community Mental Health Team caseload per 10,000 weighted populations is 147 within Cardiff and Vale, which is similar to NHS Benchmarking data of 140. Within this service, there are 252 contacts per whole time equivalent, compared to 240 across the UK.

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[9] This is taken from the results of the Welsh Index of Multiple Deprivation 2016.

[10] National Survey for Wales 2016/17

[11] Quality and Outcomes Framework, 2018, WG https://www.gpcontract.co.uk/browse/262/Dementia/16

[12] Psymaptic, http://www.psymaptic.org/prediction/psychosis-incidence-map/

The numbers of admissions per 100,000 populations are 245 in Cardiff and Vale, compared to 234 across UK benchmarking data. Bed occupancy in Cardiff and Vale is 115%, whereas across the UK it is 91% on average.

Suicide

During the period 2012-2016, European age-standardised rates (EASRs) (aged 10+) in Cardiff and Vale ranged from 13.6 per 100,000 in the Vale of Glamorgan to 12.3 per 100,000 in Cardiff, similar to the Wales rate of 12.5 per 100,000 persons[13].

B. KEY DELIVERY PRIORITIES 2019-22

5.1 Addressing Health Inequalities The key Public Health Actions for the UHB are described here:

1. ACTIONS TO REDUCE HEALTH INEQUALITIES – PUBLIC HEALTH		
Priority area and action	**Outcome**	**Outcome / Measure**
5.1.1 Tobacco - (contact: Trina Nealon, - trina.nealon@wales.nhs.uk) Record smoking status of out-patients, and in-patients on admission (or booking) and refer all smokers admitted to hospital to the UHB's in-house smoking cessation service, or	Review the pilot in MH inpatients following 9months of a smoking ban based on the provision of NRT alternatives and smoking cessation support – balance long term health risks against risks related to in-patient ignition sources.	Reduce smoking prevalence – in at least 50% of in patient areas Number of people referred to in-house smoking cessation per quarter (by CB)Proportion of out-patients and in-patients who have smoking status recorded electronically Retain the smoking ban in all areas of

<table>
<tr><td>record offer declined</td><td></td><td>mental health that are possible following pilot review – target 50% of in-patients wards</td></tr>
<tr><td>5.1.2

Immunisations (contact: Lorna Bennett, lorna.bennett2@wales.nhs.uk

Promote and support Flu Champions and Flu Leads</td><td>Provide active and visible senior leadership to the campaign within your CB

Regularly review uptake and actions described on weekly staff flu profile</td><td>Achieve >60% uptake of seasonal flu vaccine among staff with patient contact

% uptake of flu vaccine among staff in ‘frontline’ ESR groups</td></tr>
<tr><td>5.1.3

Healthy weight - (contact: Dr Suzanne Wood, suzanne.wood@wales.nhs.uk)</td><td>• Develop a robust action plan to tackle obesity, to include:
  ○ raising the issue through MECC
  ○ routine weighing/measuring, with BMI recorded electronically
  ○ discussion and signposting of all individuals identified as being obese, with these actions recorded electronically
• Optimise the adult Level 3 obesity services to reduce waiting time
Implement the obesity pathway for pregnant women</td><td>Reduce prevalence of obesity among residents

% staff trained in level 1 MECC

% of outpatient areas recording BMI routinely

% of obese patients where there has been a conversation about weight, and this has been recorded electronically</td></tr>
<tr><td>5.1.4

Alcohol

(contact: Cheryl Williams, cheryl.williams9@wales.nhs.uk</td><td>Offer clinical staff training in alcohol brief interventions (ABI)</td><td>Reduce alcohol-related admissions

