Agenda – Health, Social Care and Sport Committee

Meeting Venue:	For further information contact:
Committee Room 2 – Senedd	**Claire Morris**
Meeting date: 15 November 2017	Committee Clerk
Members pre-meeting: 09.15	0300 200 6355
Meeting time: 09.30	SeneddHealth@assembly.wales

Informal pre-meeting (09.15 – 09.30)

1 Introductions, apologies, substitutions and declarations of interest

2 Scrutiny of the Welsh Government Draft Budget 2018-19 – evidence session 1 – Cabinet Secretary for Health and Social Services and the Minister for Children and Social Care

(09.30 – 11.30) (Pages 1 – 63)

Vaughan Gething AM, Cabinet Secretary for Health and Social Services

Huw Irranca-Davies AM, Minister for Children and Social Care

3 Paper(s) to note

3.1 Use of antipsychotic medication in care homes – Additional information from the Care and Social Services Inspectorate Wales

(Pages 64 – 91)

3.2 Use of antipsychotic medication in care homes – Additional information from Hywel Dda University Health Board and Aneurin Bevan University Health Board

(Pages 92 – 111)

3.3 Use of antipsychotic medication in care homes – Additional information from the Royal College of Speech and Language Therapists and the Royal College of Occupational Therapists

(Pages 112 – 115)

3.4 Letter from the Cabinet Secretary for Health, Well-being and Sport regarding cancer waiting times

(Pages 116 - 122)

4 Motion under Standing Order 17.42 to resolve to exclude the public from the remainder of the meeting

5 Scrutiny of the Welsh Government Draft Budget 2018-19 - consideration of evidence

(11.30 - 11.45)

Agenda Item 2

Document is Restricted

Health, Social Care and Sport Committee

Date: 9 November 2017
Venue: Senedd Cardiff Bay
Title: Scrutiny of Draft Budget 2018-19

1. Purpose

The Committee's Chair wrote to both the Cabinet Secretary for Health, Well-being and Sport and the Minister for Social Services and Public Health on 3rd August inviting them to give evidence on their Draft Budget proposals and asking them to provide a paper in relation to the Draft Budget.

2. Introduction

The Draft Budget process is now in two stages. The outline budget (Stage1) was published on 3rd October 2017, and the detailed budget (Stage 2) on 24th October. The outline budget focuses on the overall fiscal envelope for Welsh Government and the main MEG level allocations, while the detailed budget covers the Budget Expenditure Level (BEL) spending plans within each MEG.

This paper provides information for the Health, Social Care and Sport Committee on the Health, Well-being and Sport (HW&S) Main Expenditure Group (MEG) future budget proposals for 2018-19 and also provides an update on specific areas of interest to the Committee.

3. Budget Overview

	2018-19
Revenue	**£m**
Revised 2017-18 DEL Baseline	7,018.570
MEG allocation	230.000
Agreed Savings reduction to MEG	(7.292)
Agreed Specific grants savings	(2.400)
MEG to MEG Transfers	(7.670)
Revised DEL as @ Draft Budget 2018-19	**7,231.208**
Capital	
Capital baseline as at Final Budget 2017-18	260.289
MEG allocation	23.500
MEG to MEG Transfers	10.985
Revised DEL as @ Draft Budget 2018-19	**294.774**
Overall Total HWB&S MEG	**7,525.982**

The table above does not include Annual Managed Expenditure (AME), which is outside the Welsh Government's Departmental Expenditure Limit (DEL).

The following table shows the reconciliation from the published First Supplementary budget 2017-18 to the revised baseline budget for each element of the MEG.

Revenue DEL	£m
Published First Supplementary Budget 2017-18	7,065.650
Transfer to Local Government MEG	(30.000)
Reversal of MEG transfer NHS Bursary Scheme	0.800
Removal of non recurrent funding	(17.880)
Revised 2017-18 Baseline	**7,018.570**
Capital DEL	
Published First Supplementary Budget 2017-18	251.971
Adjustment to agree with 2018-19 plans (as per 2017-18 Final Budget)	8.318
Revised baseline as @ Final Budget 2017-18	**260.289**

Compared to the revised baselines for 2017-18, the total revenue allocation for Health, Well-being and Sport has increased by **£212.638 million** and for capital an increase of **£34.485 million**. In summary, the movements are:

Revenue	£m
Additional investment from reserves in line with Welsh Government priority to support the NHS in Wales	230.000
Net savings amount transferred back to reserves	(9.692)
Transfer to Local Government MEG in respect of Grants review (Welsh Independent Living Grant (£27.000 million) and Secure Estates (£0.39m million))	(27.391)
Transfer to Central Services Administration MEG Wales for Africa Grant	(0.050)
Transfer from Central Services Administration MEG for 2017-18 Invest to Save baseline adjustment	9.049
Transfer to Central Services Administration MEG for 2018-19 Invest to Save approvals	(0.278)
Additional Budget Agreement investment	**11.000**
Revenue net increase	**212.638**
Capital	
Additional investment from reserves	23.500
Transfer to Central Services Administration MEG for 2018-19 Invest to Save	(0.015)
Additional Budget Agreement investment	**11.000**
Capital net increase	**34.485**

Details of all transfers are shown in Annex A to this paper

4. Approach to Budget proposals

The Health, Wellbeing and Sport MEG supports the Welsh Government's ambitions for a healthy and active population. It contains the core revenue and capital funding for NHS Wales, as well as funding for:

- Public Health Wales and other public health programmes
- education and training of the NHS workforce
- other NHS and health programme budgets, including substance misuse and research and development
- supporting social services, including funding for Social Care Wales, the main element of social care is delivered through the Local Government MEG
- supporting community and elite sport, including funding for Sport Wales

The Welsh Government continues to prioritise investment in the Welsh NHS. The most significant budgetary change to the Health, Well-being and Sport MEG for 2018-19 is the additional investment of a further £450 million in the Welsh NHS over the next two years. The evidence from recent reports by the Health Foundation and Nuffield Trust was that health spending would need to rise annually to keep pace with an increasingly elderly population, and with the rising prevalence of chronic conditions, such as diabetes. Through this additional investment, we are planning for the medium and long-term sustainability of health services in Wales.

Details of the allocation of this funding to NHS organisations will be provided in the 2018-19 NHS revenue allocations, which will be published later in the autumn.

We have reviewed and reduced spending plans for some central health and wellbeing programmes, where we can be assured that the impacts of these reductions can be mitigated through other core areas of funding. We will continue to monitor the impact of these spending changes to ensure that they do not prevent us delivering our aims in *Prosperity for All*.

5. Funding arrangements for Local Health Boards

In order to help the Committee's scrutiny and to provide a greater understanding of how the NHS spends its allocation of funds contained within the 'Delivery of Core NHS Services' Action line, the following section provides more information on the funding arrangements for Local Health Boards.

Within the BEL tables shown at Annex A the Core NHS Allocations BEL shows a budget of £6.5 billion for 2018-19. Notwithstanding a few minor adjustments, this budget is the main revenue allocation budget issued to Health Boards at the beginning of the financial year. The allocation provides funding for:

- Hospital and Community Health Service (HCHS) and Prescribing revenue discretionary allocation.
- HCHS protected and ring-fenced services

- General Medical Services Contract allocation
- Community Pharmacy Contract allocation
- Dental Contract allocation

The 2017-18 Health Board revenue allocation was issued in December 2016, setting out the allocations between the various funding streams shown above. The table below summarises the allocation by Health Board.

2017-18 Health Board Revenue Allocations

Health Board	Discretionary & Prescribing Allocation	Ring Fenced Allocation	GMS Contract	Pharmacy Contract	Dental Contract	Total
	£m	£m	**£m**	**£m**	**£m**	**£m**
ABM	743.608	172.827	75.428	29.335	27.082	1,048.280
AB	841.766	147.338	85.870	31.453	27.107	1,133.533
BC	989.138	202.681	116.087	33.471	27.097	1,368.474
C&V	613.716	124.949	64.568	22.218	24.497	849.948
CT	455.740	91.352	45.617	18.501	11.733	622.943
H Dda	531.815	112.761	60.879	20.923	17.576	743.954
Powys	185.316	42.103	30.659	4.753	5.577	268.408
Total	**4,361.099**	**894.009**	**479.109**	**160.654**	**140.669**	**6,035.540**

The figures in the table above do not include funding issued in year in 2017-18 or the funding I have held back in 2017-18 on a non recurrent basis to manage deficits in the four health boards in escalation. I have still to determine in detail how this unallocated funding from 2017-18 will be used to support delivery and service transformation in 2018-19, along with the **additional £230 million** for the NHS announced in this Draft budget for 2018-19. I set out more detail on my plans later in this paper.

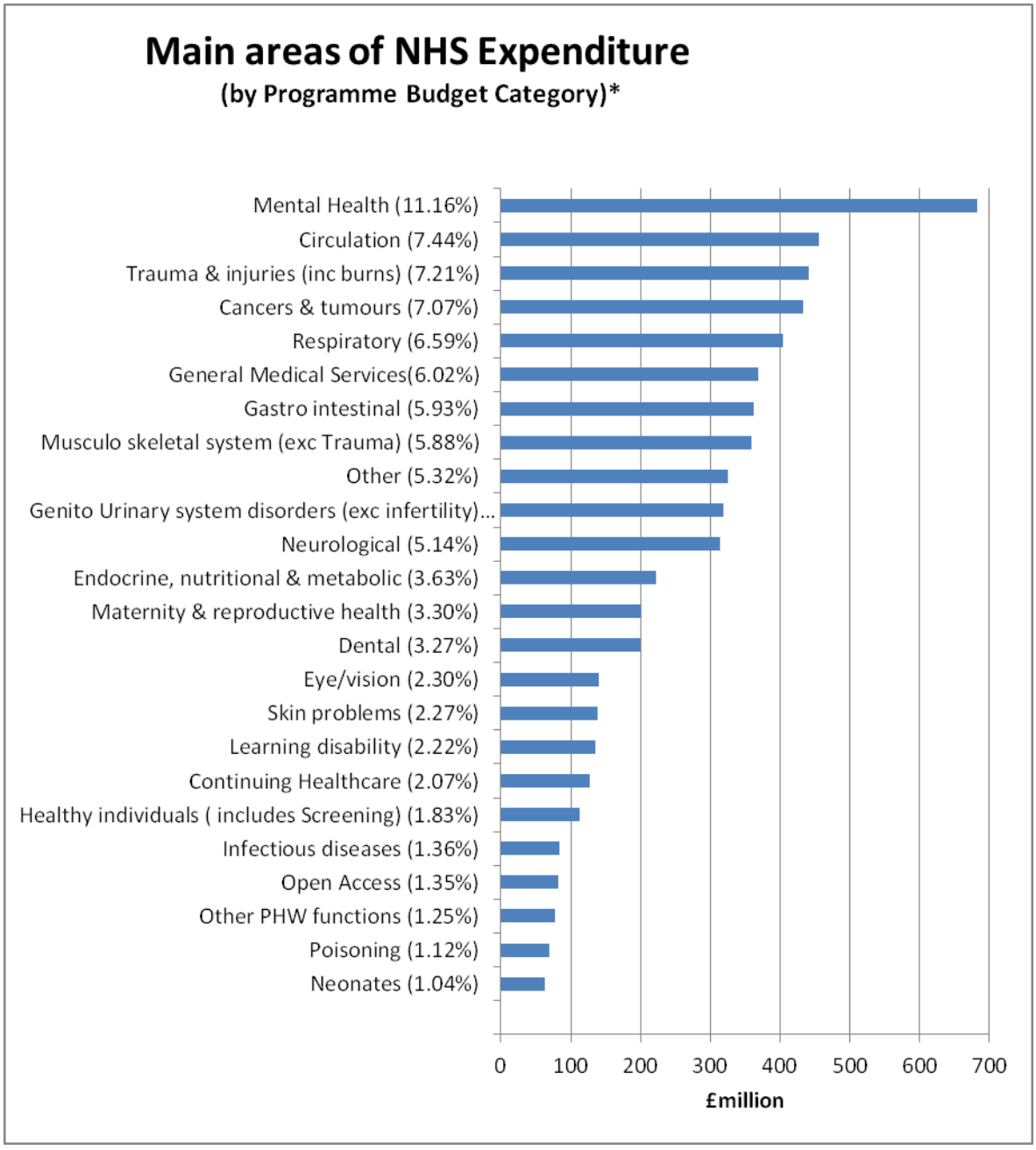
Within the 'Core NHS Allocations' BEL, there are some elements of funding that are issued to Health Boards in year, based on actual costs or agreed criteria which may differ from year to year, so are not included within the above recurrent funding amounts. Examples of these items of expenditure are:

- Substance Misuse funding
- Dental and Pharmacy Trainee costs
- Treatment fund

6. Expenditure by Programme Budget Category

A further analysis of historical expenditure can be shown by Programme Budget category. This information is produced each year but is only available approximately 12 months following the end of the financial year. Consequently the information

shown below has been compiled from expenditure during the 2015-16 financial year. The areas of expenditure are detailed in the graph below:



The categories of spend shown above are based on the World Health Organisation International Classification of Diseases

The chart above illustrates the main areas of spend in the NHS in Wales. The information is drawn from the programme budgeting returns for 2015-16 and covers over 93% of the expenditure in that year (circa £6.1bn). NB The programme budgeting information for 2016-17 is not yet available, and is expected to be published in early 2018.
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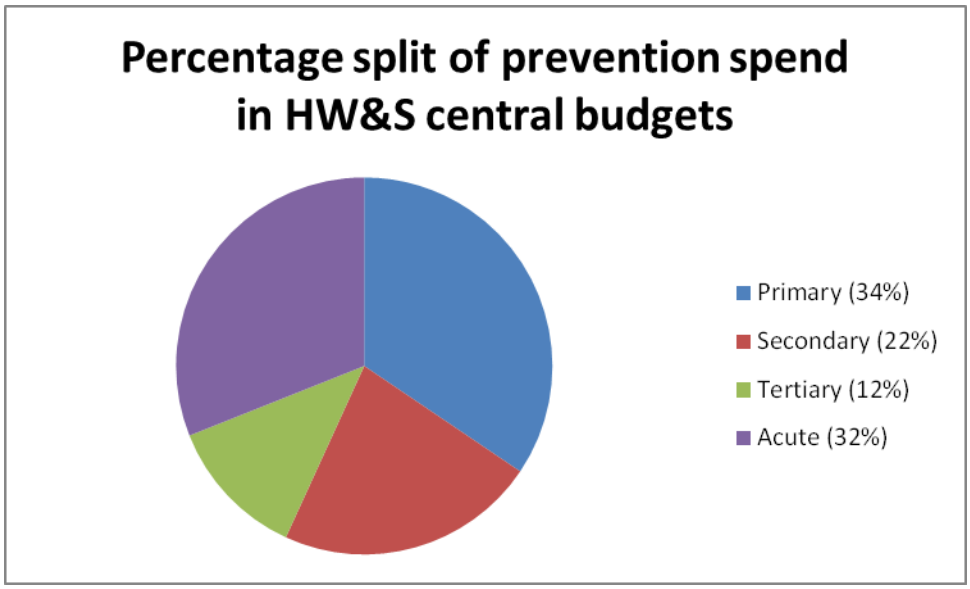
7. Preventative Spending

Our aim is to take significant steps to shift our approach from treatment to prevention. To support this, we have undertaken a review of our spending plans to assess the level of current spending on prevention. The Early Action Task Force, which produced the 'Towards Effective Prevention' report have built on the proposed definitions set out in the National Audit Office's early action landscape review, developing them in discussion with practitioners. Work is underway to determine a set definition of prevention across Welsh Government based on this work. We have classified expenditure using the Early Action Task Force definitions.

In looking at our preventative spend for the Health, Wellbeing and Sport Central budgets we have used their definitions as follows:

Definition	Explanation of Definition
Primary Prevention	Preventing, or minimising the risk, of problems arising usually through universal policies like health promotion or a vaccination programme.
Secondary Prevention	Targeting individuals or groups at high risk or showing early signs of a particular problem to try to stop it occurring. For example screening programmes.
Tertiary Prevention	Intervening once there is a problem, to stop it getting worse, and redress the situation. For example the "Choose Well" campaign or funding for psychological therapies.
Acute Spending	Spending which acts to manage the impact of a strongly negative situation but does little or nothing to prevent negative consequences.

We have reviewed our centrally held budgets against the above categories and the percentage split is shown in the table below:



Welsh Government does not set detailed requirements for NHS organisations on how they should use their discretionary revenue allocation to meet national and local priorities, and the proportion of their funding they should spend on preventative activities. So, in terms of assessing the level of NHS spending on prevention, we have had to use an alternative approach. Within the UK Health Accounts 2015 publication, published by the Office for National Statistics in April 2017, the analysis of expenditure by healthcare function identifies, at a UK level, that spend on prevention equates to £9.6 bn of a total spend of £185 bn. For government funded healthcare, expenditure on prevention equates to £7.4 bn, or 5.05%, of total government healthcare expenditure of £147.1bn.

The ONS led Health Accounts Steering Group are considering whether future annual publications could include breakdown of UK expenditure by country. At this stage no decision has been made on this development, however if this was agreed by the steering group (which includes the devolved administrations) it would then be possible to identify prevention spend by country. The next UK Health Accounts publication, UK Health Accounts 2016, is due be published in early 2018. We will continue the work to improve our understanding of spending on preventative activities.

Some specific examples of where we are providing preventative funding include:

- Funding for the three year study into the availability of Pre-exposure Prophylaxis to reduce the risk of sexually-acquired HIV1 infection in adults of high risk as part of a wider HIV prevention service.
- Investing in prevention of avoidable diseases through expanding the children's flu vaccination programme by an additional school year in 2017-18, and then accelerating the roll out to all primary school children in 2018-19. This is expected to significantly lower the public health impact of flu by preventing a large number of cases of disease in immunised children as well as in unvaccinated infants and older people in clinical risk groups through reduced circulation and transmission of flu.
- Health & Social Services and Education are investing in a cross cutting initiative to pilot the provision of mental health in-reach support for children in school settings. £1.4 million is being jointly invested in three pilots that will run from 2017-18 to 2019-20; one in North East Wales, one between North Gwent and South Powys and one in West Wales. The pilot schemes will test approaches on early identification and intervention for children with emotional and mental health problems. There will also be funding to support a national coordinator to support the pilots. The contribution from the Health & Social Services MEG for 2018-19 will be £0.229 million.
- Investing in preventing cancer. The HPV immunisation programme started in 2008. There is already evidence from Australia, Denmark, Scotland and England that the vaccine is making a difference. There has been a large drop in the rates of infection with the two main cancer-causing HPV types in women and men. The programme is expected to eventually prevent significant numbers of deaths from cervical cancer every year. As it can take

many years for the cancer to develop after infection then the overall benefit of the programme will take some time to be evaluated.

- Investing in genomics for precision medicine. The strategy outlines our plan to harness new genomics technologies to improve the health and prosperity of the people of Wales. Through the strategy, we want people across Wales to have access to quicker, more accurate diagnosis and better information to support treatment decisions. We also want to apply the latest techniques for improved disease prediction and gain a better understanding of disease outbreaks.

8. Capital funding

We are continuing to prioritise investment in NHS infrastructure, and have an ambitious programme over the next three years which will see the delivery of new facilities and the major redevelopments in some of our most strategic assets.

Work commenced on the Grange University Hospital in July 2017 and this is a key component in the NHS Wales Capital Programme going forwards. This 470 bed state of the art hospital is due to open in 2021. Significant redevelopment and modernisation works are also underway at Prince Charles Hospital and Ysbyty Glan Clwyd, and in 2018-19 work will continue to progress on the development of the new Velindre Cancer Centre.

As well as schemes within the acute sector, this budget provides £11m next year to support the construction of the Cardigan Integrated Care Centre as part of the budget agreement with Plaid Cymru. Subject to the approval of the Full Business Case later this autumn, work is expected to commence in April 2018, with an estimated 17 month build period.

Next year will also see £10 million to progress a pipeline of primary and community care projects as part of the implementation of the Taking Wales Forward commitment, which is reiterated in Prosperity for All, to invest in a new generation of integrated health and care centres. This pipeline will see 19 projects across Wales being delivered by 2021. I previously announced £40.5 million of capital funding to deliver this commitment. As part of this budget, I am building on this funding allocation and can now confirm a total of £68 million capital will be used over the coming three years to deliver the schemes.

This budget also provides £3.5 million in 2018-19 to support the delivery of the Emergency Services Mobile Communications Programme (ESMCP). This will provide the next generation communication system for the three emergency services (police, fire and rescue, and ambulance) and other public safety users in England, Scotland and Wales. ESMCP has been established by the Home Office to provide an integrated critical voice and broadband data communications service for the Emergency Services that meets the public safety requirements for coverage, functionality, availability and scrutiny. The earmarked funding will be used by the Welsh Services Ambulance Trust as part of its preparations and implementation

Specific Areas

Commentary on Actions and detail of Budget Expenditure Line (BEL) allocations

The detailed budget published on 24th October set out our spending plans for the HW&S MEG by BEL. An analysis and explanation of the budget changes since the June 2017 Supplementary Budget is set out in Annex A.

Mental Health

The allocated budget on mental health services: We continue to spend more on mental health services than on any other part of the Welsh NHS. The mental health ring fence currently stands at £629m for 2017-18. In line with the Budget Agreement with Plaid Cymru, we will be increasing the mental health ring-fenced allocation by a further £20 million in 2018-19 and 2019-20, to nearly £650 million. The ring fence allocation for mental health forms a protective floor, below which expenditure on core services must not fall.

