Aneurin Bevan University Health Board

Response to Health & Social Care Committee – request for information from Health Boards (September 2018)

Mental Health

1. Breakdown of spend on Mental Health Services (excludes Learning Disability services)

Expenditure over the last 3 years (2015-16 to 2017-18) is shown as follows:-

	2015-16	2016-17	2017-18
	£m	£m	£m
Resources			
Mental Health Division:			
Older Adult services	12.8	13.3	13.4
Adult services	14.8	17.0	17.7
Primary Care Measure	3.0	3.3	3.9
Forensic	3.6	2.9	2.9
Substance Misuse services (provided by the Health Board)	1.3	1.4	1.7
Specialist Services	1.0	1.3	1.4
Local Authority and third sector agreements	1.3	1.3	1.3
Continuing Health Care (CHC) – excluding LD/EMI	10.4	11.1	12.7
Mental Health Management/Support services	4.6	5.7	5.3
Sub-total	**52.9**	**57.2**	**60.4**
Continuing Health Care (CHC) – Elderly Mental Illness	**17.7**	**17.1**	**18.2**
Family and Therapies Division: Children's	5.7	6.1	7.5
Primary Care Division (Prescribing, GMS, Local Authority)	11.3	10.1	11.6
All other Mental Health Services: Externally Commissioned less WHSSC, overheads and activity in other Divisions	32.5	22.6	22.0
Total resources	**120.2**	**113.1**	**119.8**

Table 1:- Mental Health expenditure 2015-16 to 2017-18

	2015-16	2016-17	2017-18
Mental Health ring-fenced funding	**£m**	**£m**	**£m**
Allocation	**95.6**	**96.4**	**100.8**
Expenditure	**120.2**	**113.1**	**119.8**
Variance	**24.6**	**16.6**	**18.9**

2. Mechanisms to track spend and Health Board priorities

Through the Board's planning, performance and reporting structures, including local partnership arrangements, spend on mental health services is tracked along with associated performance indicators. As part of the Health Board's Value Based Health Care Programme, the intention is to capture patient outcome data across pathways/health conditions, at scale, and there is a programme of work in place across a range of services, including mental health services.

Health Board priorities

In addition to discretionary funding, the Health Board received ring-fenced funding in 2017/18 which has been invested in mental health services. Further ring-fenced funding has been made available in 2018/19 which the Health Board is investing in mental health services. These include the following services:

- Development of care packages in community settings

  Investment in more innovative 'In One Place' joint housing schemes, for those patients with complex needs, to access better support arrangements.

- Improving support for adults who present in crisis

  Investment in increased staff levels in acute in-patient wards and the remodelling of Crisis Resolution Home Treatment teams, providing an extended service. Following consultation with users, carers and partners an increased provision for crisis services in the community.

- Improved integration and more streamlined access to emotional and mental health services for children and young people and their families.

- Improved access to services for patients with eating disorders.

- Expansion of Psychiatric Intensive Care Unit (PICU)

An increase in local services (4 to 9 inpatient beds) should improve the pathway for patients and increase access to locally provided services. This expansion is due to be completed by March 2019.

- Implementation of WCCIS

  The implementation of the new community information system should improve management information and support improved patient care for mental health services both in and out of hospital and links between providing health and social care.

The Health Board's provision of mental health services – including financial resources - is managed across the following areas:

1. Mental Health Division

   Secondary care acute inpatient care, community services and adult mental health/learning disability continuing health care (CHC) services.

2. Family and Therapies Division

   Provides CAMHS services, Out of county children's CHC placements and paediatric psychology services.

3. Primary and Community Care Division

   GP/Primary mental health services and prescribing in primary care.

These Divisions provide specific mental health services whilst also working collaboratively to deliver a pathway approach. This includes developing long term plans, in partnership with local authorities and 3rd sector partners, through the Gwent Mental Health and Learning Disability strategic partnership arrangements.

Mental Health funding supporting other services

In addition the Mental Health Division provides support to patients in surgical and medical wards as well as the Emergency Department to ensure their mental health needs are assessed and met whilst receiving physical care. The integrated planning and delivery structures enable a more balanced and holistic approach to delivering appropriate patient care.

3. Demand and Capacity – Mental Health

The Health Board's planning processes incorporate the assessment of need and level of service provision required to deliver appropriate mental health services. This includes joint partnership arrangements which consider service priorities and develop plans, taking account of best practice evidence and benchmarking intelligence.

The Health Board recognises this is an area which needs to be developed further and has identified actions to make progress. Hospital mental health service information is captured routinely. However, information on some aspects of community and other mental health services requires further improvement. The implementation of WCCIS and collection of outcomes data for patients with mental health conditions, should help achieve a more systematic approach to planning and measuring the effectiveness of services along patient pathways.