Alcohol-related admissions

Number of staff trained in ABI</td></tr>
</table>

5.1.5 Making Every Contact Count (contact: Dr Siân Griffiths, sian.griffiths6@wales.nhs.uk)	Develop and implement a plan for embedding health improvement/prevention within the work of at least one clinical team (to include 'Making Every Contact Count'), using the employment cycle as a framework for identifying opportunities to support staff development i.e at recruitment, induction and as part of PADR Staff in relevant clinical areas to undertake MECC level 1 e-learning via ESR	Support clinical teams to routinely offer brief health improvement support and advice Number of staff trained in MECC
5.1.6 Dementia (contact: Dr Suzanne Wood, suzanne.wood@wales.nhs.uk	Ensure frontline staff undertake mandatory dementia awareness training Roll out 'read about me' person-centred tool for dementia in clinical areas	Improve care for people with dementia Dementia care bundle indicators
2. ACTIONS TO REDUCE HEALTH INEQUALITIES		
5.1.7 To measure cultural awareness and fitness for purpose through BME accreditation program with Diverse Cymru	Research supports that Black and ethnic minorities have a poorer experience of Mental Health services, with higher rates of emergency admissions, poor engagement with educational approaches, longer lengths of stay in hospital and higher rates of restraint.	Achieve accreditation against policy, information and service standards to commence in November 18 over an 18 month to 2 year period
5.1.8 Review the provision of self help literature in languages other than English and commission further translations as appropriate.	Greater availability of self help resources in a wide range of languages.	Number of languages supported by self help literature – at least 5 common languages to C&V
5.1.9 Provide professional guidance and advice across the UHB to support the commissioning of psychologists and	Assurance that governance issues relating to the delivery of psychological services is of a high standard.	Ongoing dialogue and support through the UHB Psychological Therapies Management Committee (PTMC)

2. ACTIONS TO REDUCE HEALTH INEQUALITIES		
psychological therapists in non mental health clinical settings.		
5.1.10 The WG IS to pilot its new national outcomes framework for mental health within volunteer Welsh UHBs	C&V UHB MHCB has been an early volunteer and agreed a pilot in the transforming Vale of Glamorgan community services as part of the Well Being Hub for the Health Board The outcome framework will focus practitioners clinically on the areas that service users aimto improve areas of their lives, including those which the mental health services need to support.	To engage with and undertake the outcomes pilot in the first half of 2019. For all service users to have at least one outcome measure as part of their therapeutic recovery I the pilot areas after 12 months. To see allied improvements in health and well being measurable scores
5.1.11 Upscale and roll out across Cardiff and Vale the Primary Care Liaison Mental Health model piloted successfully in Cardiff East. The model includes bespoke third sector support to the model.	This mental health practitioner model providing mild to moderate mental health first aid and signposting as a augmentation of the GPs work - supported by a third sector psychological support service based on the Australian CCI model has been supportive in the GP sustainability program of work, reducing GP demand, improvements in psychological wellbeing (core 10 results) and reducing activity and referrals into other primary care and secondary mental health services. To deliver the model across C&V according to the business plan.	To achieve the same profile of qualitative and quantitative benefits as the pilot project for each cluster following implementation: • Adhere to the project timescales • Reduce GP demand by at least 5% • Significant Core 10 results on well being • Reduce CMHT referrals 40-50% • Reduce PMHSS referrals between 80-90% • Reduce PCC referrals by 10-15%
5.1.12 Extend cover of Mental Health	- Improved timely access to MH services for EU patients	- Decrease in waiting times for MH assessment and treatment for EU patients

2. ACTIONS TO REDUCE HEALTH INEQUALITIES		
Services in the EU through innovation fund in MH to improve access to MH services there and reduce likelihood of breaches.		– 100% under 12 hours - Increase in EU liaison psychiatry service establishment by X1WTE Band 7

5.2 Prevention Priorities

5. PREVENTION PRIORITIES		
ACTION	OUTCOME	MEASURE
5.2.1 Enhance the provision of Tier Zero interventions in collaboration with the 3rd Sector. Redesign and implement a revised stepiau.org website.	Building on the successful implementation of the open access didactic courses “Stress Control” and “Action for Living” by increasing the number of courses provided and by utilising larger venues to increase the number of course places available. Refresh the existing website to provide a more modern and engaging user interface. Increase the use of multimedia content, providing more video based materials to complement the existing text based self help literature.	Increase in the number of Cardiff & Vale Residents attending these interventions sufficiently to ensure at least 70% of UHB MHCB referrals meet caseness and are appropriate.. Increased visits to site and greater use of available resource. Tracking and site usage analytics will provide this information. It is possible to compare this with current data held on existing usage. To increase by 25%in 12 months