Budget agreement: Recurrent funding for Eating Disorders, Gender Identity Services and Mental Health Services

The Welsh Government's 2018-19 budget ensures that the additional £1million of additional funding for 2017-18 to improve eating disorder (ED) and gender identity services is provided on a recurrent basis.

Eating Disorders: This additional funding builds on Welsh Government investment of £1.25 million per annum to improve provision for children and adults. The £0.500 million is being targeted on services for older adolescents, as they transition between children's and adult services. In particular, funding will be used to foster close working relationships between existing CAMHS ED and adult tier 3 ED teams, working together in the best interests of the patient in a clinically- led, rather than an age driven, model of care. This includes improving training and providing additional sessions for existing staff, and recruiting new specialist staff.

Gender Identity Services: The All Wales Gender Identity Partnership Group (AWGIPG) is leading on the development of a new treatment pathway for Wales. This includes the development of a new multidisciplinary service, known as the Welsh Gender Team (WGT). The WGT will provide support to a network of GPs across Wales with a specialist interest in all areas of gender care, including hormone replacement therapy, and will accept direct referrals from GPs. The WGT plans to accept new referrals and repatriate appropriate individuals who are currently on waiting lists for treatment from the end of March next year. This new set of arrangements will result in shorter distances to travel to access services, improved waiting times and better user experience.

Additional funding for mental health services: The Welsh Government's 2018-19 budget includes a further £20 million of funding for mental health services. This will support the ongoing delivery of priorities in Together for Mental Health and Prosperity for All.

Allocations for delivery of the mental health strategy and delivery plan

Spend on mental health services is the largest single area of the budget and health boards are requested to give it proportionate consideration in their Integrated Medium Term Plans (IMTPs). The 2016-19 delivery plan published to underpin the "*Together for Mental Health*" strategy sets out clear priorities and IMTPs are also requested to demonstrate the organisation's delivery of these priorities. IMTPs should demonstrate how the organisation is meeting its statutory responsibilities under the Mental Health (Wales) Measure 2010 and how the organisation is delivering improved access and outcomes for service-users from the additional significant investment by Welsh Government in targeted areas of provision. More generally, IMTPs should clearly set out the organisational service change programmes to ensure the availability of high quality, sustainable, accessible and timely care with associated timescales and risks.

The allocated budget on mental health services delivered on the prison estate

Mental Health funding for prisoners is not separately identified in the NHS funding allocation. Health Boards are responsible for commissioning services for their resident population for hospital and community health services and this will include the prison population in their area.

Patterns of demand and expenditure on mental health services in the last 5 years

The most recent information available from the NHS Programme budget returns relates to the period from 2011-12 to 2015-16. This demonstrates that Mental Health spending has risen by over £40 million from £642 million in 2011-12 to £683 million in 2015-16.

Since 2015-16 an additional £25 million has been recurrently allocated to Health Boards to target the provision of Mental Health Services and as part of the budget agreement for 2018-19 a further £20 million will be added to the Mental Health allocation. A total increase in funding over that three year period of £45 million.

Details of the operation of the ring fence for the mental health budget, including the level at which it is set, defining what is included within it, the extent to which it has determined spending on mental health; and the purpose and value of the ring fence and future plans for it.

Mental health funding has been ring-fenced since 2008. The ring fence looks to protect and enhance core services and also includes specialist services and primary care spending. The ring-fence provides a floor below which expenditure on mental health services should not fall and any savings must be re-invested into mental health services.

The Welsh Government have made increases to the mental health ring fence over the last couple of years in recognition of areas where we have seen an increased demand to services. This includes additional funding for CAMHS services, older

people's mental health, community perinatal services and psychological therapies. It is the health boards responsibility to demonstrate an understanding of the mental health and mental well-being needs of their own population across the life course and as part of this work include a capacity and demand analysis which also demonstrates how the health boards is actioning areas for improvement. This will be monitored through the IMTP process.

Other Budget Agreement changes:

Recurrent funding for End of Life Care: Additional funding of £1 million will enable the End of Life Care Board to continue to take forward its national priorities. These include building further capacity in Hospice at Home provision, empowering patients to advance care plan, supporting people to remain in their place of residence, improving bereavement care and will also enable better use of both digital technology and research.

Funding for Welsh Buurtzorg Pilot: This £4 million funding is to be used to introduce elements of the Buurtzog approach in Wales, in line with Nurse Staffing principles for community nurses. This will be focused on the training of 80 new district nurses.

Funding Transformational Change in the NHS

Prosperity for All sets out our ambition to maintain high quality health services, supporting and promoting good health and wellbeing for individuals, families and communities, and taking steps to shift our focus from treatment to prevention. I am determined to use the additional investment in NHS Wales to support this ambition and drive forward transformation change in our health and care services.

The evidence base contained in the Nuffield Trust and Health Foundation reports points to the need for continued annual investment in the NHS to keep up with cost growth and increases in the demand for services. In 2017-18, I increased NHS allocations and other NHS funding streams by a universal uplift of 2%, equating to approximately £110 million overall, to meet cost growth. I will plan to make a similar funding uplift in 2018-19 from within the additional £230 million funding allocated in this Draft Budget.

My ambition is to use the balance of the additional investment, after allocating funding for cost growth, to demonstrate our commitment to transforming services and to maintain and improve performance. I am also determined to incentivise organisations to attain and maintain the status of having an approved medium term plan, by giving these organisations more flexibility in how they apply additional funding to drive transformation at a local level.

The extent to which we are able to meet this ambition will depend greatly on our progress in addressing operating deficits in those health boards in escalation. In 2017-18, I have had to hold back a significant proportion of the additional £240 million investment on a non-recurrent basis to offset deficits in these organisations. The targeted intervention of these organisations being undertaken by my officials is

creating traction in terms of stabilising the position, but I will need to have assurance that further improvement is being achieved and sustained during the second half of 2017-18 before making any decisions to commit additional transformation funding on a recurrent basis in 2018-19 and beyond.

In using funding to drive transformation change, we should not focus solely on new investment, but also in ensuring that we are taking action to redirect existing spending towards new models of care.

International evidence shows primary care is the core element of a sustainable health system. Our national primary care plan sets out how we will achieve a sustainable and effective health system through a more social model of health and wellbeing. This creates a response to people's needs which draws in and makes prudent and innovative use of all available financial, workforce and other resources, not just those of NHS Wales, helping support people to take responsibility for their own health and wellbeing.

Alongside the additional investment we are making in 2018-19, this budget supports this transformational change and improvement through maintaining several existing targeted funding allocations, including maintaining the primary care fund, the integrated care fund and funding for the national delivery plans. £10 million of the primary care fund has been allocated for the primary care clusters to decide how to invest and is proving successful in demonstrating the benefits of collaboration at a very local level to drive transformation.

Our Budget includes ring fenced funding for health boards for the services contract with GPs, community pharmacists, dentists and optometrists. We continue to explore with the relevant professional bodies how the nationally negotiated contractual frameworks can enable our aim to transform care and support and to meet people's needs as close to home as possible.

We also plan to increase frontline treatment services for substance misuse by increasing the ring fence by £0.920 million in 2018-19, to over £18 million annual investment.

Social Services

Welsh Government is aware of the potential tension between day-to-day cost pressures and preventative spend for social services. Our major legislative and service reform aims to free up local authorities and the wider sector to respond to the demographic and other challenges by taking a longer term approach focusing on prevention and early intervention and meeting personal well-being outcomes in improving the well-being of people in Wales.

We have targeted funding of £1.3 million in years 2013-14 and 2014-15 increasing to £3.0 million in years 2015-16 and 2016-17, through the Delivering Transformation Grant 2013-14 to 2016-17 (now transferred to the revenue support grant from 2017-18), recognising the transitional costs of planning for and then implementing the

changes necessary to drive improvement in the systemic delivery of social care in Wales under the aegis of the Social Service and Well-being (Wales) Act 2014. The evaluation arrangements for the Act are currently being co-developed with stakeholders. However, current indications are that, although implementation is progressing at different rates in different areas, the use of grant funding to advance national priorities has been welcomed as a tool to speed the progress of implementation and encourage the wider adoption of best practice across Wales.

We have also put in place, over and above this, a total of £55 million of additional recurrent funding that was allocated to local government from 2017-18. In supporting front line service delivery, addressing the effect of the national living wage and targeting action on three priority areas of the social care workforce, looked after children, and carers, this funding is intended to give local government and its partners the headroom in order to take forward their prevention and early intervention agendas.

Partnership working and regional partnership boards

On 10 October the Minister for Social Services and Public Health gave an oral statement to the Assembly, setting out the importance of integration and partnership working for health and social services.

The Social Services and Well-being (Wales) Act 2014 recognises that standards can best be raised by partners working together. The Act provides for regional partnership boards to drive the effective integration of health and social services. These boards are now firmly established and are improving the effectiveness of service delivery.

Seven boards, on the health board area footprint, have been established that bring together health, social services, the third sector and other partners. Their purpose is to improve well-being outcomes and make best use of resources to support sustainability.

Regional partnership boards are required to establish pooled budgets including, from April 2018, in relation to the provision of care home accommodation for adults. These pooled budgets will support integrated commissioning, allowing local authorities and health boards to focus on improved quality as well securing better value for money.

The Social Services and Well-being Act also requires regional partnership boards to take an integrated approach to the planning and delivery of services. In April, the regional boards published population assessments, as required by the 2014 Act. These provide a clear and specific evidence base of the full range of care and support needs. Regional boards are now producing area plans in response to those assessments by April 2018 which will set their agenda for the integrated delivery of services.

Integrated Care Fund (ICF)

The now rebranded ***Integrated*** Care Fund (ICF) was established in 2014-15 to support older people to maintain their independence, avoid hospital admission and prevent delayed discharge. It also aims to drive partnership working and the delivery of integrated services across health, social services, housing and the third sector. The fund was expanded in 2016-17 to support the development of integrated care and support services for other groups of people.

As a key delivery mechanism for the Social Services and Well-being (Wales) Act, from 2017-18 the objectives of the ICF are linked to regional partnership board's priority areas of integration:

- Older people with complex needs and long term conditions, including dementia;
- People with learning disabilities;
- Children with complex needs due to disability or illness; and
- (for the first time) Carers, including young carers.

Regional partnership boards have oversight and ensure the effective use and delivery of ICF.

With the £130 million funding provided through ICF to date and the £60 million in 2017-18, the Welsh Government is supporting improved access to integrated health and social care so more frail and older people are being cared for at or near home.

ICF funding is being used to develop a wide range of innovative models of integrated working. These have created increased capacity in the care system and improved consistency in the provision of services within regions.

The emerging evidence indicates funding is making a real difference to many people's lives as well and reducing the pressure on vital NHS and social care services. This has been achieved by the development of a culture of collaboration and partnership working between social services, health and housing, along with third and independent sector partners.

The Programme for Government includes a commitment to retain this important fund.

Any allocated budget for technology and infrastructure to support quality and efficiency

Investment in ICT and digital technologies supports wider service transformation, enabling more effective use of resources across the service, and empowers both patients and professionals through the provision of information anywhere at anytime.

Through our £55 million investment in NHS Wales Informatics Services (NWIS), we have an established national architecture, with health boards using common clinical systems such as the Welsh Patient Administration System and the Welsh Clinical Portal (WCP). Investment has improved the IT infrastructure, allowing replacement of ageing equipment and strengthening systems against cyber attack.

The WCP is the main access point to information for hospital clinicians. It pulls together key information from the many systems used by hospitals, allowing the clinician to view a patient's record in one place and use a common system to perform various tasks e.g. requesting tests, reviewing results or creating a discharge advice letter.

Other examples include My Health Online through which GPs are able to offer online appointment booking and repeat prescription requests.

The Welsh GP record is available to GPs in out-of-hours settings as well as clinicians and pharmacists in secondary care. Choose Pharmacy is used by 51% of community pharmacists. It supports delivery of the common ailments and the discharge medicine review services. Pharmacies using the Choose Pharmacy service are able to view the patients GP record and supply prescribed medicines to patients in an emergency.

The Welsh Community Care Information System (WCCIS) supports the delivery of integrated health and social care services. It allows staff working in health and social care to use a single system and a shared electronic record of care.

Welsh Government hypothecated funding for innovation through the Efficiency through Technology Fund will reduce by £4 million in 2018-19. The Programme has been developed and delivered by Welsh Government as a competitive grant, with funding allocated to specific accelerated projects. This differs from the traditional consolidated funding arrangements for health boards and trusts. The Programme and its approach are considered to be a proof of concept or demonstrator and has been externally reviewed, receiving positive endorsement and recommendations.

Welsh Government believes that this approach should be more widely adopted across NHS Wales. We will share this model and learning with health boards and trusts, so that they can use it to drive technology adoption and innovation from their own resources, as part of core business. We will use IMTPs to agree with health boards and trusts how they will do that, including the level of resource which they will individually and/or collectively commit to this important area. We will monitor activity and outcomes through our regular oversight and reporting mechanisms.

Views on how the Welsh Government can effectively balance the need for preventative spending whilst addressing day-to-day cost pressures.

The day-to-day cost pressures facing the NHS in Wales, as with all other modern healthcare systems, are very challenging. The predicted change to Wales' population is a rise from 3.1 million to £3.3 million by around 2039, mainly through in-migration from England and to a lesser extent from outside the UK. Within this overall rise the proportion of over 65s is projected to increase from 20% of the population to over a quarter. With a growing and ageing population, and the associated patterns and burden of disease that accompanies that, we will have need, and have come to expect, timely access to high quality treatment and support.

A very significant proportion of the population of current and future generations will be needing treatment and support- many individuals who will have taken full responsibility for their own health, and been lucky enough to enjoy the broader circumstances that are conducive to good health, will still have a call on costly and complex treatment.

It is not always right to assume that preventative approaches will reduce the costs of healthcare provision. A recent analysis by the Nuffield Trust[1] considered various initiatives beneath the umbrella of shifting care out of hospitals. Of 27 common schemes, they found only seven to be cost saving and found six to have actually increased costs. There are two main factors: i) expanding care outside of hospitals (even assuming the expanded workforce can be attracted and then paid for) can mean uncovering previously unmet need or providing extra services that patients effectively use on top of what already exists, and ii) there is a tendency to assume that preventing an admission means that all the associated costs can be chalked up as savings, when in truth the reality is that taking costs out can be extremely complex.

Despite the challenges, Welsh Government takes a number of steps towards securing an optimum balance of spend:

- Being clear on our expectations of Health Boards to focus on prevention – not only through legislation such as the Wellbeing of Future Generations (Wales) Act and the Social Services and Wellbeing (Wales) Act, but also in setting out prevention priorities through the planning framework and through performance and accountability discussions;
- There is a section of this document that categorises prevention spend within the budget. Improving transparency of spend is one way of supporting a greater shift towards prevention;
- Supporting Health Board and partners to invest in prevention through the provision of evidence and advice on interventions with return on investment. For example, Public Health Wales published a *Making a Difference: Investing in Sustainable Health and Well-being for the People of Wales*[2] document last year, which provides evidence on what works in prevention, and details where returns of investment can occur.
- Welsh Government also makes a number of direct investments, such as through the introduction of screening and immunisation programmes.

Financial performance by LHBs and health inequalities

An update on the four health boards who failed to meet their financial duties and mechanisms in place for monitoring progress;

The four health boards (Abertawe Bro Morgannwg, Betsi Cadwaladr, Cardiff and Vale and Hywel Dda University Health Boards) who failed to meet their financial duties are currently being managed through the Escalation and Intervention

[1] https://www.nuffieldtrust.org.uk/research/shifting-the-balance-of-care-great-expectations
[2] http://www.wales.nhs.uk/sitesplus/888/page/87106

Arrangements, either under Special Measures or Targeted Intervention. This includes additional monthly Special Measures or Targeted Intervention meetings with senior Welsh Government officials to agree support, actions and delivery.
For the three organisations subject to the Targeted Intervention arrangements, independent Financial Governance Reviews were commissioned, produced and presented. Each Board considered the recommendations and agreed actions at their respective September Board meetings. These actions will be monitored through the monthly Targeted Intervention meetings.
In light of the continuing financial performance in Betsi Cadwaladr a further Financial Governance Review has been commissioned and due to be completed by mid November.

Details of when the Welsh Government's review of the funding formula for health boards to ensure fairness across Wales will be completed

The aim for Phase 2 of the resource allocation review is to develop an updated funding formula by summer of 2018 to inform the distribution of any additional discretionary hospital and community health services allocation in 2018-19. It is recognised that this will be a complex technical exercise that will need to reflect the most appropriate needs measures and any recognised unique factors. Additionally the new formula will be designed to be transparent and, regularly updated with available and reliable updated population and needs data.

Response to Wales Audit Office report on the implementation of the NHS Finances Act.

Welsh Government welcomed the findings of the report and provided the following response to the two recommendations contained within it.

Recommendation 1

We recommend that the Welsh Government:

a) sets out more clearly in its guidance how, working in partnership with the Welsh Government, NHS bodies that have incurred a deficit should plan to recover their financial position in order to meet the duty in future years; and
b) enhances its monitoring returns to include the position against the three-year rolling periods, not only the annual picture.

Welsh Government Response: Partially Accepted

Welsh Government do not accept that NHS bodies require additional guidance from Welsh Government on the action they need to take to recover a deficit in order to meet the duty in future years. The operation of the duty was detailed in the Explanatory Memorandum to the Act, and also has been set out in Welsh Health Circular (2016) 054 – Statutory Financial Duties of Local Health Boards and NHS Trusts. However, Welsh Government recognise the need to ensure that all new board members fully understand the organisation's duties, and this requirement will be addressed in the Independent Member's Induction Programme.

Welsh Government accepts the recommendation that our regular monitoring process needs to include a three-year perspective as well as the annual position for those organisations working to approved three-year plans. Welsh Government will consider the additions we need to make to the monitoring process to include this perspective. This will be completed by 31st October 2017.

Recommendation 2

We recommend that the Welsh Government *swiftly completes the review of its funding formula for health boards to ensure that variations in funding levels properly reflect differences in population health needs and other determinants of healthcare costs*

Welsh Government Response:

Accepted

Phase 1 of the resource allocation review was completed within the Finance Regime element of Together for Health. Welsh Government intend to take forward Phase 2 in due course.

Workforce pressures

Details of particular pressures and staff shortages and further financial plans to address this;

NHS Wales is not alone in experiencing difficulties recruiting to some posts. There are not only UK wide challenges, but world wide shortages for some professions.

In such a competitive market and to address these issues the Welsh Government has allocated funds to undertake a national and international marketing to recruit campaign, developed in partnership with the professions, university medical schools, royal colleges, NHS employers and the Wales Deanery, to market Wales and NHS Wales as an attractive place for doctors (including GPs), nurses, pharmacists and allied health professionals (AHPs) and their families, to train, work and live. The first phase launched in October 2016 was primarily focussed on doctors (including GPs) and has been re-launched this month; the second phase launched in May 2017 centred on nurses and the third and fourth phases for pharmacists and AHPs will be launched in March 2018.

These campaigns are intended to support local recruitment undertaken by health boards and trusts.
Social Care Wales, the Welsh Government sponsored body which came into operation from 1 April 2017, has responsibility for driving service improvement and incentivising high quality care, as well as raising the profile of the workforce and supporting its professionalization. It is taking forward a range of actions to deliver these responsibilities including developing career pathways, reviewing social work degrees and developing a national dataset to identify future trends for demand for social care. This will help to raise the profile of the sector and address current

difficulties around recruitment and retention, contributing to the longer term sustainability of the social care sector.

Details of plans for new skills and career paths for health and social care staff and any allocations in this regard (recommended in the Interim Parliamentary Review report which says these need to be planned on a large scale without delay);

In NHS Wales robust workforce planning remains the responsibility of health boards and trusts, as they are best placed to ensure their organisations are appropriately staffed to deliver services that are matched to the needs of their local population – both now and in the future.

In order to meet the challenges the health system faces both now and in the future it is important to ensure the workforce of the future is sufficiently agile to enable changes in service models to be supported through adaptive education and training programmes. It is equally important to enable as many individual as possible to aspire and achieve a career in the health system. This will include the nature of programmes and the access routes. New part time programmes for nurse education have been introduced in 2017, while these are limited at present the intention is to build upon this approach in future years. The health care support worker framework continues to evolve and provide more flexible career routes for individuals.

In addition advanced practice and extended skills programmes are in place, with specific allocations for individuals in general practice to gain additional skillsets.

Any planning/ assessment undertaken on future funding needs post-Brexit, for example given possible changes to agency staff costs.

We are not able to make any financial projections about the impact of Brexit on staffing costs until we have seen the outcome of negotiations and what those mean for NHS from the EU and those from elsewhere in the world. The Welsh Government are clear that we want to enable all those dedicated staff working in the NHS in Wales to remain here to contribute to the life of Wales and the running of the operation of our NHS.

We are working with the NHS to continue to consider the impact of Brexit proposals as they develop and employers are working in the wider UK Cavendish coalition to both assess impact and influence the UK Government on these issues.

Integration of health and social care

Funding allocations to drive integration e.g. development of health/social care professionals who are able to work across service boundaries.