Spend for mental health services is captured through various mechanisms, e.g. programme budgeting, Divisional financial reports and standard costing returns. Table 1 provides an example of the financial data available.

4. Emotional and Mental Health Services for children and young people

The following table provides a summary of the expenditure for mental health services (for children / young people) over the last three years:

	2015-16	2016-17	2017-18
Mental Health spend children and young and people	**£m**	**£m**	**£m**
CAMHS	3.3	4.3	4.2
Continuing Health Care (CHC) – CAMHS	0.5	0.3	0.9
Paediatric psychology	0.9	1.0	1.0
WHSSC expenditure - CAMHS / eating disorders for young people	1.1	0.5	1.4
Children and Young People -Primary care Measure Spend	0.2	0.4	0.5
Total (excludes proportion of externally commissioned spend)	**5.9**	**6.5**	**8.0**

The costs reported above include the most significant spend areas, but do not include elements such as overheads, some services commissioned with other health bodies and direct spend with the voluntary sector.

Primary Care / Secondary care spend

The following table provides an analysis of spend, which identifies that primary care services increased at a greater proportion than spend on other healthcare services between 2016-17 and 2017-18.

Extract from Health Board's annual accounts 2017/18 – cost growth

	Note	2017-18 £'000	2016-17 £'000	Increase £'000	Increase %

Primary Healthcare Services	3.1	262,060	253,163	8,897	3.5
Healthcare from other providers	3.2	334,735	324,394	10,341	3.2
Hospital and Community Health Services	3.3	666,452	658,945	7,507	1.1
Sub-Total		1,263,247	1,236,502	26,745	2.2

However, the Health Board recognises that a more appropriate analysis and measurement of spend needs to consider the level of resources used in hospital and out-of-hospital care in line with its strategic aims. As a result, work has been undertaken locally to develop a different analysis which measures spend in hospital, out-of-hospital services and overhead functions. The methodology, and its application, is still being refined and the following table provides a summary of the initial results of developing this approach.

Aneurin Bevan Health Board (Hospital v Out of hospital care) spend	Hospital (£)	Out of hospital (£)	Overhead (£)	Expenditure on Primary Healthcare services (as per Annual accounts)
2015-16	536,152,682	475,885,804	70,166,831	260,628
2016-17	581,151,745	484,796,587	77,884,088	253,163
2017-18	595,293,817	506,411,801	68,528,962	262,060
2015-16 %	49.5%	44.0%	6.5%	24.1%
2016-17 %	50.8%	42.4%	6.8%	23.4%
2017-18 %	50.9%	43.3%	5.9%	24.2%

The level of spend in out of hospital services has increased over the last three years – in cash terms - but has fluctuated in proportion to total spend. The following comments should be noted:

- Expenditure on externally commissioned acute hospital services (including specialist services) continues to increase.
- The level of overheads including estates, energy and costs and how they are apportioned requires further investigation.
- There will always be an element of cross-over in certain specialities such as therapies and therefore further work is required to validate the appropriate allocation of spend between the three broad categories.
- Specific examples of investment in out of hospital services include 'Frailty (virtual ward)' teams, ophthalmology diagnostic and treatment centres, community cardiology, minor oral surgery and pulmonary rehabilitation teams and community mental health services.

The Health Board's IMTP priorities and Clinical Futures Strategy aim to deliver care closer to home and in doing so achieve a shift in resources from hospital to out-of-hospital care. As part of this strategy, the Health Board are investing in and strengthening primary, community and social services in partnership to create the capacity to support and treat patients in their homes and local communities.

The submission of funding bids (Transformation Fund), submitted through the regional partnership arrangements, aims to support significant transformation by providing more out-of-hospital care and improving integration between health, social care and housing.

The majority of the Health Board's capital investment programme is naturally focussed on the building of the Grange University Hospital over the next three years.

However, the Board plans to invest in several primary care developments, including joint facilities with social care and the 3rd sector, where the Health Board would use revenue funding to support them. Examples include proposals being developed for Tredegar and Newport East. Working with our partners through the Regional Partnership Board, the Board plans to invest in several joint community based development schemes, providing multidisciplinary care, utilising the ICF (Integrated Care Fund) capital funding.

Preventative spend/integration

1. Prevention / early intervention

The Health Board's Clinical Futures Strategy includes a significant focus on both out-of-hospital care and prevention of ill health. This will be critical to the success of the Strategy.