5. PREVENTION PRIORITIES		
ACTION	OUTCOME	MEASURE
5.2.2 Expansion of First Episode Psychosis services for adolescents and young adults through WG MH Innovations fund to support from age of transition.	- Improved timely access to MH services for primary care and CAMHS patients Coalesce and strengthen services for this age group with associated collaborative management and leadership – MH based Integrated Autism and Neuro-developmental Participate in CAMHS repatriation project Strengthen Operational links between CAMHS and Adult Mental health service	Reduction in Duration of Untreated Psychosis – to less than 3 months by December 2019 Increase in early intervention service establishment as per costed plan from Innovation and Transformation WG MH fundingby July 19- Adult MH adherence to tier 1 targets in relation to the development Care and Treatment Plans for patients – 90%
5.2.3 Design psychologically focussed care in adult mental health community services	Clear pathways for treatment and support of people with emotional dysregulation and deliberate self-harm Collaborative development of group based and individual PIs Workforce redesign to increase the availability of Matrics Cymru compliant psychological therapists	Established Psychological Therapy Pathway with referal criteria by June 2019. Emotional Regulation groups in operation in all localities delivered collaboratively The development of new roles for high intensity psychological therapists within adult CMHTs – one per locality

5. PREVENTION PRIORITIES		
ACTION	OUTCOME	MEASURE
		Compliance with the 26week PT waiting time target by October 2019
5.2.4 Develop an Interdisciplinary Neuropsychiatry In-reach/ Outreach Service Model: To develop and present to WHSSC a model that complements and expands the current multi-disciplinary neuropsychiatry service. The team will have an “All Wales” remit, providing assessment, advice, joint working and training to support specialist and non-specialist rehabilitation providers in appropriately managing those in their care presenting with neuropsychiatric sequelae of brain injury. The case will need to be approved and funded by by WHSSC, and will support recent developments within neuro rehabilitation services	Facilitate discharge from inpatient units and avoid re-admissions. Admissions to neuropsychiatry and inpatient complexity may alter as a consequence of specialist neuropsychiatry intervention being delivered within locality hospitals or community settings. Provide timely specialist email and telephone advice and support to other health boards and care providers. Wider geographical specialist medical cover, closer working with trauma and neuro services and consistent medical cover throughout the service Improved education for care placements will result in improved patient experience and reduced admissions to inpatient services, with increased support to avoid placements breaking down. Improved medical trauma care has meant that the acuity of patients arriving in the	Enhanced discharge support, to reduce the average delays from 4 per month to 1 by July19 More patients seen across Wales, and closer to home. To increase spread from current average of 81% of referrals being from Cardiff and Vale, Aneurin Bevan and Abertawe Bro Morgannwg Health Boards. Reduced number of inappropriate referrals (identified at referral meeting stage) to 30% by year end Improved relationships with Placement providers, working together on discharge planning Improved relationships with other Health Boards. Potential income generation, if suitable step down placements are developed

5. PREVENTION PRIORITIES		
ACTION	OUTCOME	MEASURE
	Neuropsychiatry service has increased considerably over the last few years. With Cardiff and Vale UHB becoming the major Trauma Centre, we will need to adapt our Neuropsychiatry service to work closer with neuro rehabilitation and neurosurgical units, to effectively manage a smooth flow of patients through the system.	and beds are reduced. This could be in the region of £11k per month.
5.2.5 **Band 7 nurse with specialist knowledge of dementia and functional illness to work within the UHB 'team around the individual'** Working to a Community RAID model of consultation and advice to manage an individual's holistic needs as part of the community, without the need for costly secondary care and CMHT caseloads the post would integrate mental health expertise into existing services, providing advice and support, signposting and rapid assessment and intervention. The post holder will provide support	A Band 7 nurse funded from 2018/19 transformational funding will provide specialist knowledge of dementia and functional illness to work with the cluster-based 'team around the individual' to bridge the gap between Primary Care and Secondary MH services. The directorate will look to expand this to include a further Band 7 post from existing establishments and community reinvestment. The posts will integrate mental health expertise into existing services, providing advice and support, signposting and rapid assessment and intervention; offering assessments individually or with the referrer. There will be enhanced integration between	Reduced number of inpatient admissions by 5-10%, from current 216 per annum, bringing the directorate closer to the peer benchmarked mean total of 188. Reduced number of re-admissions into MHSOP inpatient beds from an average of 11%, thereby making best use of specialist beds. Service user and carer feedback (plaudits & complaints include) Improvements in working relationships between Mental Health and Primary Care services. Improved quality of life for service users and carers.