One of main principles of the Social Services and Well-being (Wales) Act 2014 focuses on partnership, and the Act makes it possible for health and social services to be delivered in a more joined-up way. This means services will work together

more closely, and new types of services and jobs will be developed that work flexibly across organisations.

A learning and development framework for Occupational Therapists in Social Care has been developed to provide guidance for Occupational Therapists working in social care in Wales. It will facilitate Occupational Therapists' professional, clinical and management development to ensure skills are maximised and services are effective. It will assist in meeting the career needs of Occupational Therapists and shaping future Occupational Therapy careers in Wales, in order to maximise the impact of the Occupational Therapy workforce in their delivery of social care services. The framework aligns with the new NHS Allied Health Professional framework, "Modernising Allied Health Professional Careers in Wales", the Continuing Professional Education and Learning (CPEL) framework for social workers and the forthcoming general career framework being developed by the Royal College of Occupational Therapists to facilitate movement towards more integrated health and social services.

Similarly, a Health and Social Care Induction Framework for Wales has been developed for social care workers and healthcare support workers employed in community-based settings for adults and children and young people. It provides a structure for induction and outlines the knowledge and skills new workers need to evidence in the first six months of employment. The induction framework supports Welsh Government's commitment to deliver health and social care services in a seamless, effective and efficient way to promote well-being and achieve the best possible outcomes for people in Wales.

Sport Wales

Funding allocated to Sport Wales, the monitoring of spend and whether allocations are being used effectively to delivering outcomes for people in Wales.

Sport Wales has the dual remit of supporting elite and performance sport, for which it uses Lottery funding, and delivering community sport and physical recreation to the population, for which it uses a mix of Lottery and Welsh Government funding.

Physical activity is shown to play a significant role in health and prevention of illness, and can contribute to mental well-being and reducing isolation. Sport has a meaningful role to play in contributing to physical activity levels. It is for this reason that Sport and Public Health were brought together in this Government.

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According to the National Survey for Wales, people participating in sporting activities are more likely to meet the physical activity guidelines. And people who take part in sport and physical recreation are also less likely to smoke, more likely to eat five fruit and vegetables a day and less likely to be obese

Sport Wales is tasked with increasing the number of people meeting the CMO guidelines for activity and has a number of established programmes in place,

delivered by a range of established partners. In addition their Calls4Action programme has worked with new partners to target specific under-represented cohorts, whether by gender, ethnicity or area of deprivation.

The Minister for Social Services and Public Health in 2017 commissioned an independent review of Sport Wales and subsequently made a policy statement making clear her priorities for the organisation in delivering physical activity outcomes. Sport Wales' is currently undertaking evaluations of its long-established programmes to challenge delivery outcomes and to respond to these priorities. The current remit letter tasks Sport Wales with developing a new outcomes framework and measures which will demonstrate its contribution Prosperity for All.

In addition the Minister is requiring Sport Wales and Public Health Wales to work together to deliver the commitment to significantly increase physical activity levels contained with the Healthy and Activity action plan which is being developed.

Vaughan Gething AM, Cabinet Secretary for Health, Wellbeing and Sport

Rebecca Evans AM, Minister for Social Services and Public Health

Annex A

Commentary on each of the Actions within the Health, Well-being and Sport MEG, including an analysis and explanation of changes between the Draft Budget 2018-19 and the First Supplementary Budget (June 2017).

Realignment with the Health, Well-being and Sport MEG
Within the Health, Well-being and Sport MEG, we have reviewed the BEL budget structure, and have made a number of changes, necessitating a number budget transfers between BELs, that are detailed below.

In particular, you will wish to note that we have made the following changes:

- In response to repeated call from previous committees on the transparency of health funding, we have established a new BEL titled "Other Direct NHS Allocations" which will contain funding issued to NHS bodies outside of the core local health board revenue allocation, for example funding for NWIS and funding for demand led primary care services such as sight tests.

- As a consequence, this will ensure there is a closer alignment between the "Core Allocations" BEL and the health board revenue allocations that we will issue later in the Autumn.

- We have closed a number of BELs that contained specific budgets which are all eventually allocated to NHS organisations, for example the Information Central Budgets BEL, that included the NWIS funding and the Primary Care BEL, that included the centrally managed demand led primary care budgets

BEL 0020 Core NHS Allocations

2017-18 First supplementary budget £'000	2017-18 Revised Baseline £'000	Change £'000	2018-19 New Plans Draft Budget £'000	Change £'000	2019-20 New Plans Draft Budget £'000
6,353,668	6,344,788	174,530	6,519,318	220,000	6,739,318

Explanation of Changes to Delivery of Core NHS Allocations BEL

2018-19
Change between First Supplementary and revised Baseline for 2017-18

- Removal of in year non recurrent funding (Immigration Surcharge and Contaminated Blood)

Change between 2017-18 Revised Baseline and 2018-19 New plans (Draft Budget)

- £230,000 MEG allocation in respect of NHS services
- (£1,531) to the Other NHS Budgets - Expenditure (BEL 0682) in respect of the realignment exercise of HW&S BEL tables (miscellaneous budgets)
- (£53,939) to the Other Direct NHS Allocations (BEL 0030) in respect of the realignment exercise of the HW&S BEL tables (other NHS direct budget allocations issued)

2019-20

Change between 2018-19 Draft Budget and 2019-20 new plans (Draft budget)

- £220,000 MEG allocation in respect of NHS services

BEL 0030 Other Direct NHS Allocations

2017-18 First supplementary budget £'000	2017-18 Revised Baseline £'000	Change £'000	2018-19 New Plans Draft Budget £'000	Change £'000	2019-20 New Plans Draft Budget £'000
0	0	251,935	251,935	0	251,935

Explanation of Changes to Other Direct NHS Allocations BEL
2018-19

Change between First Supplementary and revised Baseline for 2017-18

- No changes, new BEL created in Draft budget

Change between 2017-18 Revised Baseline and 2018-19 New plans (Draft Budget)

- £53,939 from the Core NHS Services (BEL 0020) in respect of the realignment exercise of the HW&S BEL Tables (other NHS Direct budget allocations issued)
- £42,319 from the NHS Primary Care (Closed BEL 0180) in respect of the realignment exercise
- £129,192 from the Other NHS Budgets - Expenditure (BEL 0682) in respect other realignment exercise of the HW&S BEL Tables (various other NHS Direct allocations issued)
- £28,369 from the Information Central Budgets (Closed BEL 0257) in respect of the realignment exercise of the HW&S Tables (Other Direct NHS allocation (NWIS))
- £1,116 from the Hospice Support (Closed BEL 0286) in respect of the realignment exercise of the HW&S BEL Tables (Other direct NHS allocations (Hospice funding))

- £1,000 from Central Reserves: Budget agreement in respect of End-of-life funding
- (£4,000) contribution to agreed savings reduction to HW&S MEG for Efficiency through Technology

2019-20

Change between 2018-19 Draft Budget and 2019-20 New plans (Draft budget)

- No changes

BEL 0250 Public Health Wales

2017-18 First supplementary budget £'000	2017-18 Revised Baseline £'000	Change £'000	2018-19 New Plans Draft Budget £'000	Change £'000	2019-20 New Plans Draft Budget £'000
88,880	88,880	-464	88,416	0	88,416

Explanation of Changes to Public Health BEL

2018-19

Change between First Supplementary and revised Baseline for 2017-18

- No changes

Change between 2017-18 Revised Baseline and 2018-19 New plans (Draft Budget)

- (£464) to the Targeted Hlth Protection & Immunisation (BEL 232) in respect of the realignment exercise of the HW&S BEL Tables (Health Protection Agency)

2019-20

Change between 2018-19 Draft Budget and 2019-20 New plans (Draft budget)

- No changes

BEL 0180 NHS Primary Care – CLOSED BEL

2017-18 First supplementary budget £'000	2017-18 Revised Baseline £'000	Change £'000	2018-19 New Plans Draft Budget £'000	Change £'000	2019-20 New Plans Draft Budget £'000
46,906	46,906	-46,906	0	0	0

Explanation of Changes to NHS Primary Care BEL

2018-19

Change between First Supplementary and revised Baseline for 2017-18

- No changes

Change between 2017-18 Revised Baseline and 2018-19 New plans (Draft Budget)

- (£42,319) to the Other Direct NHS Allocations (BEL 0030) in respect of the realignment exercise of HW&S BEL tables (other NHS direct budget allocations issued)
- (£4,587) to the Other NHS Budgets - Expenditure (BEL 0682) in respect of the realignment exercise of the HW&S BEL tables (other miscellaneous budgets)

2019-20

Change between 2018-19 Draft Budget and 2019-20 New plans (Draft budget)

- No changes

BEL 0257 Information Central budgets – CLOSED BEL

2017-18 First supplementary budget £'000	2017-18 Revised Baseline £'000	Change £'000	2018-19 New Plans Draft Budget £'000	Change £'000	2019-20 New Plans Draft Budget £'000
28,369	28,369	28,369	0	0	0

Explanation of Changes to Information Central budgets BEL

2018-19

Change between First Supplementary and revised Baseline for 2017-18

- No changes

Change between 2017-18 Revised Baseline and 2018-19 New plans (Draft Budget)

- (£28,369) to the Other Direct NHS Allocations (BEL 0030) in respect of the realignment exercise of the HW&S Tables (Other Direct NHS allocation (NWIS))

2019-20

Change between 2018-19 Draft Budget and 2019-20 New plans (Draft budget)

- No changes

BEL 0265 Patient Safety Quality & Involvement – CLOSED BEL

2017-18 First supplementary budget £'000	2017-18 Revised Baseline £'000	Change £,000	2018-19 New Plans Draft Budget £'000	Change £'000	2019-20 New Plans Draft Budget £'000
2,588	2,588	-2,588	0	0	0

Explanation of Changes to Patient Safety Quality & Involvement BEL
2018-19
Change between First Supplementary and revised Baseline for 2017-18

- No changes

Change between 2017-18 Revised Baseline and 2018-19 New plans (Draft Budget)

- (£2,588) million to Health Improvement & Healthy Working (BEL 231) in respect of the realignment exercise of the HW&S Tables (miscellaneous health budgets

2019-20
Change between 2018-19 Draft Budget and 2019-20 New plans (Draft budget)

- No changes

BEL 0275 Chronic Diseases – CLOSED BEL

2017-18 First supplementary budget £'000	2017-18 Revised Baseline £'000	Change £'000	2018-19 New Plans Draft Budget £'000	Change £'000	2019-20 New Plans Draft Budget £'000
72	72	-72	0	0	0

Explanation of Changes to Chronic Diseases BEL
2018-19
Change between First Supplementary and revised Baseline for 2017-18

- No changes

Change between 2017-18 Revised Baseline and 2018-19 New plans (Draft Budget)

- (£72) to Other NHS Budgets - Expenditure (BEL 0682) in respect of the realignment exercise of the HW&S Tables (miscellaneous health budget)

2019-20

Change between 2018-19 Draft Budget and 2019-20 New plans (Draft budget)

- No changes

BEL 0682 Other Health Budgets - Expenditure

2017-18 First supplementary budget £'000	2017-18 Revised Baseline £'000	Change £'000	2018-19 New Plans Draft Budget £'000	Change £'000	2019-20 New Plans Draft Budget £'000
95,674	104,723	-77,368	27,355	-13,247	14,108

Explanation of Changes to Other Health Budgets - Expenditure BEL

2018-19

Change between First Supplementary and revised Baseline for 2017-18

- Removal of in year non recurrent funding (Invest to Save)

Change between 2017-18 Revised Baseline and 2018-19 New plans (Draft Budget)

- £1,531 from the Core NHS Services (BEL 0020) in respect of the realignment exercise of the HW&S BEL Tables (various miscellaneous budgets)
- (£129,192) to the Other Direct NHS Allocations (BEL 0030) in respect of the realignment exercise (Other direct NHS budget allocations issued)
- £4,587 from NHS Primary Care (Closed BEL 0180) in respect of the realignment exercise of the HW&S BEL Tables (various miscellaneous budgets)
- (£63k) to the Health Improvement & Healthy Working (BEL 0231) in respect of the realignment exercise of the HW&S Tables (miscellaneous budget changes)
- (£4,190) to the Targeted Health Protection & Immunisation (BEL 0232) in respect of the realignment exercise of the HW&S BEL Tables (Organ & Tissue budget)
- £72k from the Chronic Diseases (Closed BEL 0275) in respect of the realignment of the HW&S BEL Tables
- £140k from the Hospice Support (Closed BEL 0286) in respect of the realignment of the HW&S BEL Tables (miscellaneous budget change)
- £53,000 to the Other NHS Budgets - Income (BEL 0682) in respect of the realignment of the HW&S BEL Tables (PPRS Income budget)
- (£24k) to Mental Health (BEL 0270) in respect of the realignment of the HW&S Tables (miscellaneous mental health budget)£230,000 million MEG allocation in respect of NHS services

- (£278k) in respect of agreed Invest to Save adjustment with CSA MEG
- (£522k) contribution to agreed savings reduction to HW&S MEG for Ser Cymru grant funding
- (£300k) contribution to agreed savings reduction to HW&S MEG for Choose Pharmacy pilot funding
- (£2,129) contribution to agreed savings reduction to HW&S MEG for HSS Central reserve

2019-20

Change between 2018-19 Draft Budget and 2019-20 New plans (Draft budget)

- £1,131 MEG allocation in respect agreed Invest to Save adjustments with CSA MEG
- £20k MEG to MEG transfer for Secure Estates
- (£13,881) contribution to agreed savings reduction to HW&S MEG for HSS Central reserve
- (£517k) contribution to agreed savings reduction to HW&S MEG for Ser Cymru grant funding

BEL 0682 Other Health Budgets - Income

2017-18 First supplementary budget £'000	2017-18 Revised Baseline £'000	Change £'000	2018-19 New Plans Draft Budget £'000	Change £'000	2019-20 New Plans Draft Budget £'000
0	0	-53,000	-53,000		-53,000

Explanation of Changes to Other Health Budgets - Income BEL

2018-19

Change between First Supplementary and revised Baseline for 2017-18

- No changes, new BEL created in Draft budget

Change between 2017-18 Revised Baseline and 2018-19 New plans (Draft Budget)

- (£53,000) from Other NHS Budgets - Expenditure (BEL 0682) in respect of the realignment exercise of the HW&S BEL Tables (PPRS Income budget

2019-20

Change between 2018-19 Draft Budget and 2019-20 New plans (Draft budget)

- No changes

BEL 0140 Education and Training

2017-18 First supplementary budget £'000	2017-18 Revised Baseline £'000	Change £'000	2018-19 New Plans Draft Budget £'000	Change £'000	2019-20 New Plans Draft Budget £'000
194,051	187,851	8,985	196,836		196,836

Explanation of Changes to Education and Training BEL

2018-19

Change between First Supplementary and revised Baseline for 2017-18

- Removal of in year non recurrent funding

Change between 2017-18 Revised Baseline and 2018-19 New plans (Draft Budget)

- (£15k) million to Health Improvement & Healthy Working (BEL 0231) in respect of the realignment exercise of the HW&S BEL Tables (miscellaneous budget change
- £9,000 from Central Reserves: Budget Agreeement in respect of Development Fund North Wales (£7,000) and Welsh Buurtzorg pilot (£2,000)

2019-20

Change between 2018-19 Draft Budget and 2019-20 New plans (Draft budget)

- No changes

BEL 0185 Workforce Development Central Budgets

2017-18 First supplementary budget £'000	2017-18 Revised Baseline £'000	Change £'000	2018-19 New Plans Draft Budget £'000	Change £'000	2019-20 New Plans Draft Budget £'000
2506	2506	-50	2,456	0	2,456

Explanation of Changes to Workforce Development Central Budgets BEL 2018-19

Change between First Supplementary and revised Baseline for 2017-18

- No changes

Change between 2017-18 Revised Baseline and 2018-19 New plans (Draft Budget)

- (£50k) in respect of agreed grant funding transfer (Wales for Africa) to CSA MEG

2019-20

Change between 2018-19 Draft Budget and 2019-20 New plans (Draft budget)

- No changes

BEL 0270 Mental Health

2017-18 First supplementary budget £'000	2017-18 Revised Baseline £'000	Change £'000	2018-19 New Plans Draft Budget £'000	Change £'000	2019-20 New Plans Draft Budget £'000
3,255	2,255	1,024	3,279	0	3,279

Explanation of Changes to Mental Health BEL

2018-19

Change between First Supplementary and revised Baseline for 2017-18

- Removal of in year non recurrent funding

Change between 2017-18 Revised Baseline and 2018-19 New plans (Draft Budget)

- £24k from Other NHS Budget - Expenditure (BEL 0682) in respect of the realignment exercise of the HW&S BEL Tables (mental health budget transfer)
- £1,000 from Central Reserves: Budget Agreement for Eating Disorders and gender dysphoria services

2019-20

Change between 2018-19 Draft Budget and 2019-20 New plans (Draft budget)

- No changes

BEL 0286 Hospice Support – CLOSED BEL

2017-18 First supplementary budget £'000	2017-18 Revised Baseline £'000	Change £'000	2018-19 New Plans Draft Budget £'000	Change £'000	2019-20 New Plans Draft Budget £'000
2,256	1,256	-1,256	0	0	0

Explanation of Changes to Hospice Support BEL

2018-19

Change between First Supplementary and revised Baseline for 2017-18

- Removal of in year non recurrent funding

Change between 2017-18 Revised Baseline and 2018-19 New plans (Draft Budget)

- (£1,116) to the Other Direct NHS Allocations (BEL 0030) in respect of the realignment exercise of HW&S BEL tables (other NHS direct budget allocations issued)
- (£140k) to the Other NHS Budgets - Expenditure (BEL 0682) in respect of the realignment exercise of the HW&S BEL tables (other miscellaneous budgets)

2019-20

Change between 2018-19 Draft Budget and 2019-20 New plans (Draft budget)

- No changes

BEL 1682 Substance Misuse Action Plan Fund

2017-18 First supplementary budget £'000	2017-18 Revised Baseline £'000	Change £'000	2018-19 New Plans Draft Budget £'000	Change £'000	2019-20 New Plans Draft Budget £'000
26,975	26,975	-500	26,475	-1,980	24,495

Explanation of Changes to Substance Misuse Action Plan Fund BEL

2018-19

Change between First Supplementary and revised Baseline for 2017-18

- No change

Change between 2017-18 Revised Baseline and 2018-19 New plans (Draft Budget)

- (£500k) contribution to agreed savings reduction to HW&S MEG from Operation Tarian funding. This is accompanied by a recurrent increase to LHB ringfenced allocations for substance misuse treatment services.