Some examples where there has been an increase in preventative services include:

1. Living Well, Living Longer scheme,
2. Improved capacity and incentives to increase the uptake in vaccinations and immunisations (including staff),
3. The development of 24 hour/7 day services e.g. community nursing,
4. Weight management services,
5. Pulmonary rehabilitation services,
6. Access to smoking cessation services, and
7. Alternatives to hospital based surgical interventions where appropriate (e.g. greater access to therapy services).

The Health Board's value based approach to planning and prioritising resources to delivering improved health also means that patient outcomes will influence future priorities. In some cases, this will involve greater access to preventative services.

2. Integrated Health and Social Care Services

Integrated service developments with local authorities and the 3rd sector include the 'frailty' service (a multi-million pound investment pooled budget for Gwent), integrated community equipment service, provision of health and social care resource centres and many joint community schemes funded through partnership ICF arrangements e.g. Home First. A number of these schemes have been referred to previously.

Gwent has made significant progress in developing a pooled fund for older adult care home services in partnership between the Health Board and the five local authorities.

The measurement of outcomes is a complex area. Through its Value Based Health Care approach the Health Board has invested in ICT capability to collect outcomes data at scale, working with International Consortium for Health Outcomes Measurement (ICHOM) to develop outcome measures that can be used universally.

National Programme Budgeting data linked to Health Survey data is another approach which is available to link resources to health status.

The WCCIS system will also help capture certain outcomes based information.

Admitted patient care

The following table provides a summary of the expenditure for elective and non-elective admitted patient care over the last two years:

	Actual expenditure	
	2015-16 £m	2016-17 £m
Elective	85.23	92.28
Non-elective	243.97	251.88
Total	**329.19**	**344.16**

The forecast spend is based on the Clinical Futures Strategy and modelling projections which aim to improve performance and reduce length of stay. The number of hospital beds is expected to reduce and therefore the increase in expenditure would arise through a shift in resources and more acute and intensive use of hospital based services. The Health Foundation 'Path to Sustainability' report suggests a 3.2% growth with some offset through savings/cost avoidance. The table below illustrates the impact of spend increase assuming 1.2% and 3.2% growth scenarios.

	Forecast (£m)					
	2017-18 (£m)		2018-19 (£m)		2019-20 (£m)	
	Minimum (1.2%)	Maximum (3.2%)	Minimum (1.2%)	Maximum (3.2%)	Minimum (1.2%)	Maximum (3.2%)
Elective	93.4	95.2	94.5	98.3	95.6	101.4
Non-elective	254.9	259.9	258.0	268.3	261.1	276.8
Total	**348.3**	**355.2**	**352.5**	**366.5**	**356.7**	**378.3**

Workforce

1. Progress in addressing workforce pressures

The Health Board continues to address workforce pressures through a number of different initiatives designed to increase overall substantive staffing numbers in a cost effective way.

Medical/nursing staff – a range of different recruitment initiatives, well-being support to reduce sickness and improve retention, incentives to encourage greater but appropriate use of staff through the staff bank/locum arrangements and reduce reliance on agency staff

Developing alternative roles – such as enhanced nursing, therapy, pharmacist and physician associate roles – in primary care and hospital services.

2. Actions taken to ensure a sustainable workforce following the UK's withdrawal from the EU.

The Health Board is aware of the potential implications of the UK's withdrawal from the EU. The actions outlined previously, with regard to achieving a more sustainable and cost effective workforce, place less reliance on recruiting staff from abroad and focus on developing roles and our workforce locally to deliver future requirements. This does however still remain a significant risk.

The potential risk of lower economic growth, as a result of Brexit, leading to lower tax revenues and public spending is understood, along with potential price increases. In line with other Health Boards an NHS Wales wide approach is being undertaken to assess the financial implications post-Brexit.

The Health Foundation's report (Path to Sustainability) still provides a useful basis on which to make resource planning assumptions going forward, whilst allowing further sensitivity analysis to be undertaken in

relation to the potential impact post-Brexit on workforce costs, costs of drugs and other essential supplies.

3. Evidence about progress made in reducing and controlling spend on agency staff

The Health Board continues to focus on control and minimising the use of agency staffing. There are however service and workforce sustainability issues in specialities such as paediatrics, obstetrics and gynaecology.

The centralisation of critical and acute care services, as part of the Health Board's Clinical Futures Strategy, will consolidate some of our key medical and nursing staff, which in turn should help address some of the medical and nursing workforce pressures currently being experienced. Alongside this, the re-investment in out-of-hospital services and the development of alternative workforce roles and more integrated working with social care staff should help move towards a more sustainable workforce solution, with less reliance on agency staff.

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