5. PREVENTION PRIORITIES		
ACTION	OUTCOME	MEASURE
and education to carers, directly or through signposting to appropriate services and teams, around behaviour management and positive approaches to care for people with dementia, to provide care closer to home and reduce hospital admissions, attendance at A&E and transfers to long term care.	physical and mental health service and social care provision. The primary work of this post would be with people with a dementia, but also supporting functional health.	Smoother transition between primary and secondary care Improved engagement with localities through CRT GP memory team etc
5.2.6 **Extend the Care Homes Liaison Inreach service on a multi-disciplinary level:** To provide a multidisciplinary specialist service for older people with a mental health need to all (approximately 59) Care Homes in the Cardiff and Vale area With a change from a reactive to a proactive service, this will facilitate a single point of contact to care homes and providing joined-up care, with the	Enabling a collaborative support model across primary care and secondary mental health care which is effective in improving care quality, efficiency and patient outcomes. To provide 4 cluster inreach clinics per week, within care homes; seeing new referrals, follow up existing patients open to the CMHT and identifying residents with mental health problems including dementia. With a proactive approach to improve patient quality of care, the team will facilitate a single point of contact to care homes, providing equality of access and support with crisis	Prevent unnecessary admission to hospital, and decrease the number of urgent / emergency hospital admissions by 5% against an average of 90 over the last 5 years. Reduced spend on antipsychotics, by 10% against a total spend of £37,267 in 2017/18 Decrease the number of urgent referrals to CMHT/ REACT/OPC/Care home liaison team by 10% against a current average of 53 per month

5. PREVENTION PRIORITIES		
ACTION	OUTCOME	MEASURE
aim to reduce inpatient admissions and support patient discharges back to care homes.	prevention and palliative end of life care as well as: Advice and support for mental capacity and best interest decision making Promote multidisciplinary approach to assessment in the community Provide timely diagnosis and appropriate interventions Medication monitoring and review, in particular antipsychotics, with associated health benefits and cost reduction Interface working with Primary Care and CRT to promote seamless and collaborative care Offer alternatives to medication through psychological therapies, in line with the Welsh Matrix	Reduced number of referrals from Nursing and Residential Homes, by 5%, against a current average of 34 per month Reduction of sector domiciliary and outpatient waiting times over 10 weeks to an average of 8 per month, from the current 18 Reduced number of inpatient admissions by 5% from an average of 221 per annum Increased number of inpatient discharges by 10%, from 236 in 2017/18 Reduced number of Mental Health funded CHC placements, from the current average of 11 per annum, costing an average of £50k per annum, per placement
5.2.7 **Prison Services – develop a flexible needs based model in Cardiff**	Increased access to mental health care for a hard to reach group Urgent support and advice available 365 days	Increased access to mental health care for a hard to reach group Urgent support and advice available 365

5. PREVENTION PRIORITIES		
ACTION	OUTCOME	MEASURE
remand prison	a year to the whole prison Urgent response to Mental Health Crisis and Self harm incidents Reduction in self inflicted deaths and deaths in custody. Reduction in Self Harm incidents Development of expertise in managing the mental health effects of NPS and contributing to the wider harm reduction within HMP Cardiff Improved detection and early treatment of ADHD, and Autistic Spectrum Disorders Improved detection, liaison and support for people who have learning difficulties Improved detection and support for people with Acquired Brian Injury	days a year to the whole prison Urgent response to Mental Health Crisis and Self harm incidents Reduction in self inflicted deaths and deaths in custody. Reduction in Self Harm incidents Development of expertise in managing the mental health effects of NPS and contributing to the wider harm reduction within HMP Cardiff Improved detection and early treatment of ADHD, and Autistic Spectrum Disorders Improved detection, liaison and support for people who have learning difficulties Improved detection and support for people with Acquired Brian Injury