2019-20

Change between 2018-19 Draft Budget and 2019-20 New plans (Draft budget)

- (£1,980) contribution to agreed savings reduction to HW&S MEG from All Wales Schools Liaison Core Programme (AWSLCP)

BEL 0231 Health Improvement & Healthy Working

2017-18 First supplementary budget £'000	2017-18 Revised Baseline £'000	Change £'000	2018-19 New Plans Draft Budget £'000	Change £'000	2019-20 New Plans Draft Budget £'000
3,903	3,903	9,641	13,544	-156	13,388

Explanation of Changes to Health Improvement & Healthy Working BEL
2018-19

Change between First Supplementary and revised Baseline for 2017-18

- No change

Change between 2017-18 Revised Baseline and 2018-19 New plans (Draft Budget)

- £15k million from Education & Training (BEL 0140) in respect of the realignment exercise of the HW&S BEL Tables (miscellaneous budget change))
- £63k from the Other NHS Budgets - Expenditure (BEL 0682) in respect of the realignment exercise (miscellaneous budget changes)
- £2,588 from the Patient Safety Quality & Improvement (BEL 0265) in respect other realignment exercise of the HW&S BEL Tables (miscellaneous changes)
- £7,500 from the Welfare Food (Closed BEL 0400) in respect of the realignment exercise of the HW&S Tables (Healthy Start budget)
- £125k from the Safeguarding & Advocacy (BEL 0460)in respect of the realignment exercise of the HW&S BEL Tables (Children's Health budget)
- (£600k) contribution to agreed savings reduction to HW&S MEG from Healthy Start budget
- (£50k) contribution to agreed savings reduction to HW&S MEG from Health Quality Initiative budget

2019-20

Change between 2018-19 Draft Budget and 2019-20 new plans (Draft budget)

- (£156k) contribution to agreed savings reduction to HW&S MEG from Health Improvement budget

BEL 0232 Targeted Health Protection & Immunisation

2017-18 First supplementary budget £'000	2017-18 Revised Baseline £'000	Change £'000	2018-19 New Plans Draft Budget £'000	Change £'000	2019-20 New Plans Draft Budget £'000
3,987	3,987	4,597	8,584	0	8,584

Explanation of Changes to Targeted Health Protection & Immunisation BEL
2018-19

Change between First Supplementary and revised Baseline for 2017-18

- No change

Change between 2017-18 Revised Baseline and 2018-19 New plans (Draft Budget)

- £4,190 from the Other NHS Budgets - Expenditure (BEL 0682) in respect of the realignment exercise of HW&S BEL tables (organ & tissue budget)
- £464k from the Public Health Wales (BEL 0250) in respect of the realignment exercise of the HW&S BEL tables (Health Protection Agency)
- (£57k) contribution to agreed savings reduction to HW&S MEG from Special Initiatives budget

2019-20

Change between 2018-19 Draft Budget and 2019-20 New plans (Draft budget)

- No change

BEL 0400 Welfare Food – CLOSED BEL

2017-18 First supplementary budget £'000	2017-18 Revised Baseline £'000	Change £'000	2018-19 New Plans Draft Budget £'000	Change £'000	2019-20 New Plans Draft Budget £'000
7,500	7,500	-7,500	0	0	0

Explanation of Changes to Welfare Food BEL
2018-19

Change between First Supplementary and revised Baseline for 2017-18

- No changes

Change between 2017-18 Revised Baseline and 2018-19 New plans (Draft Budget)

- (£7,500) to Health Improvement & Healthy Working (BEL 0231) in respect of the realignment of the HW&S BEL Tables (Healthy Start budget)

2019-20

Change between 2018-19 Draft Budget and 2019-20 New plans (Draft budget)

- No changes

BEL 0230 Health Emergency Planning

2017-18 First supplementary budget £'000	2017-18 Revised Baseline £'000	Change £'000	2018-19 New Plans Draft Budget £'000	Change £'000	2019-20 New Plans Draft Budget £'000
6,712	6,712	-653	6,059	-34	6,025

Explanation of Changes to Health Emergency Planning BEL

2018-19

Change between First Supplementary and revised Baseline for 2017-18

- No change

Change between 2017-18 Revised Baseline and 2018-19 New plans (Draft Budget)

- (£53k) contribution to agreed savings reduction to HW&S MEG from Hazard Area Response Teams budget
- (£600k) contribution to agreed savings reduction to HW&S MEG from Health Emergency Planning

2019-20

Change between 2018-19 Draft Budget and 2019-20 New plans (Draft budget)

- (£34k) contribution to agreed savings reduction to HW&S MEG from Hazard Area Response Teams budget

BEL 0260 Research and Development

2017-18 First supplementary budget £'000	2017-18 Revised Baseline £'000	Change £'000	2018-19 New Plans Draft Budget £'000	Change £'000	2019-20 New Plans Draft Budget £'000
43,365	43,365	-860	42,505	-430	42,075

Explanation of Changes to Research and Development BEL

2018-19

Change between First Supplementary and revised Baseline for 2017-18

- No change

Change between 2017-18 Revised Baseline and 2018-19 New plans (Draft Budget)

- (£860k) contribution to agreed savings reduction to HW&S MEG from DHSCR budgets

2019-20

Change between 2018-19 Draft Budget and 2019-20 New plans (Draft budget)

- (£430k) contribution to agreed savings reduction to HW&S MEG from DHSCR budgets

BEL 0460 Safeguarding and Advocacy

2017-18 First supplementary budget £'000	2017-18 Revised Baseline £'000	Change £'000	2018-19 New Plans Draft Budget £'000	Change £'000	2019-20 New Plans Draft Budget £'000
985	985	280	1,265	0	1,265

Explanation of Changes to Safeguarding and Advocacy BEL

2018-19

Change between First Supplementary and revised Baseline for 2017-18

- No change

Change between 2017-18 Revised Baseline and 2018-19 New plans (Draft Budget)

- (£125k) to Health Improvement & Healthy Working (BEL 0231) in respect of the realignment of the HW&S BEL Tables (Children's Health budget)
- £405k from Sustainable Social Services (BEL 0920) in respect of the realignment of the HW&S BEL tables (miscellaneous budget change)

2019-20

Change between 2018-19 Draft Budget and 2019-20 New plans (Draft budget)

- No change

BEL 0661 Older People Carers & Disabled People

2017-18 First supplementary budget £'000	2017-18 Revised Baseline £'000	Change £'000	2018-19 New Plans Draft Budget £'000	Change £'000	2019-20 New Plans Draft Budget £'000

29,197	29,197	-27,000	2,197	0	2,197

Explanation of Changes to Older People Carers & Disabled People BEL
2018-19
Change between First Supplementary and revised Baseline for 2017-18

- No change

Change between 2017-18 Revised Baseline and 2018-19 New plans (Draft Budget)

- (£27,000) MEG to MEG transfer to Local Government for Welsh Independent Living Grant

2019-20
Change between 2018-19 Draft Budget and 2019-20 New plans (Draft budget)

- No change

BEL 0920 Sustainable Social Services

2017-18 First supplementary budget £'000	2017-18 Revised Baseline £'000	Change £'000	2018-19 New Plans Draft Budget £'000	Change £'000	2019-20 New Plans Draft Budget £'000
42,132	12,132	-817	11,315	0	11,315

Explanation of Changes to Sustainable Social Services BEL
2018-19
Change between First Supplementary and revised Baseline for 2017-18

- MEG to MEG transfer of Local Government Grants

Change between 2017-18 Revised Baseline and 2018-19 New plans (Draft Budget)

- (£405k) to Safeguarding & Advocacy (BEL 0460) in respect of the realignment of the HW&S BEL Tables (miscellaneous budget change)
- (£391k) MEG to MEG transfer to Local Government for Secure Estates funding
- (£21k) contribution to agreed savings reduction to HW&S MEG from Sustainable Social budget

2019-20
Change between 2018-19 Draft Budget and 2019-20 New plans (Draft budget)

- No change

Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru
Care and Social Services Inspectorate Wales

Care and Social Services Inspectorate for Wales (CSSIW)

Evidence for Health, Social Care and Sport Committee: Use of anti-psychotic medication in care homes - Additional information requested by 6 November

Details and explanation in relation to home closures:

CSSIW has a clear enforcement pathway. Where care services provide poor care and fail to improve they are identified as “services of concern”. This means they are subject to formal enforcement action. This can include pursuing cancellation of the registration of the service; this occurs in about half of the services identified as services of concern. Other options pursued include restricting further admissions or cancellation of the manager’s registration.

The process of cancellation is complex and can result in a number of outcomes;

- the service closes completely,
- the service run by the existing provider closes but is then taken on by a new provider either as a brand new services of as a going concern or
- the service improves and avoids actual closure.

Sometimes a registered provider will decide to voluntarily cancel their registration once they have received notification of CSSIW’s intentions as a means of avoiding legal action.

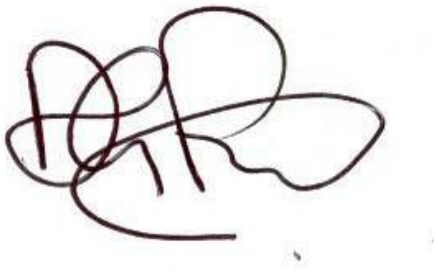
In respect of older people’s care homes and nursing homes, in just over four years CSSIW has pursued cancellation of the registration of 33 older people’s care homes in Wales. As a result the registration of 30 older people’s care homes were cancelled either directly by CSSIW or agreed through voluntary cancellation. 21 services were nursing homes, 10 were residential. These services were spread across Wales and included a number of large homes as well as some small to medium size homes.

20 of the homes completely closed, one partially closed (nursing floors). 9 of the homes were taken on by new owners as going concerns.

One service, Gibraltar House in Monmouthshire improved. CSSIW decided not to enforce the notice of cancellation. The committee may be interested to note that the concerns related to the care of people with dementia. Dementia Care Matters were brought in to provide consultancy and training which resulted in improvements in the care provided.

When considering and pursuing cancellation CSSIW must be able to demonstrate that regulations have been breached and provide evidence serious concerns which impact on the wellbeing of people living in the services or place them at significant risk. Failing to meet basic health care needs is a common theme in older people's care homes where CSSIW takes action including nutrition and hydration, pressure area and diabetes care. People with dementia are often found to be at greater risk because of the particular challenges in providing care and support.

In nine of the services above poor medication administration was one of the legal grounds on which cancellation was pursued.



David Francis

Assistant Chief Inspector

Examples of care homes which pride themselves on reducing use of antipsychotics.

Three Cliffs Care Home

Three Cliffs is a 50 bed nursing dementia care home on the Gower. On the day of a recent visit there were 48 people in the home, 27 people are funded as continuing health care, 14 funded nurse care the remainder privately funded. The home uses a dependency measurement tool which includes psychological / behavioural scales. A number have a history of mental health diagnoses for example schizophrenia. According to the manager the majority of people living at the home are assessed "top / end stage dementia". The home takes people which other homes cannot cope with. Nearly all residents need a lot of assistance to eat / drink and have mobility problems. Home prides itself on caring through to end of life.

At the time of the visit 5 of the 48 people in the home were prescribed with very low doses of antipsychotics.

The low use of antipsychotics is referenced in the last inspection report (attached).

In some ways the home is very ordinary which is what makes its achievements more remarkable. It is an old building not specially built or adapted for dementia care.

Why does this home work well:

- Excellent relationship with mental health in reach team who are very responsive and lead by a consultant who is said to really care and is very committed to reducing medication.

- Excellent relationship with GP; weekly half day in house surgery, good system for best use of GP time faxing list of residents and concerns beforehand. Also other health services; e.g. in-reach dentistry and "dementia" optician.
- Strong emphasis on building an in depth understanding of every person; their backgrounds, needs, why they behave and respond as they do. Senior carers know residents really well and spot and respond to changes early.
- Strong commitment to and investment in activities which are individually tailored. Sense of a busy home.
- A high commitment to improvement and ongoing learning stealing and trying others ideas, linking to and reading research (Stirling, Bradford, Bangor, David Sheard, Scandinavia) and taking part in projects e.g. West Wales Adverse Drug Reaction research. The home has no "model" of care as such, just a strong commitment to kindness and individualised care;

- Wide range of dementia training. Aim for level 3 in dementia for senior staff. Strong in house mentoring, very experienced managers.
- Tight grip on medication reviews; medication profile sheets highlight in red all high risk medications including antipsychotics and requiring staff to ensure they are reviewed three monthly;
- Differentiated areas to suit people with different needs. In particular the "Sea view" wing; low stimulation to reduce triggers, small numbers / high staff ratio.
- Staff ratios. Willingness to be flexible in relation to changing needs which can mean increased costs at times.

What challenges this home:

- LHB funding; protectionism between budgets community vs. hospital. LHB being unwilling to fund when levels of need increase.
- Reduced in-patient assessment facilities available to provide crisis hospital admissions puts undue pressure on the registered manager if she continues to provide a placement that may conflict with registration conditions (e.g meeting the person's needs & needs and safety of others)
- Staff turnover. Home is on the Gower but close to Swansea. As staff are trained they are poached by city based homes / NHS. Relentless effort to build and retain teams of experienced staff.

Case example:

Took a lady who could not be managed / supported elsewhere. Very high levels of confrontational behaviour. In addition to dementia she had learning disabilities and was diagnosed with schizophrenia. She spent time on Sea View, staff made careful observations, trying to understand what was causing behaviour. Concluded that the underlying issue was she had strong feelings of not being wanted, that she could never "belong" anywhere. Range of approaches tried including undertaking simple tasks about the home. In time she moved to live in communal area. She is now happier and her behaviour is settled and the use of psychoactive medication has been significantly reduced. She is able to go out to brother's house and attend church; these would have been considered impossible when she was first admitted to Three Cliffs.

Clydach Court

Clydach Court is a residential care home in Tonypandy registered to care for 36 people with dementia.

It is one of six Butterfly Care homes in Wales accredited with Dementia Care Matters, who have an inspirational programme for the care of people with dementia developed by David Sheard. Dependency levels are not as high as those in nursing homes although Clydach Court does take people who can have complex needs and who can be challenging to care for.

The manager reports that the home is successful in stopping / reducing the use of antipsychotic medication particularly when people come into the home from the community or hospital

Why does this home work well:

- Butterfly homes place emphasis on having a care home culture where people are respected and supported as individuals, where "people really matter", feelings are recognised and supported and the home's environment and routines are busy and adapted for individuals.
- Staff are given in depth training and the home has to work hard (often over a year) to meet the high standards which are set by Dementia Care Matters.
- Clydach Court provides responsive care and has a strong proactive relationship with the health board's consultant lead Dementia Intervention Team. When behavioural problems arise the intervention team will be asked to come in. They provide a support worker who will undertake a 12 week assessment during which they develop an individualised support plan, often based on distraction techniques. This approach is always pursued as a way to avoid the use of medication.
- Clydach Court has recently moved to allocation to a single GP practice. The GP undertakes fortnightly ward rounds and reviews each person. The manager says having consistent GP oversight is very beneficial. She says that reviewing and challenging the use of medication is uppermost in the GP's priorities.

What challenges this home:

- Not being able to care for people who are very frail towards the end of their lives and have to move into nursing care.

Case example:

A person who was admitted from home having been prescribed respiradone. When the manager questioned the reason no one could explain why. She was particularly concerned about the effect on the person's mobility. As a result of the manager's intervention the medication was withdrawn and the person has happily settled in the home.

Rickeston Mill Nursing Home

Rickeston Mill is a 28 bed nursing dementia home near Milford Haven caring for people with dementia. It takes people with high levels of dependency.

Why does this home work well:

- It is the commitment of the manager which really makes a difference in this home. She does not like to see people who are drowsy and will challenge the use of antipsychotics. She is also concerned about the use of lorazepam and diazepam. She says she has a good rapport with the GP and mental health team but they do not visit the home or undertake reviews unless she prompts them. The success in reducing antipsychotics and other medication is a result of her willingness to challenge.
- The staff are well trained and well lead (emphasis on the Butterfly approach).
- The home focusses on understanding individuals, finding ways round behaviours and promoting activities.

What challenges this home:

- Disputes over whether people are funded for residential or nursing care.
- Unrealistic funding levels for people requiring very high levels of care e.g. 1:1 support.

Case example:

We reference this home because of our experience of dealing with a complaint about quality of care in another dementia nursing home. A lady transferred between the homes because she had been seen as very difficult to manage. She had dementia and other underlying psychiatric problems. She could be challenging very resistive to personal care and being supported to eat and drink. As a result they were prescribed high doses of Epilim, an anticonvulsant with the effect she lost a lot of weight, was drowsy and lost mobility.

The staff at Rickeston pursued medication reviews and asked for the Epilim to be reduced and withdrawn; which it was. The person became alert, responsive and mobile. They also gained weight.

There are two others recent cases where the manager has challenged the use of medication, including antipsychotics and the medication has been withdrawn or substantially reduced.

The home has recently adopted a medication review prompt sheet for all residents.

Care and Social Services Inspectorate for Wales

Evidence for Health, Social Care and Sport Committee: Use of anti-psychotic medication in care homes: Additional information in respect of care homes which are committed to reducing the use of antipsychotic medication

Please find attached examples of three homes which are examples of good practice. One of the homes is an accredited “Butterfly” home; additional information about the success of Butterfly homes is included.

What is evident in these examples it that care homes are dependent on the support they receive from primary care and psychiatric in-reach teams.

We have also been advised of the work being undertaken by the Four Seasons group in addressing over medication of older people in care homes. This includes the introduction of a medication “App” which care workers complete on a monthly basis for each resident. The App identifies medications / dosages which create risk (including antipsychotics) and auto-generates a letter to the GP requiring a medication review if the medication profile suggests there is a concern.

Four Seasons have also developed a comprehensive “experiential” training package for all care home staff which they believe has been successful in enabling staff to support people with dementia and reduce the use of medication.

Additional information and CSSIW’s role and plans going forward:

Following CSSIW’s appearance at the Committee we have reviewed our inspection frameworks in light of the feedback from the committee. We will be updating these in response to the 2016 Act and will use the opportunity to make specific reference to the timeliness of medication reviews and the use of antipsychotics as areas inspectors must consider on inspection. We will however not be able to do this for all residents. To strengthen our inspections we will be exploring how we can obtain feedback from community pharmacists linked to homes who will be funded under the new enhanced contract to check medication reviews and the use of antipsychotics in care homes.

As explained in our evidence to the committee CSSIW will be considering the use of antipsychotic medication when we undertake a thematic national review into the quality of care in residential care of people for people in 2019/20. We will be asking for pharmacist input into the design and evaluation of this thematic inspection.

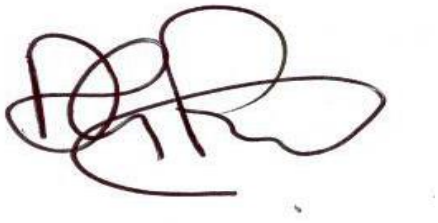
From 2019 CSSIW plans to ask care homes to report on the frequency of medication reviews and the use of antipsychotic medication in the annual on-line self assessments which are completed by care homes. This will enable inspectors to be sighted on those where usage is particularly high.

Following our recent discussions with pharmacist advisors and care home staff we note that antipsychotics are just one of a range of psychoactive drugs used to manage behaviour for people with dementia. A number of these also have adverse side effects. We also recognise that the use of the antipsychotics can have benefits. It is not the use of them per se that is the issue; it is the dosage.

The Committee raised the question of pharmacy inspectors being employed by CSSIW. CQC and Care Inspectorate Scotland have advised us that they employ pharmacists. This is primarily in an advisory role and although in CQC pharmacists are used on a small proportion of inspections where there are significant concerns about medication practice. CSSIW made the decision not to employ pharmacists in 2012 following a cost benefit exercise. CSSIW concluded that it could not justify employment of pharmacy inspectors given that £2.7m savings had to be made over 2/3 years. A further reduction in CSSIW's operating budget is envisaged over the next two financial years.

Although CSSIW does not employ pharmacists our inspectors are trained in to inspect medication practice in relation to the requirements of the regulations. In the past 12 months CSSIW issued 54 Notices of Non Compliance in relation medication practice in older people care homes. These notices are not issued for minor problems but when there is a serious risk to the health and well being of residents.

Yours sincerely



David Francis

Assistant Chief Inspector

Enc: attached profiles.

Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru
Care and Social Services Inspectorate Wales

Inspection Report on

Three Cliffs Care Home

Cefn Bryn Lane
Penmaen
Gower
SA3 2HQ

Date of Publication

Tuesday, 25 April 2017

Description of the service

Three Cliffs Care Home is registered to provide nursing and personal care for up to fifty one older adults with dementia, requiring nursing or personal care. Variations to the registration have been approved from time to time for individual persons who are younger.
The home is located on the cliffs above Three Cliffs Bay with panoramic views out to sea. The registered provider of the service is Heart of Wales Care Limited. The home's joint registered managers are Tom Watson and Marion Reading.

Summary of our findings

1. Overall assessment

People living at the care home receive a high standard of care from nurses and care assistants. They are treated with dignity and respect, which extends to the many visitors who are greeted and spoken to as friends. The care assistants have many skills in observations and gentle interventions, through their knowledge of each person's background and needs, which was a positive feature at this inspection.

2. Improvements

- The provider has invested in a high quality computer system for care records, accessible for nurses and care staff to enter detailed care for the people living in the home.
- The appointments of a well-being development manager and a well-being coordinator have focused staff awareness on furthering well-being development for each person.

3. Requirements and recommendations

Section five of this report sets out our requirements and recommendations to improve the service

1. Well-being

Summary
People relate well and also have good relationships with the nurses and care assistants who care for them. We saw people being treated in a kind and caring way throughout our visit. Staff took time to speak with each person and reassure them by being polite, respectful and friendly. This enabled people to feel safe and protected, if disturbed or confused. Staff are present at all times in the four day rooms around the home.

Our findings
Care staff approach people with a quiet manner, knowing that those with mental frailty may feel anxious and be confused. We observed that staff gave each person sufficient relaxed time while being assisted with eating and drinking. When a person was unsure while walking around, we noted the person was given help with unhurried kindness. Visiting family members told us they were very satisfied and variously said, for example, *'such good care'…'play nice music'….'right place for…'.* We heard so many compliments and were impressed with the really friendly interactions with staff, including some banter and laughter. We also saw people were being listened to as they expressed their thoughts, thereby being treated with dignity and respect. The home is well-staffed and staff know how to provide appropriate and compassionate care, so that people experience positive relationships.

People are provided with a good nutritional diet and supported to maintain a healthy lifestyle as appropriate. We discussed the average day with the duty nurse and others, finding that some people started getting up after the day staff arrived at 7am, although a few would have woken earlier and some remained in bed until later. Breakfast was served mainly in the four day rooms, but a few received breakfast in bed or at the bedside. Later, a fruit platter was taken around and we saw people eating small pieces of fresh fruit. Lunch would be served about 1pm, the main meal of the day, freshly prepared by the experienced catering team led by the chef. People had drinks available. Afternoon tea with homemade cakes and biscuits was followed by high tea at 5pm, which on the day was sandwiches, a popular regular option. That would be followed by milky hot chocolate and various options for snacks at 7pm. Some people were reportedly still up until 10pm, if content. We were informed that the diet included plenty of honey, butter, milk and cream and we saw evidence of that emphasis on good nutrition. We heard about and saw regular weight records, which would be done according to the nurse's assessment. Food supplements were given as needed. Many people needed total help with feeding; we saw that done quietly and with dignity. Each person is provided with an effective nutritional assessment and provision of wholesome food and regular meals to keep them as healthy as possible.

Contact with relatives and the community is encouraged. People had a daily transport service, with two drivers who were also available to collect infirm relatives from their homes three days a week and bring them in to visit and then return them home; an invaluable and thoughtful service. We were told how the drivers also collected prescriptions, or took people to appointments and also were available for trips to the village café and heritage centre, for example. At the care home, people had use of the large front and rear gardens with fine views in good weather. The managers and the team of nurses and care assistants are dedicated to providing a responsive service to each person and to their relatives.