B.2 PLANNED CARE

6.1 Detailed 2019/20 Actions

The details of the clinical board's priority planned care actions for 2019/20

5 ACTIONS TO DELIVER SUSTAINABLE PLANNED CARE – 2019/20		
ACTION	OUTCOME	MEASURE
6.1.1 To open the Young Onset Dementia Health and Wellbeing Centre in St Barruc Unit, Barry Hospital: Following a successful ICF bid for £472,704, the current St Barruc ward and Morfa Day unit are being refurbished to facilitate a move of the Young Onset Dementia (YOD) team from UHL to Barry Hospital. The move will see the community team and inpatient service being co-located in an age-appropriate, safe environment, with space for improved activities, health and holistic care, community groups and family support.	The modern, refurbished space will create a larger, safe space for patients who are younger and fitter and who like to walk continuously; encouraging increased mobility and improved physical health. The creation of an appropriate environment in which further development of the service would be made possible with future funding opportunities, for example, specialist day care and repatriation of out of area CHC placements. To implement service changes and environmental designs in accordance with the principles within shared visions and strategies including the Dementia Action Plan for Wales 2018-2022, and the All-Wales strategy, Together for Mental Health. Appropriate space to work with Third Sector and Local Authorities to improve services to meet the needs of the YOD team caseload (average 135 patients at any one time for the Cardiff and Vale population).	Reduce the number of inpatient admissions into age-inappropriate environments, from the current average of 12 per annum. Development of appropriate respite care, thereby reducing the number of urgent inpatient admissions from the current average of 4 per annum. May attract income into the service from other organisations, if bed numbers can be reduced. This would be an average of £8k per month, All Young Onset Dementia services on one site, allowing a smooth transition between outpatient, day care, respite and inpatient services for patients and their families. Will improve the capacity for some patients to return directly to their own home, rather than needing accommodation solutions.

5 ACTIONS TO DELIVER SUSTAINABLE PLANNED CARE – 2019/20		
ACTION	OUTCOME	MEASURE
6.1.2 Substance Misuse - Lead on the delivery of the Cardiff and Vale Dual Diagnosis Action Plan & Establish joint working protocols for dual diagnosis. C&V aims to integrate 'dual diagnosis' provision for those with SM, utilising the COMPASS model, well established in Birmingham.	Improved treatment outcomes for service users with a dual diagnosis	Increase in the number of service users with joint case management between adult mental health and addiction services >50 Increase in the number of staff receiving dual diagnosis training >100
6.1.3 Younger people's services – to prepare for the contribution of the MHCB to the repatriated CAMHS specialist services to C&V and explore the possibility of a 'Younger People at Risk' services integrating the transitional work, IAS and FEP services	The establishment of a collaborative commissioning and delivery structure for Young People at risk	Existence of commissioning and delivery arrangements for younger people between 15 and 25
6.1.4 Review the scope and practices of outpatients	Scope the out-patient use and function with patient outcomes – recommendations for service change in the context of the community services review	Improved patient outcomes based on a baseline assessment to be completed by July 2019 Compliance with the principles within new ways of working for mental health professionals New to follow up outpatient target split of

5 ACTIONS TO DELIVER SUSTAINABLE PLANNED CARE – 2019/20		
ACTION	OUTCOME	MEASURE
		50/50 by Sept 19
6.1.5 Within The Rehabilitation and Recovery Services in partnership with Occupational Therapy we are aiming to achieve this through the review of existing services and the development of a **Recovery College at Park Lodge**. To implement the Recovery College, it is necessary to recruit to **peer support positions** whose role is to enable attendance and to support the specific learning needs of students/service users	Improved access to services- an outcome of increased referrals for psychological therapy and Occupational Therapy within secondary care and inpatient provision. This is monitored within reporting arrangements to Welsh Assembly Government. Increase in the number of self-management plans held by service-users. The scope and effectiveness of the Recovery College can be monitored by the number of enrolments, course attendance, courses offered, satisfaction scores and student stories. Integration of services, measured by the engagement of stakeholders within the committee and the number and range of courses offered by non-health providers.	Reduced service use can be measured through reductions in: a) the length of stay to upper quartile performance UK benchmarking b) the number of new to follow-up sessions 50/50 by September 2019 Care and Treatment Plans where evidence of self-management actions should be recorded in 100% 0f CTPs by year end 2019. Higher employment rates for service-users – currently only 3% of people with a serious mental illness are employed..
6.1.6 For the **early intervention in psychosis** service: Headroom to lead the development of a NICE concordant clinical pathway for people aged 14-25 who are referred to secondary services with first episode psychosis.	For more than 60% of patients aged 14-25 with first episode psychosis to commence a NICE recommended package of care within two weeks of referral. All eligible patients with first episode psychosis are offered the following interventions	The proportion of people aged 14-25 referred with a first episode of psychosis who commence a package of care within 2 weeks of referral. The proportion of people with first episode psychosis who are offered FI,

5 ACTIONS TO DELIVER SUSTAINABLE PLANNED CARE – 2019/20		
ACTION	OUTCOME	MEASURE
Increase the number of staff within the Headroom service who are accredited and supervised in NICE recommended psychological therapies and psychosocial interventions for psychosis.	delivered by a competent practitioner: • family intervention (FI) • cognitive behaviour therapy for psychosis (CBTpsy) • individual placement and support (IPS) Welsh Government through the mental health delivery plan 2016-2019 have the above targets. Early intervention for first episode psychosis reduces suicide, increases the changes of employment and saves money (£4,000 per patient per year). These actions are further supported by NICE, Clinical Guidelines 155 and 178.	CBT, IPS. The time from referral to treatment commencement for FI, CBTpsy, IPS.

6.2 High level 2019/20 and 2020/21 Actions

The high level clinical board's planned care actions for **2020/22**

ACTIONS TO DELIVER SUSTAINABLE PLANNED CARE – 2020/22		
ACTION	OUTCOME	MEASURE
6.2.1 **Primary Care Mental Health Workers** The medium term strategy for this	By 2022 the service will be well established with a mature service model. Transferring clinical and corporate responsibility to the	Reduction in multiple assessments of service users for each referral. Matched care rather than a stepped care model

ACTIONS TO DELIVER SUSTAINABLE PLANNED CARE – 2020/22		
ACTION	OUTCOME	MEASURE
service is to consider the transfer of these workers to the developing locality model for community mental health.	localities will allow for increased integration and allow for better seamless local working. Service integrated within locality structure.	when appropriate. Sustained reduction in GP workload of at least 5%, with allied reductions in demand of 40-50% CMHT referrals, 80-90% of PMHSS and 10-15% of PCCS
6.2.2 **Locality bases for Primary Care Psychological Therapists**	Following the actions noted for 2019-20 and the establishment of a revised service model, to establish new locality bases for the delivery of psychological interventions, In Cardiff North, Cardiff South and the Vale of Glamorgan. Existing provision in Primary Care practices to transfer to new locality bases. This action is subject to capital requirements.	Specialist and high intensity interventions delivered from one locality base of 70%.of referrals
6.2.3 Review treatment and support options for patients diagnosed with alcohol related brain damage (ARBD), or assessed as being at high risk of sustaining ARBD	Improved treatment outcomes for patients diagnosed with an ARBD Prevention of advanced ARBD in patients identified at an early stage and supported to reduce alcohol consumption	Increase in the number of ARBD diagnosed patients in receipt of an evidence-based treatment plan >50 Increase in the number of patients at risk of ARBD provided with a preventative treatment programme >50
6.2.4 For the **early intervention in psychosis** service: Headroom to lead the development of a NICE concordant clinical pathway for people aged 14-25 who are referred to secondary services with first episode psychosis.	Advancing the outcome from 2019/20 For more than 80% of patients aged 14-25 with first episode psychosis to commence a NICE recommended package of care within two weeks of referral.	The proportion of people aged 14-25 referred with a first episode of psychosis who commence a package of care within 2 weeks of referral.

ACTIONS TO DELIVER SUSTAINABLE PLANNED CARE – 2020/22		
ACTION	OUTCOME	MEASURE
Within the Headroom service increase the number of staff who are accredited and supervised in NICE recommended psychological therapies and psychosocial interventions for psychosis.		