2. Care and Support

Summary
People are provided with appropriate care and support by staff who have the skills and knowledge to carry out their roles and responsibilities; they do this with kindness and respect for the people in their care. Staff receive effective supervision and support and undertake the training and qualifications necessary to fulfil their duties.

Our findings
People are supported and cared for by trained staff in sufficient numbers working in the four units. Staffing levels on the daily rota were one nurse and thirteen care assistants. At night, there was one nurse and six care assistants. The clinical lead nurse told us that she was generally supernumerary to the staffing levels and supervised the nursing care. We spent much of our inspection going around the four units to observe the changes during the course of the day. We found that the care staff were excellent at all times in the supervision of vulnerable older people and in their interactions with individuals, with occasional wider exchanges of conversation. Their vigilance was a highlight of the inspection. However, we would like to have seen more creative action to stimulate individuals or groups of people at times. People's lives and well-being are enhanced as they are provided with safe, active and responsive care by a well-motivated care team.

People receive appropriate and good nursing and personal care. We were told about the care routines that assisted in good care provision. We examined the excellent computerised daily personal and nursing care records and noted these were in good detail in the sample viewed. We considered that the level of nursing and personal care skills were of a good standard. Staffing levels were good for the current needs of everyone on the day of inspection. People were protected by deprivation of liberty safeguards. People are cared for by a female and male team of nurses and care staff who maintain a very good service to ensure people are safe, comfortable and properly supported in their daily life.

People are protected by a safe medicine administration and storage system, with only nurses giving out medicines. We looked at the medicine arrangements and charts and found an organised system with good records completed. Drugs were correctly stored and recorded on the day of inspection. The nurse said that few anti-psychotic drugs were needed and other medicines, such as benzodiazepines were only provided for the well-being of individuals. We noted the lower prescribed use of these medicines on the charts. Medicines were given out at breakfast so the nurse could assess each person and how they were managing food. A pain assessment was also done as people could not always verbally express any pain, so the nurse said he would give paracetamol to people who could be in pain by observing their demeanour. People are safely provided with medicines by the home's registered nurses.

People receive GP, consultant psychiatrist, dental and other NHS services, including specialist nurses. We discussed dementia care services with the duty nurse; he suggested that more reminiscence therapy and exploration of suitable projects and fiddle boards would be useful. People are able to access suitable and generally responsive NHS medical and nursing specialist services, but would benefit from further dementia care activities.

3. Environment

Summary
People are supported in comfortable surroundings, as the provider has invested in improving the environment to enhance the well-being of the people living at the home. However, one or two of the many hoists should be stored with more consideration, so as to maintain safety and personal space in the corridors and bedrooms.

Our findings
The care home has sufficient space and facilities to meet the needs of the people. We saw that good standards were being maintained in general maintenance and refurbishment, although paintwork had been damaged in the narrow corridors. Individual bedrooms were variously personalised, furnished and decorated. Profiling beds were provided, being adjustable for height and positioning for comfort. Toilets, showers and bathrooms were mostly of a good standard of space and facilities, including extras, for example, a male urinal, shower trolleys and a range of hoists. In the dayrooms, we saw that people were able to move around the rooms and corridors, although most seemed content to remain in the chair they occupied. Meals were taken at individual chairs or small adjustable tables, depending on mobility and assessment. We were told that the garden had been used by some people in the summer and that it was planned to do further safety work to make it more accessible. People spend each day in a pleasant, comfortable environment.

People benefit from efficient housekeeping services provided by the laundry and domestic staff. We were pleased with the standard of knowledge and care of the experienced laundry person. She had good knowledge of infection control procedures and laundering, so that people's clothes were being well processed. She was also the home's valued hairdresser. We were impressed with the excellent labelling machine that printed and securely fixed name tags to clothing. We met two domestic cleaners who were efficiently cleaning the large home, which looked clean and did not have any odours. People are provided with a good laundry and domestic cleaning service.

The home has an on-site maintenance workshop service. The maintenance of the home was generally efficient, but we found a tool cupboard unlocked by a stairway. We also noted that some bedroom door hinges needed attention. We found a number of instruction notices for staff that should be removed from public areas. One room had some plaster damage to the wall and the manager could not explain why it was in that condition. In one bedroom, we noticed a hoist inappropriately stored that we were told was for general use. In addition, we detected a serious safety issue when we found a mobile hoist blocking a fire exit. We informed the manager that this was dangerous and that she must organise safety checks to ensure that all escape routes were kept clear at all times. The home has a problem with the storage of hoists.

People can make use of alternative facilities with a room set out like a pub, with bottled beer. We were told that Friday night was fish and chip evening during the warmer weather. The pub was situated in a nicely converted outside room by the car park with an adjoining staff training room. Overall, the home provides people with a warm and safe environment that promotes a sense of well-being for many people.

4. Leadership and Management

Summary

The home is effectively managed and run for the benefit of the people living at the care home. The managers are committed to improving the care provision and facilities. They also are committed to the professional development of the nurses and care assistants.

Our findings

People are provided with a very good level of nursing and personal care because the team is competently led by the clinical lead nurse. We found staff had a sound understanding of the aims and objectives of the service for the people who had made their home at Three Cliffs. Nurses and senior carers, on rota, supervised the many other staff employed, ensuring that each person was given appropriate nursing and personal care and other services. The management of staff is organised and efficient.

People receive care and support from staff who undergo regular training and supervision. We saw that recruitment checks were being carried out to assess whether applicants were suitable to work at the home. However, there was a vacancy for a registered nurse, requiring employing a regular agency nurse. We saw that the clinical lead nurse and the duty nurse were involved in direct care or supervision throughout the day. Staff had received regular individual supervision meetings. This indicates that people benefit from a service where staff are well-led, supported and trained.

People and their relatives are consulted about the care provision. We read some of the comments from a recent survey suggesting some small improvements, such as more proactive care at times. We viewed the online annual quality review and development plan, written to a high standard of detail and completion by the senior manager. We were assured that the responsible individual's quarterly report had been completed, but we did not view it. We asked the manager about any incidents or accidents and discussed one incident. One relative told us that they were kept informed of any changes or incidents. People and their relatives enjoy good relationships with the staff team.

Staff work really well as a team; they are valued and given support and direction in their duties. We observed how staff were confident and relaxed in their work. A training company had been employed, with a tutor who provided support for staff whose first language was not English. Local staff and overseas staff worked cohesively and respectfully together and we were heartened to see the enormous positive contribution everyone made to the lives of the people living at the home. Staff were assisted in travel to the home. Drivers collected and returned staff to and from Swansea every day. We were informed that staff were progressively trained in care qualifications to levels 2, 3,and 5. Three nurses were doing the higher qualification. In-house training had included the core topics of health & safety, moving & handling, food hygiene and first aid, with extra topics of dementia care and mental capacity provided by a MIND trainer. We met the well-being development manager who described his role as '*looking at things and if not quite right, making changes'.* He showed us the excellent *'About Me'* booklets which contained useful information about each person; information sharing was a key feature. Dementia care maybe unpredictable but the ethos of care here was to kindly and gently anticipate and interpret signs before a problem arose. The service provides leadership by ensuring everyone understands these important principles and achieves a good degree of success in caring for people with dementia.

5. Improvements required and recommended following this inspection

5.1 Areas of non-compliance from previous inspections

No areas were formally identified as non-compliant at the previous inspection.

5.2 Areas of non-compliance identified at this inspection

Regulation 24 (4) (b). Adequate means of escape. We advised the registered manager that the risks to people's health and safety had been compromised by failure to ensure that fire exits were kept free from obstruction. A notice has not been issued on this occasion as there was no immediate or significant effect for people using the service, and the obstruction was quickly removed. A daily safety check should be undertaken to remove any hazards.

5.3 Recommendations for improvement

We recommend the following:

- Immediately identify and ensure safe storage of mobile hoists around the home.
- Ensure tool cupboards are kept locked shut when unused.
- Continue to seek a registered nurse/s to join the team.
- Provide more spontaneous creative action to stimulate individuals or groups of people.
- Arrange reminiscence therapy and exploration of suitable projects, such as dementia aids and equipment like fiddle boards or similar appropriate items.
- Remove staff instruction notices from inappropriate public areas.

6. How we undertook this inspection

- This was a full inspection undertaken as part of our inspection programme. We made an unannounced visit to the home on 14 March 2017 from 10.30am to 6.15pm. The following method was used:
- We met the clinical lead nurse and registered manager and toured the home.
- We spent a considerable part of the day circulating around the home to make many observations of the care provision and to meet people in the four lounges.
- We met and had short chats with several people living at the home.
- We met with and had many conversations, some in private, at various times with the twenty care and housekeeping staff on duty.
- We met and had short or longer conversations with the eleven visitors.
- We had in depth discussions with the manager, these included the home's management and looking at a range of care and management records.
- We discussed the role of the clinical lead nurse and her management of nursing.
- We spent time talking about nursing care with the registered nurse on duty
- We viewed computerised care records to consider the content of the written records.
- We selected two staff files to check on recruitment, training and supervision.We had a discussion with the well-being development manager and the coordinator.We read the quality of care review and requested the responsible visit report.

Further information about what we do can be found on our website www.cssiw.org.uk

About the service

Type of care provided	**Adult Care Home - Older**
Registered Person	**Heart of Wales Care Limited**
Registered Manager(s)	**Marion Reading** **Thomas Watson**
Registered maximum number of places	**53**
Date of previous CSSIW inspection	**06/07/2015 & 27/07/2015**
Dates of this Inspection visit(s)	**14/03/2017**
Operating Language of the service	**English**
Does this service provide the Welsh Language active offer?	**No**
Additional Information:	

21 YEARS dementia care matters®

Feelings Matter Most

Consultancy • Training • Service Development • Research

Butterfly Homes

Qualitative and Quantitative Evidence

Awards for Butterfly Care Homes

DCM is proud that Butterfly Care Homes in the UK at the end of 2016 won :

Best Dementia Care Home
Best Care Home
Best Dementia Team
Best Care Home Manager
Best Dementia Garden
Best Resident / Relative Contribution
Best Dementia Care Interior Design
Best Inspiring Dementia Care Leader

David Sheard (Dr)
CEO / Founder, Dementia Care Matters.
Director, The Butterfly Community
Visiting Senior Fellow, University of Surrey, UK

Winner 2017 with TSAACP in Singapore for Asia Pacific Eldercare Award - Best Dementia Care Philosophy

Winner in 2017 for Asia Pacific Eldercare Award – Best Dementia Programme

Shortlisted for UK NHS Patient Safety Award 2017

10 Butterfly Homes awarded 'Outstanding' by Care Quality Commission

UK Care Personality of the Year - 16th National Care Awards

TV Series Consultant - Dementiaville : Channel 4

BUTTERFLY HOMES – SUMMARY OF EVIDENCE

• **Occupancy**	**Care Home Sector Norm 85% – 92%** **Butterfly Homes 98% - 100%**
• **Waiting Lists**	**10 to 50 people per Butterfly Home**
• **Staff Turnover**	**Care Home Norm 40% - 70% per year** **Butterfly Homes less than 20% per year**
• **Boredom Levels**	**Care Home Sector Norm 70%** **Butterfly Homes average less than 20%**
• **Falls**	**Butterfly Homes reduced incidence 43%**
• **'Behaviours'**	**Butterfly Homes reduced incidence 58%**
• **Positive Care**	**Increased evidence by 40% - 70%**
• **Weight Gain**	**Increased evidence by 40%**
• **Anti-psychotic Use**	**Care Home Sector Norm 40% - 80%** **Butterfly Homes less than 10% usage**
• **Sedatives**	**Reduced usage from 77 occasions per month to zero % usage**
• **Life Expectancy**	**Increased in Butterfly Homes x three**
• **Sustainability**	**90% of Butterfly Homes maintaining Level of care over 4 years**

Butterfly Homes – Quantitative and Qualitative Evidence

There have been over 100 Butterfly Care Home Projects in the UK and in 90% of these Dementia Care Matters has raised the care home up a minimum of 2 levels on its Qualitative Observational Audit tool within 1 year and in the majority of cases, up more than 2 levels.

Sustainability i.e. maintaining a Level 1 or Level 2 Butterfly Quality of Life Kitemark Award is being proven in over 90% of the homes that began as Butterfly Care Home Demonstration Projects.

Four examples of Butterfly Care Homes evidence:

Landermeads Nursing Home, Nottingham

A large nursing home in Nottinghamshire with 86 people went from a **Level 6/7 to a Level 1** in one year after a Butterfly Project.

In **2013**, people were spending **73%** of the day in what Dementia Care Matters describes as 'neutral care' – sitting doing very little, tasks being done for them and with little or no meaningful interaction. **15%** of the day people living there were experiencing negative controlling care – being talked about, things being done without choice or consultation, staff focused on tasks not people. Only **11%** of the day were people experiencing either positive personal care or positive social interactions.

In **2016**, neutral care had reduced to **7%** and there was **NO controlling care** in evidence. Positive experiences had increased from **11% to 92% of which 54% of the time people were enjoying positive social** interactions.

Fairfield Nursing Home, County Cork

A privately owned nursing home for 48 people.

2013 - **29% positive** experiences to 2016 increased to **77% positive care and positive social of which 50% of the day in positive social experiences.**

2013 – **51%** of the day in **neutral care** reduced to **23% in 2016.**

In other words this represents a complete reversal in terms of quality of life indicators - half the day in 2013 people were experiencing boredom compared to two years later when over half the day people were experiencing high levels of social interaction and engagement and over three quarters of the day in general wellbeing (including positive personal care).

Wren Hall Nursing Home, Nottinghamshire

- 43% Reduced incidence of falls
- 58% Reduced incidence of displays of behaviours

Manor House Nursing Home, North Somerset

- Occasions of PRN medication – reduced from 77 occasions in May 2014 to 0 occasions in May 2016.
- Occasions of PRN pain relief – reduced from 213 occasions in 2014 to 0 occasion in 2016.
- Number of people with increased weight – increased from 6 people in 2014 to 23 people in 2016.

Butterfly Homes – Qualitative Evidence

Evidence below is taken from four Butterfly Care Homes who volunteered the qualitative comments below:

Lauren: Owner Manor Park Nursing Home, North Somerset

'The positives that are evident within our home at the present time are: people who live here are a lot happier they are more engaged in things that are happening throughout the day. We have seen a steady increase of people putting weight on through the last 12 months or remaining the same weight. A dramatic decrease in the use of neuroleptics, safeguarding issues and falls. The people who work at Manor Park have very positive things to say about the home - they love working here and at least 70% of them share the same vision as I do saying, it just does not feel like work it just feels like my second home with my second family. We hear this throughout the care team.

From a business aspect: for the first time in 7 years the home is making money, we don't have any empty beds and we even have a waiting list now.

Sean: Owner Fairfield Nursing Home, Drimoleague, County Cork

This culture change has been an incredible journey for all the staff and for myself personally. It has absorbed us both physically and emotionally. There were many times over the first year of the transition when we thought we would not make it. We had residents in many different stages of dementia with complex conditions and needs. How could we transform their lives? You can't half do emotional care, you can't half make people feel like they matter.

We had to accept the truth and accept the reality that what we were doing was not the best way and that there must be another way. We needed to change our attitudes, we needed to accept that even though our residents were well looked after physically and that their clinical needs were met, they spent most of their time bored. Our system and culture revolved around getting tasks completed. Our system rewarded task completion. For example mealtimes were a task to be completed, a schedule based around staff rather than residents. Now mealtimes are a social event enjoyable and relaxing.

We now understand and value what makes people feel alive, we now understand that people must feel like they matter, they must have a purpose. We understand that it is how we make people feel is what's crucial. It is what we must do every day.

Each and every person in Fairfield has responded incredibly to this challenge. They have given of themselves emotionally. Staff now share personal stories and this resonates with our residents. They have connected with our residents, there is no longer a 'them and us'- it's a family. Our culture, our ethos, our way of living a full life is about recognizing that 'feelings matter most'. People are in our nursing home to continue living.

Dr David Sheard and his team over 12 months of training has changed us all. They have shown us a better way. They have shown us that by our behaviour with our residents and that by concentrating on making people feel better, we can ensure that our residents continue to live full and meaningful lives. We have watched our residents come alive.

For me personally David Sheard changed my attitude to growing old and changed my belief system. He showed me another way. He made me face the truth, he enlightened me to change our culture within Fairfield. He showed me another way, a way based around people's feelings - moments in Fairfield now are guided by the realization that:
'It is not what you say;
It is not what you do;
It is how you make people feel''. This is what is important.

Parkside Care Home, Caerphilly ongoing DCM Butterfly Project - 7 months in

Feedback so far; I cannot believe how much money we are saving on plastic aprons that we always thought we needed to wear at mealtimes. Now these are only used when absolutely necessary.

We don't have anyone on food record charts anymore as people are eating so well. Deputy Manager.

One woman at a later point of dementia was never helped to the table to eat; she was always supported in a reclining chair by a carer to eat. The assumption was she couldn't do this herself. One day we decided we wanted her to sit at the table with us and we made every effort to make this happen. I couldn't believe my eyes when she picked up a spoon and started to use this herself. We always assumed she couldn't do it; it was amazing to see.

One of our men, was always so tearful and sad. He would sit most of the day with a magazine in front of him or a set of dominoes but not really doing much. We looked into his life and realised he used to be a gamekeeper. We have now filled his room with objects that remind him of his job. We have his old shot gun (it isn't loaded!!) and he will sit for hours in the lounge polishing this with a cloth and now he smiles; he never smiled before. It's like he has found a new lease of life here.

One of the men here was a painter and decorator. We never really thought about what he could do and he would spend most of his time just sitting and reading a paper. But recently he has just painted his room. We have been refurbishing furniture and he has been advising us and helped us to cover two seats on chairs and has painted them. He does often talk about his dad and going home to help the family, sometimes getting a bit tearful, but we tell him we also need his help here and he soon gets stuck in and feels needed.

Vida Healthcare, Harrogate

3 people including the manager attended **the Dementia Care Matters Culture Change Dementia Care 1 year course in York**.

At the end of this 12 months course the home achieved one of the first Outstanding CQC rated inspections. CQC reference DCM in their report under the heading 'Is the service effective' they were evaluating learning and development and this particular section received an 'Outstanding.'

Three staff had undertaken a course called 'Culture Change in Dementia.' This learning was being shared with all the staff to ensure their care practices were current and promoted a positive and innovative culture where the focus was on the person's wellbeing and not on tasks. The registered manager had completed a training course about Culture Change in Dementia Care and in their Dementia Care Matters training they had learnt about the 'language of dementia'.

Case Study Evidence below is taken from Manor Park Nursing Home, North Somerset:

Spring House - Early experience

John is in an early experience of dementia. He came to live at Manor Park after he was found in a state of neglect and depression whilst he was living alone at home, he wasn't looking after himself well. John was married twice but on both occasions his wives left John for someone else so he was alone. When John came to Manor Park initially he would urinate in places that were not the bathroom or toilet. John was a safeguarding concern as he would expose himself to some of the women in the home and on one occasion he attempted to cajole a woman into his bedroom. In the old style single shared lounge John would get frustrated by other people calling out; 'Shut up' he would shout, he wanted to watch TV in peace.

John now lives in 'Spring' a household for people in an early experience of dementia. He has a wonderful relationship with Nikki the house leader who will take him out regularly for trips in her car; John thrives on these outings. In Spring he has taken the role of 'Dad' and looks after everyone else living there as well as visitors, making and offering cups of tea. At mealtimes John serves himself his food and will often help other too. In Spring snacks of fruit and a large open mixed tin of biscuits are available over the day; Tea and homemade cake are shared together in the afternoon. In Spring John can help himself to food and drinks throughout the day. John is chatty and interested in people, he has a wicked sense of humour. John tells the team at Manor Park how happy he is. At the start of the project his weight was 79.1 kg now it is 87.1kg. He is no longer a safeguarding concern.

Spring House - Early stage

Robert is new to Manor Park, only coming in over the last three months. He came in after an admission from hospital having had a fall at the residential home he lived in. he didn't return to the residential home.

He wasn't able to walk, he didn't talk and wouldn't eat. He needed two people to help with his personal care. On admission to Manor Park he was assessed as being in a repetitive experience of dementia and was matched to live in Autumn.

After three months Robert is flourishing he now speaks to people; he is interested in them and asks how people are; he walks and can take himself to the toilet; he doesn't need two people to support him with personal care anymore he can now do this himself. Robert has now moved to Spring the early experience House and will be great company for John to talk to. Roberts's weight has increased by over 4kg in the 3 months he has lived here from 71.2 Kg to 75.6Kg. John has come alive.

Summer House - Different reality experience.

Barbara would walk throughout the day up and down the care home in and out of the main lounge. Barbara was a thin woman who would talk with herself and mutter under her breath in angry tones as if she was having a conversation with someone else; she would often call this person a pig. Her conversation would sound angry and she would become upset. Barbara would become more anxious and unhappy as the day went often becoming tearful and looking troubled. A large full length mirror hung outside the dining room and Barbara would stand in front of this talking to her image becoming increasingly angry. She would rarely socialise with anyone. Only a visit from her husband would help to alleviate some of her distress. Barbara would be given Lorazepam daily.

Barbara was always given finger foods at mealtimes as she would rarely sit and eat a meal in the large shared dining room, preferring to get up and walk out.