B.3 UNPLANNED CARE

7.1 Detailed 2019/20 Actions

The details of the clinical board's priority unplanned care actions for **2019/20**

ACTIONS TO DELIVER SUSTAINABLE UNPLANNED CARE – 2019/20		
ACTION	OUTCOME	MEASURE
7.1.1 CMHT Review – develop a locality based health and well-being service for people with mental health problems in the Vale locality as a pilot Review of evidence base and development of Case for change and for community mental health services changes – principles based on	Improving Access and Sustainability Community Adult Mental Health Transformation Completion and collaborative sign up to description of preferred model Public engagement with CHC Completion of Capital ICF project in Barry Hospital Pilot locality model in vale	Conversion rate into specialist services caseloads to be 70:30 acceptance Waiting times to treatments with psychological interventions - < 6 months Improved measured health and well-being outcomes of statistical

ACTIONS TO DELIVER SUSTAINABLE UNPLANNED CARE – 2019/20		
ACTION	OUTCOME	MEASURE
improving access, reducing waits, focus on SU outcomes desired Pilot of Clinical Model through co-location of integrated teams and new clinical pathways	Stakeholder and Public Engagement well-being hubs per locality via OCP and engagement – Vale Locality OCP for whole system (staff engagement) - Organisational Development – team development and embedding new ways of working Partnership MOU and Collaborative working with LA and 3rd sector	significance using 'Core 10' CMHT Waiting Times to be within recommended policy Reduction of the % of staff time on the CMHT duty rota to nomore than 1 day per week Real Time Feedback from SUs receiving the new service through a commissioned contract with cavamh
7.1.2 PICU & Adult acute inpatient review – further to the community review develop an inpatient locality based health and well-being service for people with mental health problems in the Vale locality as a pilot Right size PICU to need and staff appropriately with smedical leadership	Review model and begin to implement recommendations Increased patient flow – direct access to locality ward from assessment ward Increase the number of inpatient staff who have received training in the effects of Adverse Childhood Experiences and Strengthen arrangements for delivering trauma informed services in line with community developments	Waiting times to treatments with psychological interventions – 90% within first 72 hours of admission Improved measured health and well-being outcomes using an appropriate clinical tool For PICU to be operating with an appropriate number of beds to meet demand with medical leadership present.
7.1.3 To reduce the Average Length of Stay (ALOS) and number of delayed	To develop the most effective possible methodologies for overseeing delayed discharge.	To reduce ALOS by 15% from current average of 133 on assessment wards, towards the

ACTIONS TO DELIVER SUSTAINABLE UNPLANNED CARE – 2019/20		
ACTION	OUTCOME	MEASURE
discharges on MHSOP wards: A new, fixed term post will review the inpatient pathway and complex cases, eliminating barriers to effective discharge planning and communication. The post will analyse current bed pressures with a view to consider where our hotspots are, how the discharge process can be more effective and efficient, who needs to be involved in discharge planning and how key elements of our community services can best align themselves to promote effective discharge planning .	To consider alternative communication processes and structures that facilitate effective discharge planning To consider the ways in which other key discussions, such as Consultants' Ward rounds and MDTs, can best support early, effective and safe discharge planning. To review areas of high average length of stay and detailed investigation into difficult / challenging delays To inform a job description and role profile for an MHSOP Discharge Liaison Nurse post	benchmarked peer upper quartile target of 90. Reduce bed numbers on MHSOP dementia assessment wards by 10 beds, to be able to provide good quality care within manageable establishments To reduce the delayed transfers of care, measured as the proportion of occupied beds that are attributed to delay, by 2.4%, to bring in line with benchmarked mean of 12.1% Reduce the directorate nursing overspend by 23%, by reducing temporary staffing costs.
7.1.4 **Delivering on the Psychological Therapies National Plan (Integral to Together for Mental Health).** • Timely access to evidence to evidence based interventions across a range of mental health conditions matched to need. • Improving information for service	Service users receive interventions that are closely matched to their needs and in accordance with the guidance contained within Matrics Cymru. It is proposed with the development of a locality model that the front of pathway will be provided by "primary care mental health practitioners". This should enable capacity release. (Currently, counsellors work in GP practices at the front end of Mental Health care). We propose reviewing	Evidenced-based rating scales to assess caseness and level of need such as Core-10, Core-34, GAD-7, PHQ-9 and other specialist meaures as appropriate to clinical presentation. Provide a statistical analysis of outcomes based on pre and post measures at a client level and by