Barbara now lives in Summer House with a smaller group of people who are at a similar point of dementia as she is. Barbara is a different women, she still likes to walk on occasions but when she does it is not in a state of distress; she can easily walk outside into the courtyard near Spring and enjoy the fresh air; she is happy to be with people and can even be heard singing a song with Tanya the House Leader. There is no mirror to battle with, this has been removed.

At lunch time she sits and enjoys a full cooked meal with the other people she lives with. She doesn't need finger food anymore. Her husband will come and share a meal with her at least three times a week. On occasions if he visits and his wife becomes tired he will sit and share a cup of tea with Tanya whilst Pauline sleeps. He doesn't feel he must leave and has said to the team how comfortable and relaxed he feels when he visits. He also remarks that the relationship he has with his wife is much better. At the start of the project Pauline weighed 44.2Kg and her weight has increased to 51.8kg. Barbara's BMI has increased from 19 to 23. Barbara is not given Lorazepam anymore.

Summer House – Different reality experience

There were so many safeguarding issues with Winston before the project started. He would often lie on the floor and needed two people to help him to with personal care which was not always easy.

Since living in Summer House he doesn't lie on the floor anymore, he doesn't need two people to help him with care, he will happily let Tanya the House leader help him shave,
he trusts her and they have built a good relationship. Winston likes to sit in the aquarium corner seated area and will snooze in his chair. His weight has increased from 74.2kg to 82kg over 11 months. He is no longer given Lorazepam.

Autumn House - Repetitive experience

Joe lives at Manor Park with his wife Jill. Both live with a dementia but Joe's vascular dementia has progressed much faster than Jill's. A month before his admission Joe was driving them both around so the sudden change and progression for Joe happened rapidly. In Manor Park before the project Joe would rarely stay in one place for long, he would walk and search as he moved around the home. He was given lorazepam most days and sometimes twice a day.

His sleep cycle was erratic and he would often sleep in the day rather than night time. Joe never slept in bed he would always sleep in an arm chair.
Joe was always given finger foods at mealtimes as he would often walk, he did not want to sit in the large dining room with all the other people who lived there. Joe was given lorazepam most days.

Once Joe moved to Autumn House living with people at a similar point of dementia he changed. Joe is happy, he smiles and is busy and occupied throughout the day and now sleeps every night in his bed not an armchair. He drinks so well and has never had a urine infection. Jill likes to visit Joe in his house and sing to him.
Joe no longer takes lorazepam. At mealtimes he sits with the housekeeper Kath who helps him eat, she gently reminds him about his food and helps to keep him focused. Kath lets him have the ring off her finger to touch and hold as he eats; Joe loves this. There are snacks of fruit and a large mixed tin of biscuits available throughout the day that Joe can help himself too. In the afternoon everyone in Autumn shares pots of tea and home-made cake.

A year ago November 2014 Joe's weight was 45.1 kg, now he weighs in at healthy 59.6kg!! Joe is eating so well the team joke he may need to go on a diet!

Autumn House – Repetitive experience

Jeff was a farmer. He is a tall man at least 6 foot and has always looked thin. In the early days of the project (Sept 2014) Jeff's weight was 55.5Kg an approximate BMI of 17. The one word the team would use to describe Jeff at this point was 'unsettled'. He didn't seem happy or relaxed. Jeff was on Lorazepam regularly.

Jeff now lives in Autumn House. The hallways outside Autumn are covered in murals of rolling fields with sheep and tractors. The team know how to connect with him through his farming. There are bowls of fruit, open tins of mixed biscuits for Jeff to dip into as he wants. Afternoon tea with homemade cake is enjoyed and shared by everyone. The team in Autumn now describe Jeff as content and happy, he no longer takes lorazepam and his weight has increased to 73.2kg a BMI of approximately 22.5.

Butterfly Project Culture Change Programme

Baseline Measures for Butterfly Project Homes - Dementia Care Matters will conduct Qualitative Observational Audits using the QUIS methodology at the beginning of each project and also at the end. The 2 audits will provide evidence of changes in terms of the lived experience of people living in each home.

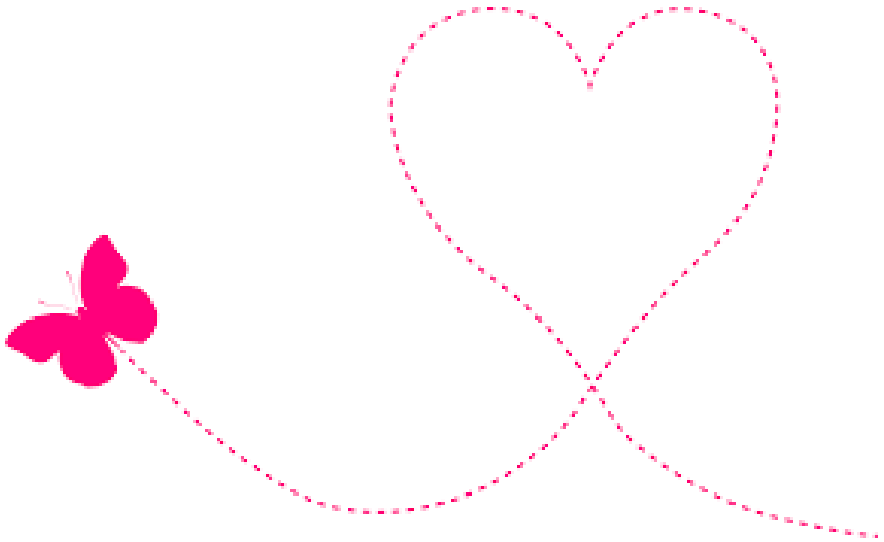
As part of the audit other measurement tools will also be used; **'Environment Matters in Dementia Care Homes: The LOOK Checklist'** enabling comparisons to be made in changes in the environment based on thirty Indicators. Also, the '**Household Model of Care Inspiring Checklist'** measuring changes in 70 fundamental aspects of the model of care.

Other baseline measures to be collated and monitored throughout the duration of the culture change programme include:

- Reduction in pain
- Reduction in safeguarding alerts
- Reduction in re-admission to hospital
- Reduction of falls
- Reduction in accident forms completed
- Reduction in neuroleptic medication
- Increase in pain control
- Increase in weight gain
- Reduction in staff sickness
- Retention of staff
- Reduction in staff recruitment costs
- Lowering of hazards in Risk Assessments
- Reduction in incidents of 'Behaviours'
- Reduction in critical incidents

- Increase in quality of life
- Increase in well-being
- Success rate in matching
- Indicators re: Household Model
- Increase in staff well-being
- Improvements in Leadership
- Increased engagement by families
- Evidence of new relationships forming
- Time spent in meaningful occupation
- Increase in specialist skills

Gathering these statistics at the beginning of the project will provide the basis for robust evaluation.



Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

GMS action 2017-18

Audit of the use of Antipsychotic Medication for Patients with Dementia in Primary Care, including Patients in Care Homes in line with NICE-SCIE Dementia Guidelines Clinical Guideline

OBJECTIVES

The audit relates to the use of antipsychotic medication for patients with dementia ensuring that their use is in accordance with NICE-SCIE Dementia Guidelines 2006.

Patient confidentiality will be respected throughout the audit process.

Patients, practice staff and local pharmacists will be informed of the work being undertaken where relevant.

SCOPE

The work covers all patients with a diagnosis of dementia, where antipsychotic medication is being prescribed; the patient may be living in the community or resident in a care home.

Patients who have been prescribed antipsychotics for other psychiatric diagnoses* will be excluded.

*Patients with a confirmed diagnosis of psychotic depression; schizophrenia spectrum disorder; bipolar disorder; manic depressive psychosis or personality disorders.

*Patients who have been prescribed antipsychotics for any other indication i.e. not Behavioural and Psychological Symptoms of Dementia (BPSD), where this has been clearly documented in the clinical notes.

RESPONSIBILITIES

The **Prescribing Support Technician** is responsible for initial searches and data collection.

Pharmacist Prescribing Adviser is responsible for obtaining agreement with the GP, or prescribing lead, of each surgery, clinically reviewing the data collected for each patient and sharing the audit information with the GP.

The **Lead GP** is responsible for reviewing the audit findings with the Prescribing Support Pharmacist and informing other GP(s) within the practice (level of GP input is to be agreed with practice).

The **Practice Manager** is responsible for disseminating relevant information to prescribing clerks and other staff in the practice where relevant.

NB: The term audit used in this document refers to the procedure of searching and reviewing patient records. The audit will provide baseline data and will be re-measured.

THE PROCESS STAGES

	The copy of the audit agreement must be completed
	Informing staff involved After the audit agreement has been signed, the practice staff and the local pharmacies must be informed of the proposed work.
	Identify potential patients for the audit **For Vision system:** • From "clinical audit" screen, identify: 1. "Register of patients diagnosed with Dementia– QOF indicators 2016-17". 2. Right Click and "Print this group". 3. Or select "copy" and paste the list of names into the data collection form in Appendix 3. **Additional identifier** It has been well recognised that there may be some underestimation of the number of people with dementia if the audit relied upon the accuracy of dementia registers since in many cases a formal diagnosis of dementia may not be recorded. In order to ensure this audit captures as many patients with dementia as possible, an alternative approach to solely relying on the dementia register may be required such as outlined below: • **Search 1:** Identify all patients who have a diagnosis of dementia by using the relevant read codes in **Appendix 2**. If possible also search within the medical history field on the clinical system for the word 'dementia'. • **Search 2.** Identify all patients who have been prescribed anti-dementia drugs in the last 6 months (see list in **Appendix 2**). The population identified by these alternative approaches may be used to identify as many patients with dementia rather than solely relying upon the dementia registers.

	Identify dementia patients who have been prescribed antipsychotics • **Search 3:** Using the patient population from the previous searches, identify those who have been prescribed antipsychotics in the last 6 months (**Appendix 2**). *Note that **Prochlorperazine** is excluded as this drug is not routinely used for Behavioural and Psychological Symptoms of Dementia (BPSD*). *Also ensure brand and generic names are included in the search as well all listed strengths (check latest BNF for the most comprehensive updated list).*
	General Exclusion Criteria Patients who have been prescribed antipsychotics for other psychiatric diagnoses* will be excluded. *Patients with a confirmed diagnosis of psychotic depression; schizophrenia spectrum disorder; bipolar disorder; manic depressive psychosis or personality disorders. *Patients who have been prescribed antipsychotics for any other indication (i.e. not BPSD), where this has been clearly documented in the clinical notes.
	Data collection **Conduct medication review** • Complete data collection for each patient identified for the audit (data collection form is provided in **Appendix 3**). • Using the questions and prompts on the data collection form, systematically go through each patient's records to gather the information required for the audit. • When you have finished, record the total numbers as required on the submission form (**Appendix 4).**
	Submit the results • Send a copy of the completed Submission Form to your Prescribing Adviser by ../../.. • Measure use against the audit standards.The audit standards have been extrapolated from relevant recommendations in the NICE-SCIE Clinical Guideline on supporting people with dementia- CG042 (2006). • Feed back data to prescribers. • Discuss best practice points in relation to antipsychotic use to be carried forward into future prescribing.

This initial audit is intended to generate information regarding antipsychotic use only and is not intended to make changes to patient medication.

Introduction

Reducing inappropriate antipsychotic prescribing in patients with dementia to improve quality of life is a key priority of the NHS. Requirements for action relating to the use of anti-psychotics in care homes are also set out in the Older People's Commissioner for Wales review report, "A Place to Call Home". Recommendation 3.5 states that "Information is published annually about the use of anti-psychotics in care homes, benchmarked against NICE guidelines and Welsh Government Intelligent Targets for Dementia".

Good quality relevant information on the use of antipsychotics for patients with dementia is needed in order to work towards reducing the use of these medications, and to ensure that, when they are used, they are used according to good practice guidelines. Current NICE-SCIE guidelines recommend the time-limited use of anti-psychotic medication with some patients with dementia, despite risks to health and quality of life. Recommended use is only in relation to severe and distressing difficulties that have not responded to other interventions.

In November 2009, an independent report commissioned by the Department of Health in England "The use of antipsychotic medication for people with dementia: Time for action" was published (Banerjee, 2009)[1]. The report quantified the health risks of the use of these medications, attributing 1800 deaths and 1620 cerebrovascular accidents (CVA) to their inappropriate use. Research studies consistently show that these medications have a relatively limited therapeutic effect in relation to agitation and challenging behaviour in dementia. Only a small proportion of patients show a worsening of their behavioural symptoms when the medication is withdrawn. Banerjee's report contains 11 recommendations, all of which were accepted by the Department of Health. Recommendation 4 states that 'People with dementia should receive antipsychotic medication only when they really need it. To achieve this, there is a need for clear, realistic but ambitious goals to be agreed for the reduction of the use of antipsychotics for people with dementia. Explicit goals for the size and speed of this reduction, and improvement in the use of such drugs where needed, should be agreed and published locally following the completion of the baseline audit.."

What are the aims of the audit?

1. The purpose of the audit therefore is to generate data on the use of antipsychotic medication for patients with dementia in primary care including care home residents. The audit will provide baseline data and will be re-measured (the Banerjee report suggests repeated for the next 3 years) to gauge progress against quality standards.
2. To publish the information relating to anti-psychotic use in care homes as required by the Older People's Commissioner for Wales review report, "A Place to Call Home". Information will be published for Hywel Dda and not on an individual practice level.
3. To benchmark whether prescribing is in line with NICE-SCIE guidance and Welsh Government Intelligent Targets for Dementia **(Appendix 1)**.

[1] The use of antipsychotic medication for people with dementia - Time for action; A report for the Minister of State for Care Services by Professor Sube Banerjee – November 2009

Audit Standards

Audit criteria	**% from Audit submission form (Appendix 4)**
• The records show that (x%) dementia patients have been prescribed an antipsychotic for indication(s) in accordance with NICE recommendations	
• The records show that (x%) dementia patients prescribed an antipsychotic for BPSD have had it reviewed in the last 3 months	
• The records show that (x%) dementia patients have been prescribed an antipsychotic for BPSD for > 9 months	

Audit agreement

(GP prescribing lead for the practice only needs to sign)

All patients identified for the audit will be reviewed by the prescribing adviser. The audit information will be shared with the GP(s).

General Practitioner (prescribing lead GP)

Name_____ Signature_____ Date_____

Prescribing Adviser

Name_____ Signature_____ Date_____

Medicines Management Technician

Name_____ Signature_____ Date_____

Appendices

Appendix 1: Excerpt from NICE-SCIE Quick Reference Guide Dementia; Supporting People with Dementia and their Carers in Health and Social Care

NICE-SCIE Quick Reference Guide: Dementia; Supporting People with Dementia and their Carers in Health and Social Care, November, 2006

CG042quickrefguide dementia.pdf

Appendix 2: Dementia read codes, anti-dementia drugs & antipsychotics

Dementia readcodes dementia antipsycho

Appendix 3: Data collection form

Data collection form.docx

Appendix 4: Submission form

Appendix 4.Submission form.do

References and further reading

References.doc

The GMS SOPs are also available electronically via http: http://howis.wales.nhs.uk/sitesplus/862/page/55185		
The original Microsoft Word file is kept on the HDUHB Medicines Management Team Shared Drive/Interface/		
Reviewed by:		
Checked by:		
Version	1.0	
Date of development	May 2017	
Date for next review		
Approved by	MMG	

Caerphilly Behavioural Support Service – Briefing Document

Overview

The Caerphilly Behavioural Support Service (CBSS) is a pilot project consisting of an integrated multi-disciplinary team, embedded within the existing CMHT structure, who deliver behavioural based interventions to older adults with mental health problems. The service has a particular focus on individuals who live in care homes and works closely with existing in-reach and CMHT colleagues to identify appropriate referrals. Assessment and intervention is based on a holistic person-centred approach which values the individual and seeks to engage carers in creating supportive environments. Positive behaviour support seeks to implement a multi-component framework for the delivery of evidence-based supports to increase quality of life and reduce the occurrence, severity and impact of behaviours that challenge. The pilot will evaluate the resources required to support carers and mainstream services to develop skills and knowledge to better care for people who engage in behaviours that challenge services. The project commenced May 2017 and will conclude March 2018. A plan is in place to seek recurrent funding thereafter and extend the service across the five boroughs in Aneurin Bevan University Health Board.

Background

It is increasingly recognised that behaviours that challenge are often an attempt at communicating an 'unmet need'. People with dementia and other mental health problems often have a reduced ability to communicate in ways that those who care for them understand. A needs led formulation based framework to make sense of behaviour provides an evidenced based approach to meeting the person's needs and reducing the need for them to engage in behaviours that challenge (i.e., Ontario Positive Behavioural Support in Dementia Group; Newcastle Model of Challenging Behaviour Formulation). Such an approach is consistent with guidance recommending the use of non-pharmacological, psychological and psychosocial approaches in the initial stages of managing behaviours that challenge (The National Dementia Action Plan for Wales, 2009; NICE/SCIE, 2006).

Service Description

The Caerphilly Behavioural Support Service is funded via the Integrated Care Fund (ICF) and seeks to provide a clinical service to people who predominately have a diagnosis of dementia and vulnerable to exclusion due to challenging behaviour. Older people who display challenging behaviour are at significant risk of exclusion and treatment with anti-psychotic medication. This service aims to provide a viable alternative to medication to address behaviour that challenges. The service, working with key partners from private residential and nursing home establishments, social services, and the third sector supports older people with mental health problems in their local community near their families and focus on three key domains:

1. Intensive support and direct clinical work with identified individuals utilising positive behavioural support
2. Promotion of meaningful activity and therapeutic environments
3. Provision of specialist teaching and sharing of good practice

The service is comprised of a multi-disciplinary team that include a lead nurse, behavioural specialists, assistant psychologists and support workers.

Interim Evaluation

The pilot has been operational since May 2017 and preliminary feedback very encouraging. The service actively seeks to reduce medication as the sole means of addressing challenging behaviour and contributed to the wider agenda of reducing anti-psychotic use in the older adult age group. To this end, we have focused on delivering person-centred approaches to care and providing 'hands on' support to care home staff; working as partners in the application of behavioural approaches. Our initial clinical outcome evaluations have been positive as to the value of such approach.

Importantly, the service aspires to be a part of a whole system change as to how we deliver care. We have plans to facilitate training events to promote sharing good practice amongst care homes. We have built links with a range of third sector agencies with a view to developing good practice links and collaborators in the wider agenda of promoting meaningful activity and safe environments. Whilst still in the formative stages, there is encouraging evidence supportive of a shift in the way services are delivered within the borough and improved collaboration between partner agencies.

Outcome measurement and Long-term Plan

The service is monitored and evaluated on the basis of the quality standards outlined in the document Psychological Therapies in Wales: Policy Implementation Guidance (2010) and guided by the outcomes detailed in Together for Mental Health (Delivery Plan 2016-2019). The service is also collecting a range of outcome measures to evaluate individual and service benefits (i.e., clinical outcome, levels of meaningful activity, reduction in anti-psychotic medication use). This data will have clinical utility in guiding treatment decisions; moreover, it will also provide direct evaluation of clinical effectiveness. An overall evaluation of service quality will be guided using testimonial forms (completed by service users, families, carers and relevant staff who have accessed input/training). This will include user satisfaction and utility ratings from a range of partner agencies. In addition, data point comparison on inpatient admission rates and unplanned transitions of care will evaluate the cost effectiveness of the pilot service.

This information will be collated via an implementation group and a written report, detailing the implementation and evaluation of the pilot will be available for wider dissemination. Long-term, the pilot would provide valuable grounding in the application of the wider implications of the model across the five boroughs of Gwent with the long-term aim of demonstrating the value of recurrent funding.

The pilot is also working on how this team interface with the already established Inreach Nurses in each borough. The preliminary view is that the Inreach service work with the reduction of medication across large case loads , but where there are particular difficulties with reducing or maintaining a reduction in medication, then the BST can add a level of intensity of support and specific positive behavioural support to overcome any issues and in so doing add a value added service to a already effective foundation service, with both services aiming to assist in the elevation of expertise in the care homes around managing behaviours that challenge with non medication interventions .

Mike Fisher (Older Adult Directorate Manager, ABUHB)
Jimmy Jones (Consultant Clinical psychologist, ABUHB)

Supplemental Data

Individual Client Outcomes

The CBSS utilises the Clinical Global Impressions (CGI) scale to evaluate outcome of input. This scale asks respondents to rate the utility of input on a 13 point scale (from maximum deterioration to ideal improvement). The service has discharged 14 clients so far and has completed outcome data for 11 clients (3 cases were brief assessments and deemed not suitable for further input). The average score on the CGI for the recorded cases was 3.1 (representing the category 'Moderate Improvement on the scale). Similarly, the mode (or most common rating provided by respondents) was 'Moderate Improvement'. This data is suggestive of the value of input but remains preliminary. Data collection is ongoing and will be elaborated in future data reports.

Case Studies

Two brief case studies are provided below to help contextualise the work of the team:

Case Study 1

Mr E is a 82 year-old gentleman referred by a voluntary sector residential facility. The referral detailed evidence of paranoia and physical aggression directed towards staff and other residents. The behaviour was described as very unpredictable and limited personal care and participation in social activities. Mr E was already taking an anti-psychotic and an increase was considered to manage behaviours that challenge. The CBSS conducted an initial assessment; identifying good care practices and successful techniques used by the care staff team (i.e., identifying potential 'flash' points, methods of distraction). The CBSS also shared information on de-escalation techniques and provided positive feedback to staff team when utilised. This intervention resulted in a significant decrease in behaviours that challenge. This improvement resulted in no increase in medication and a positive disposition to consider review existing anti-psychotic medication.