ACTIONS TO DELIVER SUSTAINABLE UNPLANNED CARE – 2019/20		
ACTION	OUTCOME	MEASURE
users and staff (as above), • Ensuring embedded outcomes measures (as shown) • Ensuring workforce competencies through expert psychological leadership, commissioning training, supervision and supervised practice Redesigning the Clinical Pathway for Psychological Interventions in Community Settings	commissioning of the third sector to support counselling for those presenting in the non caseness to mild range (14% approx). As the assessment and triage service at the front of the pathway develops, counsellors will be progressively released from the six session, generic counselling currently being delivered in GP practices, to a locality based pathway model of delivery congruent to Matrics Cymru guidance, supported by the Psychological therapies hub. Counsellors have high intensity psychological therapy competency as designated in Matrics Cymru and have received training and supervised practice in one of IPT (depression), prolonged exposure, PTSD-trauma focussed CBT or EMDR, Eating disorders CBT)	analysing the effectiveness of the referral pathway to ensure need is matched with the appropriate level of intervention intensity.
7.1.5 Improving early access in primary care to high intensity trauma focussed CBT for PTSD and improve access to high intensity and highly specialist therapies for complex presentations of PTSD (eg EMDR) to interface with the development of a National model for PTSD service delivery funded separately but potentially based in C and V UHB supporting hub and spoke model of training and governance. To also include a small number of	Increased availability of high intensity Psychological Therapy for PTSD but eh appointment of 2WTE therapists to complement the existing provision, funded by Welsh Government PT expenditure. Increased availability of CBT based interventions (individual and group) for anxiety related conditions.	Reduction in waiting times, increase in clinical activity. Reduced waiting time. Improved outcomes by reducing delay and by the prescription of a condition specific intervention. Evidenced-based rating scales to assess caseness and level of need such as Core-10, Core-34, GAD-7, PHQ-9 and other specialist measures as appropriate to clinical

ACTIONS TO DELIVER SUSTAINABLE UNPLANNED CARE – 2019/20		
ACTION	OUTCOME	MEASURE
sessions to build on previous investment in perinatal services to deliver trauma focussed therapy for perinatal trauma. Developing an evidence based provision and treatment pathway for the anxiety related conditions. This will build capacity to deliver Cognitive Behavioural Therapy. Some staff have competencies but do not have designated roles to deliver this. The plan includes optimising delivery through designated roles as well as building the workforce at high intensity Psychological therapist level and low intensity (group delivery) level. This action is supported by the recruitment of 3.6 WTE Psychological Therapists within the Therapies Hub. Appointments directly funded by new WG investment in Psychological Therapies.	Increased availability of interventions appropriately designed for this client group. Increased taker up of psychological therapies by older adults.	presentation. Evidenced-based rating scales to assess caseness and level of need such as Core-10, Core-34, GAD-7, PHQ-9 and other specialist measures as appropriate to clinical presentation. Waiting list monitoring and reporting.
Provision of Psychological Services for Older Age Adults & OCD & Eating Disorders	Increased ability to continue with effective support in the community following treatment plans designed after a spell in a specialist inpatient facility.	

7.2 High level 2020/21 and 2021/22 Actions

The high level clinical board's unplanned care actions for **2020/22**

5. ACTIONS TO DELIVER SUSTAINABLE UNPLANNED CARE – 2020/21 – 2021/22		
ACTION	OUTCOME	MEASURE
7.2.1 CMHT Review – develop a locality based health and well-being service for people with mental health problems in the Vale locality as a pilot	Improved and quicker access to specialist mental health services Improved care and treatment pathways in specialist mental health care Improved patient health and well-being outcomes	For the co-located CMHTs to be the basis for the developing Health and Well Being Hubs for Cardiff and vale.
7.2.2 Adult acute inpatient review – further to the community review develop an inpatient locality based health and well-being service for people with mental health problems in the Vale locality as a pilot	Improved treatment outcomes for inpatients Strengthen arrangements for delivering trauma informed services and ACE's training	Increased patient flow – direct access to locality ward from assessment ward. Decrease in LOS to upper quartile UK benchmarked norms. Increase staff training in ACE's to 50% of staff. Reduce adverse events in inpatient services to upper quartile national norms Waiting times to treatments with psychological interventions - 100% within first 72 hours Improved measured health and well-being outcomes using Core 10