Case Study 2

Mr W is a 69 year-old gentleman referred whilst an inpatient on a older adult mental health ward. He exhibited a number of difficult behaviours that included physical and verbal aggression, isolating himself and refusing care. A prior discharge had failed as the care home were unable to manage behaviours that challenge and Mr W had returned to the ward. The introduction of anti-psychotic medication was considered to complement existing sedative medication and help manage the situation. The CBSS became involved to support the transition from hospital to newly identified care home residence. Initial work focused on providing a positive behavioural support plan; detailing a biographical history and advising staff on effective support strategies. This was shared with the care home and guidance was provided on how to utilise effective reactive strategies. This information was incorporated within Mr W's care plan and shared with all staff. The CBSS provided direct support during the initial transition and telephone follow-up on a daily basis for a period after this. Staff were encouraged to innovate and the CBSS played an active role in supporting the care home to verbalise and share new approaches. Revisions were subsequently made to the positive behavioural support plan as the new care environment adapted to meet Mr W's emerging desire to be involved in social activities. Since the move to the new residence, there has been a significant reduction in behaviours that challenge. Anti-psychotic medication was not introduced and sedative medication significantly reduced (in terms of routine and PRN use).

PHARMACOLOGICAL MANAGEMENT OF BEHAVIOUR PROBLEMS IN PATIENTS WITH DEMENTIA (BPSD)

(Does not cover rapid tranquillisation of acutely disturbed)

GIG CYMRU NHS WALES | Bwrdd Iechyd Aneurin Bevan Health Board

Patient has **B**ehavioural and **P**sychiatric **S**ymptoms in **D**ementia (BPSD) (eg. psychosis; agitation, aggression; irritability with steady decline in cognition

Yes

Does patient have a delirium? (short history < 1 week confusion, hallucination, delusion with fluctuating cognition)

Yes

Treat underlying acute medical problems, eg UTI, chest infection, side effect of drugs, alcohol, drug withdrawal etc

No

Adopt a person centred approach. Apply **PAIN** approach and manage or treat:
P = Physical problems ie. Medical review for eg infection, pain
A = Activity-related eg dressing, washing
I = Iatrogenic eg side effects of drugs eg psychiatric and CNS treatments
N = Noise ie. Consider the physical environment

Behavioural problems unresolved

If mild to moderate symptoms adopt a watchful waiting approach. Contact the family for their views; consider non-pharmacological approaches eg. creative therapies; personalised activities; social interaction. Consider specialised psychosocial support for carer and patient.

Only consider pharmacological treatment if there is psychosis, depression or behaviour where there is extreme risk or distress.

Identify the dominant target symptom group

Psychosis: Delusions/Hallucinations

Depression: depressed mood and / or loss of ability to enjoy previously pleasurable activities. May or may not include apathy

Apathy: diminished motivation; listlessness; loss of drive to engage in activities. May be perceived as laziness.

Aggression

Agitation/Anxiety: wandering may be intrinsic to dementia

Sleep disturbance

Other symptoms: eg. vocalisations; sexual disinhibition; stereotypical movements etc

Could this be dementia with Lewy Bodies or Parkinsons Disease Dementia?
Key features: long term (>6 months) history of vivid visual hallucinations or parkinsonism or fluctuating cognition.

Yes / unsure

Get specialist advice

No

Follow guidance below and overleaf

In the event of continuing problems advice can be obtained from specialist older adult mental health services

There is only one drug (Risperidone) licensed specifically for the treatment of BPSD. For other symptoms drugs are used which have either been shown to improve these symptoms in subjects without dementia or are licensed for cognitive enhancement in patients with dementia.

General guidelines if pharmacological treatment is indicated.

The use of either typical or atypical antipsychotics in patients with dementia worsens cognitive function; increases the risk of cerebrovascular events (~3x) and increases mortality rate (~2x). They should only be used after full discussion with the patient (where the patient has capacity to understand) and carer about the possible benefits and likely risks. Risk is likely to increase with increasing age and if other risk factors for cerebrovascular events are present eg. diabetes; hypertension, cardiac arrythmias; smoking and existing evidence of **stroke or vascular dementia.**

If antipsychotic treatment is considered necessary avoid typical neuroleptics and start atypical doses low (usually one half normal elderly dose) and increase every 2-4 days if no response **(see specific dose suggestions overleaf).** **PATIENTS WHO RESPOND TO TREATMENT SHOULD HAVE THE DRUG WITHDRAWN AFTER 6-12 WEEKS**. Halve the dose for two weeks and if no re-emerging symptoms stop after a further 2 weeks. Review again after one week. If symptoms re-emerge reintroduce the drug at starting dose. BPSD can persist and treatment with atypical antipsychotics may be needed in the long term **BUT SHOULD BE REVIEWED ON A 3 MONTHLY BASIS.**

Patients with Dementia with Lewy Bodies or Parkinsons Disease Dementia are particularly vulnerable to neuroleptics sensitivity reactions and also have marked extrapyramidal side effects. Advice from a specialist is advised before starting neuroleptics.

The management of antidepressants and hypnotics in patients with dementia has little evidence base and should follow existing guidelines for the management of these drugs in elderly patients without dementia. Treatment doses should follow BNF guidelines.

Author: Dr Patrick Chance Consultant Psychiatrist for Older People & Honorary Lecturer – Based on original work done by Prof Clive Holmes, Southern Health NHS Foundation Trust & University of Southampton

Status: APPROVED
Issued: Feb 2013
Approved by: ABHB Old Age Psychiatrists & ABHB MTC
For review: Feb 2016

Prescribing Guidelines:

Alzheimer's disease

Key Symptom	*First Line*	*Evidence Type*	*Second Line*	*Evidence Type*
Depression	Citalopram, Sertraline	3	Mirtazapine	3-4
Apathy	Citalopram, Sertraline	3	Donepezil (S), Rivastigmine (S), Galantamine (S)	2
Psychosis	Risperidone	1	Olanzapine, Aripiprazole, Haloperidol, Memantine (S)	2-3
Aggression	Risperidone (L)	1	Olanzapine, Aripiprazole, Haloperidol, Memantine (S)	2
Moderate agitation/ anxiety	Citalopram	3	Trazodone, Mirtazapine, Memantine (S)	4
Severe agitation/ anxiety (after antidepressant trial)	Risperidone, Olanzapine	1	Aripiprazole, Memantine (S)	2-4
Poor sleep	Temazepam, Zopiclone	3	Zolpidem	3

Dementia with Lewy bodies or Parkinsons disease dementia

Key Symptom	*First Line*	*Evidence Type*	*Second Line*	*Evidence Type*
Depression	Citalopram, Sertraline	4	Mirtazapine	4
Apathy	Citalopram, Sertraline	4	Donepezil (S), Rivastigmine (S), Galantamine (S)	2
Psychosis*	Rivastigmine (S), Donepezil (S), Galantamine (S)	2-3	Quetiapine, Aripiprazole	3, 4
Aggression	Quetiapine	3	Donepezil (S), Galantamine (S), Rivastigmine (S)	3
Moderate agitation/ anxiety	Citalopram	3	Rivastigmine (S), Donepezil (S), Galantamine (S)	2 – 3
Severe agitation/ anxiety (after antidepressant trial)	Quetiapine	3	Rivastigmine (S), Donepezil (S), Galantamine (S)	3
Poor sleep	Temazepam, Zopiclone	3	Zolpidem	3
REM sleep behaviour (nightmares, hyperactivity)	Clonazepam**	3		

* consider reducing antiparkinsonian medication first ** 500 – 1000 microgram nocte (L) = Licensed indication (S) = Specialist initiation

Evidence levels: 1 = Metanalysis; 2 = RPCTs; 3 = Other studies; 4 = Expert Opinion;

Vascular dementia or stroke related dementia

There is little evidence for the treatment of BPSD in Vascular dementia or stroke related dementia. The cholinesterase inhibitors (Donepezil; Rivastigmine; Galantamine) and memantine are not licensed for treatment of pure vascular dementia and should not be used. Prescribers are advised to follow prescribing guidelines for Alzheimer's disease but to use with extreme caution drugs with an established increased cerebrovascular risk (ie. antipsychotics)

Other BPSD and other dementias (eg. Fronto-temporal lobe dementia)

There is little evidence base for the treatment of other BPSD or for the treatment of common BPSD in other dementias. Specialist advice should be sought.

Drug dose guidelines for use of antipsychotics in dementia

Antipsychotic	*Starting Dose*	*Optimal Dose*
Risperidone	250 microgram bd	500 microgram bd
Olanzapine	2.5mg od	5-10mg od
Aripiprazole	5mg od	10mg od
Quetiapine	25mg od	25 -150mg daily
Haloperidol	500 microgram bd	1mg bd

When antipsychotics are prescribed the 'ABHB Use of antipsychotics in dementia' information leaflet should be given to carers and relatives:
http://howis.wales.nhs.uk/sitesplus/documents/866/Dementia%20-%20The%20Use%20of%20Antipsychotics.pdf

Name:

D.O.B:

Anti-psychotic monitoring record booklet

An anti-psychotic medication is being prescribed to this individual for symptoms associated with a dementia.
This medication should be reviewed on a 3-monthly basis. At each review, **consideration should be given to** a reduction in or discontinuation of the drug.

The medication reviews may be undertaken by primary or secondary care

Risperidone	Olanzapine	Aripiprazole	Chlorpromazine
Quetiapine	Amisulpride	Haloperidol	Promazine

Flupenthixol injection (depixol)
Fluphenazine injection (modecate)
Haloperidol Injection (haldol)

Anti-psychotic initiation

NAME: ……..... DATE OF BIRTH: ……/……/……

Place of medication being commenced: ……

Reason for prescribing antipsychotic:

Target symptoms (especially distress), severity & risk of harm to self/others:

Other approaches tried (including medications):

Consider physical health review/pain/infection/depression:

Current psychotropic medication:

NB. especially benzodiazepines

Capacity:

Capacity to consent to medication	yes ( )	no ( )
Discussion with patient if appropriate	yes ( )	no ( )
Best interest decision made (discussion with family/carer and staff)	yes ( )	no ( )
Patient/carer information leaflet given	yes ( )	no ( )

- Anti-psychotic prescribed (state starting dose): ……

If **not** risperidone, state rationale for drug choice: …….....

- **Date commenced**: ……. **Planned review:** …….....
- Signature (and designation): …….....

Anti-psychotic review record

NAME: ……..... DATE OF BIRTH: ……/……/……

Place of medication review: ……

Date of review		
Current psychotropic medication (especially benzodiazepines)		
Patient seen? (Y/N)		
Any side effects? (describe)	Sedation/ weight gain	
	Parkinsonian effects	
	Poor posture, mobility, falls	
	Cognitive side-effects	
	other	
For how long has the drug been taken? (in weeks or months)		
Any changes in or benefit to target symptoms? (description of current presentation)		
Outcome of review (include **name and dose** of drug)	eg. continue/stop /trial off/ restart/ change dose /change drug	
With whom has the outcome been discussed?		
Next planned review (in weeks or months)		

- Signature (and designation): …….

Anti-psychotic review record

NAME: ……... DATE OF BIRTH: ……/……/……

Place of medication review: ……

Date of review		
Current psychotropic medication (especially benzodiazepines)		
Patient seen? (Y/N)		
Any side effects? (describe)	Sedation/ weight gain	
	Parkinsonian effects	
	Poor posture, mobility, falls	
	Cognitive side-effects	
	other	
For how long has the drug been taken? (in weeks or months)		
Any changes in or benefit to target symptoms? (description of current presentation)		
Outcome of review (include **name and dose** of drug)	eg. continue/stop /trial off/ restart/ change dose /change drug	
With whom has the outcome been discussed?		
Next planned review (in weeks or months)		

- Signature (and designation): ……

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The Use of Antipsychotics in Dementia –

Information for Patients and their Carers

People living with dementia sometimes develop behavioural symptoms of restlessness, agitation and aggression or psychotic symptoms such as hearing voices, seeing visions or abnormal beliefs which can become distressing both for the person with dementia and their carer(s). When these symptoms are distressing, severe and/or are putting the person or others at risk, then it may become necessary to treat them. A variety of medications have been tried for these symptoms of dementia. This leaflet deals with the prescribing of anti-psychotic drugs.

When should anti-psychotics be used and what are their effects?

Behaviours that challenge (as described above) may respond to non drug treatments such as reassurance, distraction with meaningful activities, relaxation and psychological therapies. These approaches should always be tried before drug treatments are considered. Anti-psychotic medication should only be used if absolutely necessary.

How long will anti-psychotic medication take to work?

Anti-psychotics may produce some noticeable effects within a few hours but the full benefits of medication may take some weeks to develop. Ultimately it is hoped that the medication will relieve the target symptoms of restlessness, agitation, aggression, delusions and/or hallucinations so that the person living with dementia will feel calmer, less distressed, more able to interact socially, engage in activities and more able to remain living at home or in the community for as long as possible.

How will the dose be decided?

Like all drugs, anti-psychotics have possible side-effects and these will normally be related to the dose prescribed. Therefore such medication should be prescribed at a very low starting dose and increased very slowly and carefully with full evaluation of both the effects and side-effects at regular intervals.

What follow-up will be necessary?

As long as anti-psychotic medication is taken, regular follow-up will be necessary so that we can ensure that the drug is working properly, not causing unpleasant or harmful side-effects and is only used for as long as is absolutely necessary. Trials of stopping the medication may be suggested to see whether or not the target symptoms return.

What side-effects may occur?

Common side-effects of anti-psychotics include drowsiness, dizziness, unsteadiness, shaking and joint stiffness. Sometimes the prescribing of anti-psychotics is associated with increased agitation and worsening confusion, and the dose may have to be reduced, the anti-psychotic changed or even discontinued. Other side-effects are less common.

Are there serious risks associated with being prescribed antipsychotics?

The use of antipsychotics in dementia is associated with an increased risk of having a stroke and an increased risk of premature death in a small number of cases. These risks are low over short periods of treatment (up to 3 months). The Committee of Safety of Medicines in the UK, therefore, advises that anti-psychotics should only be used when considered absolutely necessary, at the lowest effective dose for the shortest possible period of time, and subject to regular review.

The benefits of trying an antipsychotic in a person living with dementia should be carefully weighed against the possible risks and side-effects of the treatment.

Which antipsychotic will be chosen?

At present only one drug "Risperidone" is specifically licensed for the treatment of the behavioural symptoms of dementia (up to six weeks). It is used to treat persistent aggression in moderate to severe Alzheimer's type dementia which is unresponsive to non-drug treatments. Risperidone will normally be started at a low dose and be increased slowly and carefully as necessary. Other antipsychotics have also been shown to be of benefit in treating behavioural symptoms in dementia and, although technically unlicensed for this, may be chosen if the treating doctor considers they are more appropriate e.g. where an individual patient has particular other physical conditions. All these drugs carry similar risks when used in people with dementia and so they should all be used in low doses for short periods and discontinued when possible.

Can any other drugs be used in dementia?

Other drugs can be used in dementia to treat depression, anxiety, sleep disturbance, agitation and aggression. These other medications may include antidepressants, sleeping tablets, antiepileptics, painkillers and minor tranquillisers. "Anti-dementia drugs" may be used for the memory decline itself and help with orientation / alertness / motivation in dementia. However the anti-dementia drugs are not often effective on their own against the more severe behavioural symptoms of dementia; some people living with dementia will need a combination of drug treatments to control their symptoms. These other medications have not been linked to an increased risk of strokes or premature deaths. All medications prescribed for a person living with dementia will be individually decided upon with the person and/or their carers following a careful individual assessment/review of their changing needs.

Use of Antipsychotics in Older People in the Royal Gwent Hospital (RGH), Newport

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Dr Kelly Adjei, Dr Patrick Chance, Dr Chandra Basavaraj, Lynne Smith, Sofia Fernandez, Lori Pietrzak-Jones

RAID (Rapid Assessment, Interface and Discharge), Aneurin Bevan University Health Board

Background

Older people on antipsychotic medications are at an increased risk of several unwanted side effects, including falls and strokes[1] . A review of the available literature suggested that:

- Not all patients admitted to general hospitals already on antipsychotics come to the attention of the psychiatric liaison service if one is available[2]
- Antipsychotics initiated in the general hospital for acute and reversible indications, e.g. delirium / agitation are often not discontinued upon discharge when the indication may have resolved[3, 4]

Locally, the **R**apid, **A**ssessment, **I**nterface and **D**ischarge (**RAID**) Older Adult Liaison Psychiatry Service is a specialist multi-disciplinary mental health service working within all general hospitals in the Aneurin Bevan University Health Board for people over the age of 65 years. In this area, it is generally known that not all general hospital inpatients over the age of 65 years who are on antipsychotics are referred to **RAID**.

It was therefore proposed that an actual exploration of antipsychotic use in elderly patients admitted to the general hospital setting, specifically Royal Gwent Hospital, Newport was undertaken.

Aims

This study sought to investigate the clinical use of antipsychotics within a general hospital in acutely unwell medical and surgical patients over the age of 65 years.

The specific study aims were:

1. To estimate prevalence and incidence of antipsychotic use among elderly patients in RGH
2. To examine the nature of antipsychotic prescriptions in these patients
3. To explore the level of **RAID** team involvement in the care of these patients

Objectives

It is anticipated that results of this exploration are used to enable further consideration of:

- How best to identify these patients to **RAID**
- Whom is best to identify these patients to **RAID** (i.e. pharmacy or the medics, for example)

Ideally, this will lead to the set up of a system to capture this patient population to ensure risks of being on antipsychotics are minimised.

Methods

All patients aged 65 years and over admitted to a medical or surgical ward of the Royal Gwent Hospital over a consecutive 3 day period were included if they were either:

1. Already on antipsychotic medication at the time of admission, or
2. Initiated on antipsychotic medication during their admission

For each of these included patients, a survey of their medical records and prescription charts was undertaken over a 3 day period.
Data was collected by ward pharmacists and the **RAID** SHO.

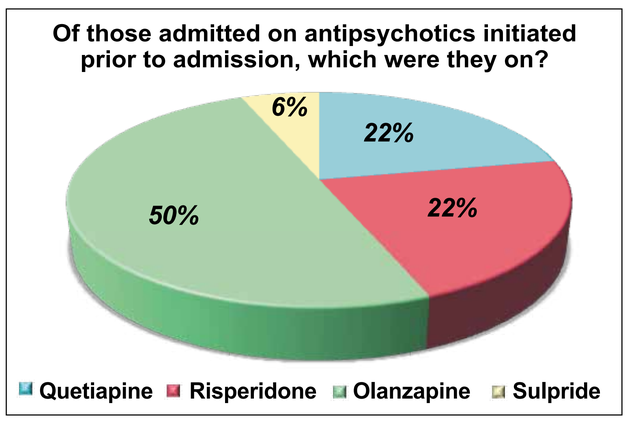
Results

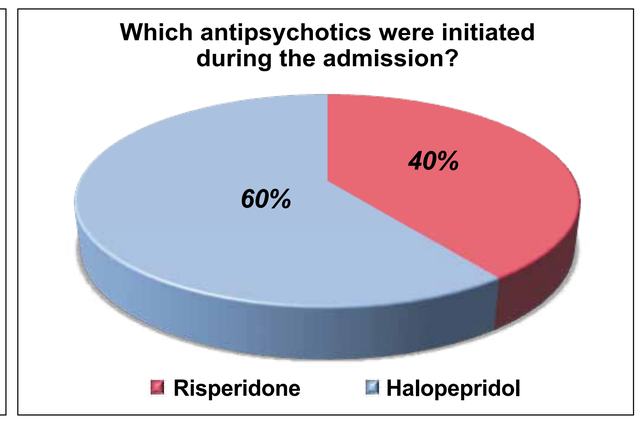
Results 1: The prevalence and incidence of antipsychotic use among older adult patients admitted to general wards within RGH

	Day 1	Day 2	Day 3
Total No. of patients identified who were aged over 65 yrs	265	270	269
No. of these over 65s who were on antipsychotics	3% (n=9)	4% (n=12)	5% (n=14)
No. on antipsychotics **PRIOR** to admission	1% (n=4)	1% (n=4)	2% (n=6)
No. **INITIATED** on antipsychotics **DURING** admission	2% (n=5)	3% (n=8)	3% (n=8)

- On any day within the study period, 3 - 5 % of over 65s were on antipsychotic medication
- Most subjects were initiated on antipsychotics during admission, rather than prior to it

Results 2: An analysis of the prescription of antipsychotics in these patients

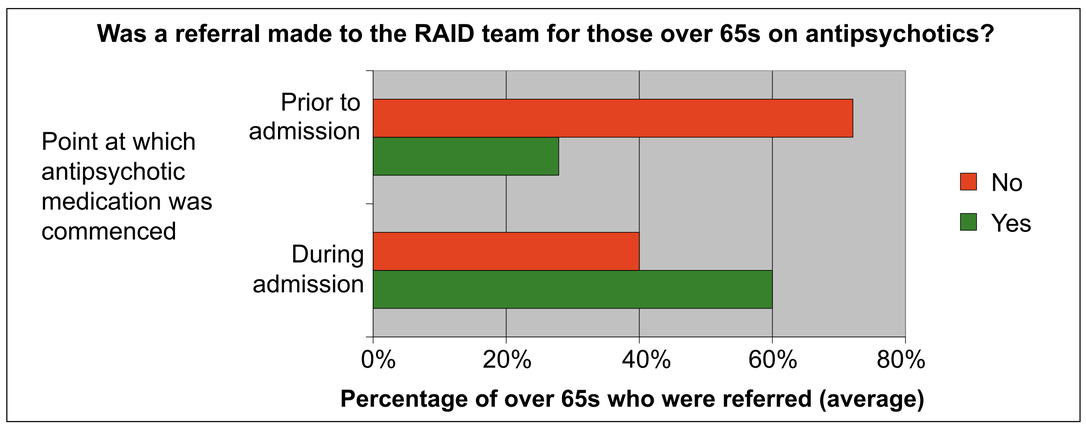




In those who were initiated on antipsychotics during admission:

- Indications documented for the prescriptions included agitation, sedation and nausea
- The number of PRN and regular prescriptions were equal
- Doses appropriate for older adults were prescribed
- Not more than one antipsychotic had been prescribed during the admission

Results 3: Level of RAID team involvement in the care of the patients within the sample



- Under 30% of those admitted already on antipsychotic medication were referred to **RAID** versus 60% of those who were commenced on an antipsychotic during the admission
- On average, it took 5 days for those already on antipsychotics prior to admission to be referred to **RAID** compared with 3 days for those initiated on antipsychotics during admission
- On average, it took 1 day for **RAID** to undertake their assessment of any patient referred to them, regardless of when they were initiated on an antipsychotic

Conclusions

This study identified that:

- On average, 4% of the Royal Gwent Hospital's patients over 65 years were on an antipsychotic on any given day in the study
- Most were commenced on antipsychotics during the general hospital admission (incidence of ~ 3 % compared with prevalence of ~1%)
- The first generation antipsychotic haloperidol appeared to be most commonly prescribed during an admission, most frequently for agitation, despite the associated risks

In relation to **RAID**:

- A considerable proportion of elderly inpatients in Royal Gwent Hospital on antipsychotics were not referred to RAID regardless of when their antipsychotic was initiated
- This raises the possibility that such patients are being discharged on antipsychotic medications unnecessarily, or without appropriate follow-up; **RAID** involvement would reduce such risks
- There is some delay in referring elderly patients on antipsychotics to **RAID**, but despite this delay, **RAID** responded quickly to all referrals

In an ideal world, every older adult on antipsychotic medication should be flagged to the psychiatry liaison service[2] during their admission to general hospital. There is a gap between this ideal and what is occurring currently in the Royal Gwent Hospital.

Recommendations

- Further studies, both of a longer duration and also within other general hospitals, are recommended in order to confirm this data
- A study to determine the frequency and nature of discharge prescriptions of elderly inpatients on antipsychotics from the general hospital would be useful in establishing baseline data
- Consideration could be given to the set up of a system to identify all ABUHB general hospital inpatients over 65 years who are on antipsychotics, with involvement of ward pharmacists who can then refer to the **RAID** team to make contact and take action if warranted
- Ongoing education of general hospital staff about the presence and work of **RAID** is of vital importance

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Royal College of Occupational Therapists
Coleg Brenhinol y Therapyddion Galwedigaethol

Dr Dai Lloyd AM
Chair, Health, Social Care and Sport Committee
National Assembly for Wales
Cardiff Bay
Cardiff,
CF99 1NA

6 November 2017

Dear Dr. Lloyd AM,

Re: Health, Social Care and Sport Committee inquiry into the use of anti-psychotic medication in care homes

Thank you for the opportunity to give oral evidence to the committee as part of its important inquiry into the use of anti-psychotic medication in care homes. As we discussed during the session, we believe that occupational therapists and speech and language therapists have a key role to play as part of a non-pharmacological approach to managing behaviour that challenges. Following on from the detailed questioning by the committee, we would like to take the opportunity to suggest a number of recommendations to the committee.

1. **Residents of care homes should have equitable access to existing community multi-disciplinary services which should include a range of therapy professionals including speech and language therapists and occupational therapists** – Our first recommendation builds on the recommendation made by the Older People's Commissioner for Wales in her written evidence to this inquiry that;

   > 'Welsh Government should ensure that multi-disciplinary team services are made available to all residents in care homes to reduce the tendency to prescribe anti-psychotic medication, improve outcomes for residents and address current inequalities in provisions for residents and older people living in the community'.

   Care home residents have arguably the greatest health and social care needs yet currently may struggle to access community services available to those living in their own homes. It is not routine for speech and language therapists (SLTs), occupational therapists and other therapy professions to support care home staff and residents. This prevents residents from accessing provision such as reablement, non pharmacological interventions and behaviour support. Community Resource

Teams, Community Mental Health, Mental health liaison Teams and community learning disability teams should all include a range of therapy professionals (including SLTs and occupational therapists) to ensure all older people, irrespective of social, economic or housing circumstance have equality of access to allied Health Professional (AHP) support. When located in appropriately resourced teams therapists can promote person-centred care through training, on-site role modelling and working directly with care home staff. Further information on equality of access can be found in the Royal College of Occupational Therapists report Living Not Existing: Putting Prevention at the Heart of Care for Older People in Wales

2. **Welsh Government should consider piloting the request for assistance scheme which is currently in place in Scotland.** The scheme would enable care homes to access specialist support and training from AHPs and others to adapt environments and change cultures above and beyond support for individual referrals. During the oral evidence sessions, the British Psychological Society highlighted the Intervention for Dementia: Education, Assessment and Support (IDEAS) service as an example of good practice in this regard. The IDEAS team in NHS Dumfries and Galloway provide specialist support to teams working with individuals who have dementia and associated behaviours contributing to stress and distress. The team works across health, social care, third sector and independent services in a rural setting and comprises a clinical psychologist, specialist nurse practitioner, occupational therapist, social worker, a speech and language therapist and an administrator. Consultation outcomes from 2016-17 showed a 50% improvement in the use of appropriate medication, 75% improvement in communication outcomes, 50% in others wellbeing and 85% improvement in stress and distress[1].

3. **The improvement functions of 1000 Lives Plus and Social Care Wales should review access to current training provision for care homes to identify best practice and ensure equitable access to the highest quality provision**. We are aware of a number of examples of award-winning, well established training packages which have been developed for care home staff such as the Dementia Reablement Training package. For more information, please see annex A. Lessons may be learnt from the recent mouthcare improvement programme for care homes.

4. **Leadership –Welsh Government should fund an AHP Dementia Consultant post to drive improvement and ensure the contribution of AHPs in Wales to post-diagnostic support**. We wish to draw the committee's attention to RCSLT, RCOT and CSP calls around the Welsh Government Dementia Strategy. A common call of families living with dementia is a lack of early, preventative support. The practical and enabling interventions provided by therapists are a key alternative to overreliance on medication and/ or social care support. Access to and investment in AHPs is critical if the strategy is to ensure people with dementia get the post diagnosis support they need and deserve wherever their place of residence. We believe there is much to be learnt from the Scottish model of post-diagnostic support which places a strong emphasis on the skills of AHPs in enabling people to do what matters to them and was developed following a key action within the Scottish dementia strategy 2013-2016. As part of this model, a National AHP Consultant has been employed by Alzheimer Scotland to drive improvement and ensure the contribution of Scotland's AHPs to post-diagnostic support in dementia though the development of Connecting People Connecting Support – **Connecting People, Connecting Support: The Allied Health Professional Offer to people affected by dementia in Scotland**. The framework is supported by professional bodies, has been prioritised by Therapies Directors and AHP dementia champions have a key role in supporting improvement throughout NHS bodies and local authorities.

[1] NHS Dumfries and Galloway. IDEAS team annual report April 2016-March 2017. Available on request.

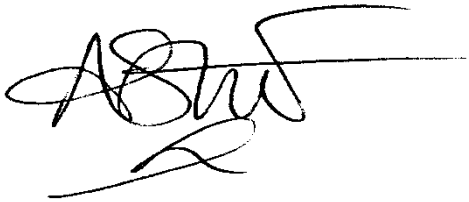
We believe there could be significant potential to create an AHP Dementia Consultant post in Wales, based in Alzheimer's Society Cymru and funded by Welsh Government. This post could benefit from the evidence base created in Scotland and drive improvement and better access to therapies post diagnosis, working closely with Directors of Therapies and Health Sciences, professional bodies, and crucially people affected by dementia. This post should be written into the Welsh strategy with a key action to create a framework for transforming the AHP contribution to supporting people living with dementia in Wales.

We hope these four suggestions are useful to the committee in deliberating the practical actions that can be taken to deal with this vital matter and to improve the lives of people of all ages, and with a range of challenging health and social care needs who live in care homes. The contribution of therapy professions is currently underutilised in helping care home providers and staff to enable people to live with dignity, control and meaning.

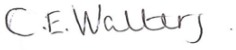
Yours sincerely,

Karin Orman, Professional Practice Manager, Royal College of Occupational Therapists

Ruth Crowder, Wales Policy Officer, Royal College of Occupational Therapists



Dr. Alison Stroud, Head of Wales Office, Royal College of Speech and Language Therapists



Dr Caroline Walters, Policy Advisor, Royal College of Speech and Language Therapists

Annex A –existing examples of high quality dementia care training

- Abertawe Bro Morgannwg University Health Board Dementia Care Training Team picked up two awards for their specialist training. The jointly funded team, based at Glanrhyd Hospital, were awarded Stage 1 Practice Innovation Unit by the Welsh Centre for Practice Innovation (WCPI) acknowledging continuing work to improve standards in dementia care. Plus, they've been Highly Commended in the National Social Care Accolades which are awarded by the Care Council for Wales.

- Helen Lambert and Alison Turner, both Occupational Therapists, and Mental Health Nurse Karyn Davies developed and delivered training to ABM and Bridgend County Borough Council staff to improve the support people with dementia received, and ensure everyone receives the same care across the area. Helen Lambert, went onto lead on the development and delivery of a Dementia Reablement Training Package for Cardiff City Council and the Social Service Improvement Agency. http://www.ssiacymru.org.uk/home.php?page_id=8644. This led to the development of a Dementia Reablement toolkit and service model: http://www.ssiacymru.org.uk/resource/english--lr.pdf. These can be translated to span care homes and the training of care home staff.

- Cwm Taf University Health Board Service News: The Mental Health Liaison occupational therapists assessments enable the multi disciplinary team to identify needs and to provide recommendations for discharge, thus reducing the length of inpatient stay within the DGH and/or community hospital settings. Data gathered has identified that 90% of patients have not been previously known to memory or mental health services prior to admission to hospital. Occupational Therapists now provide education and training to the wider multidisciplinary team including doctors and medical students. Patient's complexity and level of support required for their mental health needs is identified earlier. Patients are then offered the most appropriate service to meet their needs and hospital length of stay has been reduced on average by 3 days. The Occupational Therapy Service in Cwm Taf UHB Mental Health Liaison is seen as an exemplar of best practice which is being implemented across Wales.

Iechyd, Gofal Cymdeithasol a Chwaraeon
Health, Social Care and Sport Committee
HSCS(5)-31-17 Papur 5 / Paper 5

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon
Cabinet Secretary for Health, Well-being and Sport

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: MA-P/VG/3695/17

Dr Dai Lloyd AM
Chair of Health, Social Care and Sport Committee
National Assembly for Wales
Cardiff Bay
Cardiff
CF99 1NA

27 October 2017

Dear Dai,

Thank you for your letter of 2 October on behalf of the Health, Social Care and Sport Committee regarding cancer waiting times. I can assure you that cancer waiting times remain a priority for the Welsh Government.

Health boards are required to provide a monthly update on their cancer performance. Cancer performance is discussed between Welsh Government and health boards at the regular Quality & Delivery and Joint Executive Team meetings. I am also in regular communication with the individual health boards regarding their improvement plans and progress made.

While the Urgent Suspected Cancer (USC) performance is below target the overall trend over the past two years has been one of improvement. I am assured that the improvements are sustainable and that progress will continue to be made.

The number of patients being treated on the USC pathway has been increasing. Comparing the 12 month period from September – August from five years ago highlights that the number of patients treated within target this year has increased by 40% (1,875 patients).

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There were 95,797 referrals for urgent suspected cancer over the last 12 months (September 2016 – August 2017) which is an increase of 10% (8,739 referrals) on the previous 12 month period. Despite this in August 2017 the numbers of patients treated within target had increased by 39% (157 patients) compared to the same period 5 years ago.

In August 2017, four health boards achieved the target for non-urgent suspected cancer (NUSC), with the other two recording performances over 96% which resulted in the all Wales target being achieved for the third time in 2017. One particular health board faces challenges in maintaining consistent performance.

Cancer waiting times are a good indicator of pathway efficiency and capacity. I am in direct contact with health board Chief Executives about my expectations for further improvement in performance.

There remains some variation in performance across health boards which the NHS is working hard to reduce, for example, through the Cancer Network and their programme of peer review as well as direct interventions from the NHS Delivery Unit. Variation across cancer tumour sites is primarily linked to recruitment and retention issues and there are practical factors such as a UK national shortage in certain specialist areas.

Attached to this letter is a brief summary of the actions being taken at each health board which outlines the work being undertaken and the progress made so far.

Considerable work has taken place over the last three years to examine cancer pathways as a whole. Work is progressing now on redesigning cancer pathways to speed up and support early diagnosis, establish one stop clinics and reduce the number of steps within the pathways. There are some excellent pieces of work taking place to improve outcomes for cancer patients including:

- The use of detailed imaging techniques to help doctors target head and neck cancers more effectively in a £720,000 clinical trial. This will improve the treatment and survival rates at Cardiff's Velindre Cancer Centre and Swansea's Singleton hospital.
- Patients with unclear symptoms can sometimes wait too long for diagnosis because they do not "fit easily" into any particular treatment route. They may be referred for a series of tests and scans. As a result some patients may start treatment at a later stage than desirable. A new pilot in the Cynon Valley will focus on patients who GPs suspect may have cancer but who do not show obvious or urgent symptoms. This involves a number of new "one-stop" clinics, where as many tests or scans as necessary will be conducted - ideally on the same day - to try to get to a definitive diagnosis.

In order to focus performance, health boards participate in six national clinical audits, they have a well respected peer review programme, conduct annual reporting through the implementation group and have numerous other metrics from screening to diagnostic care to palliative care.

I am pleased to see year-on-year improvements in one and five year survival rates for cancer. The latest data was published on 28 September 2017 and showed the highest survival rates yet reported. One year survival increased by 3.3 percentage points over five years, from 69.4% for people diagnosed in the period from 2005 to 2009 to 72.7% for the most recent diagnosis period, 2010 to 2014. Five year survival also increased by 3.3 percentage points, from 53.8% to 57.1% for the same years of diagnosis.

We have seen consistently high levels of positive patient experience for cancer care across both the 2013 and 2016 cancer patient experience surveys. The most recent survey, published on 5 July 2017, had more than 6,700 responses. 93% of respondents rated their care positively (7 or more out of 10). There were similarly high scores for indicators relating to dignity, co-production and administration of care.

I trust that this letter provides a useful overview of the work in place to improve all aspects of cancer performance. I continue to expect the NHS to improve its performance further in the coming months.

Yours sincerely,

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon
Cabinet Secretary for Health, Well-being and Sport

Annex

Aneurin Bevan University Health Board

The health board has struggled to achieve consistent performance over the last 12 – 18 months due to increasing numbers of complex pathway patients, increased demand on diagnostics, some capacity issues and recruitment and retention issues in specialist areas. However following considerable pathway redesign, performance has improved and the health board is predicting to attain the NUSC target and to have a USC performance around 90% for the next few months. Actions in place to improve performance include:

- The introduction of one stop MRI and TRUS biopsy clinics to shorten waits on the urology pathway as well as ensuring more accurate and targeted biopsies.
- A two legged early diagnosis pilot in lung where direct to CT scan from primary care and direct to CT scan from abnormal chest X-ray are being made available.
- Head and neck one stop neck lump clinic being piloted.
- Dedicated lower gastro intestinal surgical slots are now in place for endoscopy services which will ensure quicker access to diagnostic scopes.
- Outsourcing routine endoscopies is in place to reduce waiting times.
- Additional surgical sessions in urology to address backlog.
- Additional consultant urologist appointed as well as an additional UGI clinical nurse specialist. An additional clinical nurse specialist for urology is also being sought.
- A one stop rectal bleeding clinic is being piloted.

Abertawe Bro Morgannwg University Health Board

The health board has generally been the lowest performing of all the health boards over the last 12 – 18 months. This has had a direct effect on the all Wales position. The reasons cited for this are many and include, diagnostic waits and reporting, administrative, outpatient capacity, waits for outpatient appointment, treatment delays, complex pathways, wait for MDT discussion and surgical waits. A material factor for ABMU is the significant growth in referrals they have received, an increase of 45% over the last 4 years.
The NHS Delivery Unit is working directly with the service to identify areas for improvement. The focus is upon making sustained improvements to cancer services rather than short term initiatives to improve performance. The health board is now predicting an incremental and continuous improvement over the next few months.

Actions to improve performance include:

- Peer review action plans revised and actions amended to demonstrate improved actions which are measurable and timely, clearly reporting the process for monitoring and ownership of delivery.
- All cancer tracking arrangements across the organisation have been reviewed to identify individuals tracking each tumour site with the aim to improve robustness and effectiveness of tracking meetings.
- Post menopausal bleeding pathway to be implemented. This is a one stop pathway which will improve on the waits in between diagnostic tests and the number of outpatient appointments required, reducing delays and improving performance. Implementation of radiology dashboard will improve access to live information for radiology departments, increasing their ability to improve performance.
- Four radiographers appointed to increase capacity and maximise second CT scanner. Interim middle grade cover for haematology appointed to provide additional

capacity for clinics. The recruitment process is underway for 3 oncology consultant posts and further posts outlined within workforce.
- Additional breast diagnostic clinics held and funding agreed for a locum consultant radiologist for 3 months.

Betsi Cadwaladr University Health Board

The health board NUSC performance has been fairly consistent over 97% and they attained the target nine times in the last twelve months. Their USC performance has fluctuated but on the whole they do consistently achieve performance above 90% for USC performance. Their profile is one of continuous improvement and sustained improvement over time and have over the last two years generally been a leading performer in Wales. The health board cites the following reasons for not achieving the target; complex pathways, delays to first appointment in colorectal, gastro and ENT, delays to urology surgery, administrative and delays for endoscopy.

Actions to improve performance include:

- Creating additional capacity in urology surgery.
- Working collaboratively with Liverpool to allow BCU urology consultant to conduct robotic surgery in Liverpool on BCU patients.
- Clinical nurse specialist led urology clinics.
- Additional gastro enterology clinics in place to reduce delays to outpatient appointments and patients are now booked in target.
- Additional clinics in colorectal and straight to test initiatives.
- Six day working in endoscopy.

Cardiff and Vale University Health Board

Since November 2015, when the health board performance dipped considerably, the position at Cardiff and Vale university health board has been one of gradual improvement. The health board has sought to ensure all improvements are long term and sustainable. They have demonstrated continuous improvement and are the only health board to have achieved both targets twice in 2017. Due to a number of issues that arose in August the health board are forecasting a slight dip in performance but will maintain USC performance of over 90% by the year end.

Actions to improve performance include:

- Maintaining their approach of ensuring that those patients who have waited longest for treatment are seen first, balancing demand and capacity and long-term sustainable pathway improvement.
- Increased scrutiny on all breaches.
- Led by the Medical Director, with the support of the continuous service improvement team, a specific project focusing on lower and upper GI pathway redesign and improvement has been initiated.
- Monitoring and management processes have been reviewed and standardised; a dedicated escalation review process through a monthly cancer challenge and support meetings with clinical boards - chaired by the Chief Executive Officer.

Cwm Taf University Health Board

Performance has varied over the past 12 months with performance on the 62 day pathway ranging from a low of 78.3% (October 2016) to 91.1% (May 2017).

The health board cites increasing referrals and radiological demand as the main areas of concern for maintaining performance.

The pathway for patients with suspected prostate cancer has been revised and the health board is confident that moving forward the delays will be minimised resulting in significantly fewer patients waiting longer than 62 days for treatment.

Similar delays have recently been realised for patients with suspected colorectal cancer as demand for CT colons has increased exponentially. The health board is currently working with the radiology demand to create additional capacity for this key investigation and reporting service. The health board is confident that the changes implemented will lead to sustained improvements in the medium term.

Actions to improve performance include:

- Actively reviewing the processes for escalating delays across the entire USC pathway to ensure patients progress through their pathways as quickly as possible.
- Put in place a revised and updated management process and escalation policy, tightening up on stages of the pathway and revisiting the respective roles and responsibilities of key staff. This will ensure delays are escalated earlier in the pathway to influence and support earlier intervention at all levels.
- The health board has revisited the demand for USC CT scans and have a plan for addressing their capacity shortfall.
- Redesign of pathways linked to the early diagnosis service implementation.

Hywel Dda University Health Board

Hywel Dda have for the last 10 months achieved a performance of above 90% for the USC pathway.

The health board expect that this level of performance will be maintained. Actions to improve performance include:

- Focus on first outpatient appointment waits.
- Outsourcing of thoracic surgery patients via the WHSSC thoracic surgery project is due to commence and is expected to have a positive impact in reducing waiting times.
- For gynaecology, lower GI, urology and head and neck, the health board is in active discussion with ABMU as the tertiary provider to improve services.