Appendix C

Our Strategic Framework for Mental Health Services for Adults

Final Draft

20.9.18

1. Introduction

In May 2017 ABMU Health Board, Bridgend County Borough Council, Neath Port Talbot County Borough Council and Swansea Council agreed that they would develop a strategic framework for mental health services for adults. This would be used to ensure there was a clear direction for these services going forward. As part of this, meaningful engagement with users of services and their carers / families plus those who have tried to access our services was felt to be crucial to ensure that this framework addressed the issues which our population face when trying to get support from our services.

This draft strategic framework has been developed by the above four organisations, based on evidence about what works best and what our service users and their carers / families have told us needs to improve and change.

2. Background

The Social Services and Well-being (Wales) Act 2014 came into force on 6th April 2016. It contains some fundamental principles:

Voice and control – putting the individual and their needs, at the centre of their care, and giving them a voice in, and control over reaching the outcomes that help them achieve well-being

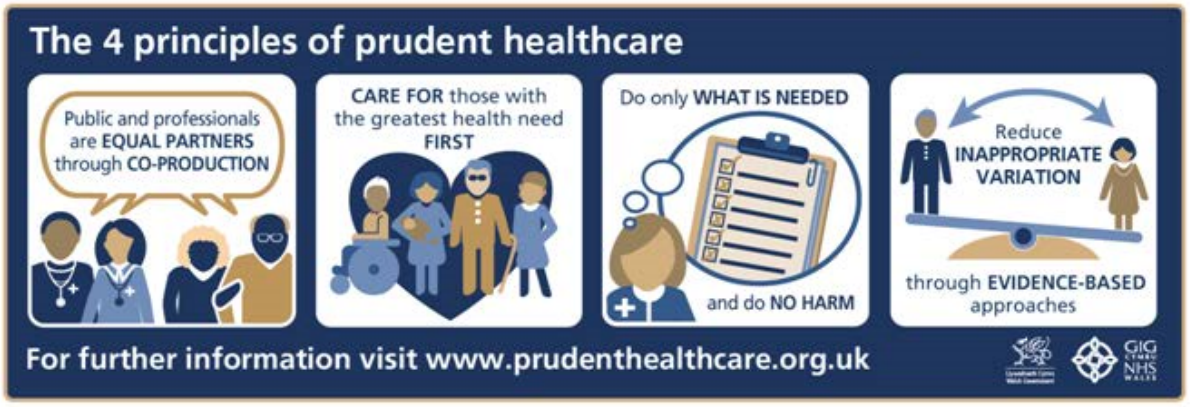
Prevention and early intervention – increasing preventative services within the community to minimise the escalation of critical need

Well-being – supporting people to achieve their own well-being and measuring the success of care, help and support available

Co-production – encouraging individuals to become more involved in the design and delivery of services

These principles are fundamental to this Strategic Framework and reflect the issues raised by service users and their carers in the engagement carried out to inform this work, as outlined in section 5 below.

Prudent healthcare was endorsed by the Minister for Health and Social Services in January 2015. The four principles of prudent healthcare are detailed overleaf:



- Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production
- Care for those with the greatest health need first, making the most effective use of all skills and resources
- Do only what is needed, no more, no less, and do no harm
- Reduce inappropriate variation (inappropriate differences between the help and support available to different people) using evidence based practices consistently and transparently

Again these principles are also fundamental to this Strategic Framework, and are consistent with the issues and priorities raised through the engagement with service users and their carers.

3. Level of Need

The following facts have been provided by the Mental Health Foundation through their 'Mental Health in Wales Fundamental Facts 2016' paper:-

- 13% of adults (aged 16 and older) living in Wales were reported to have received treatment for a mental health problem, an increase from 12% reported in 2014.
- A higher percentage of women report being treated for a mental health problem than men (16% vs 10%). Mental health problems affect more than 1 in 10 women during pregnancy and the first year after childbirth, and can have a devastating impact on new mothers and their families.
- The overall cost of mental health problems in Wales is an estimated £7.2 billion a year
- In Wales, around £600m is invested in mental health services a year, which is more than any other service in the NHS.

- Over the last 30 years, the service provision for people with a mental health problem in Wales has changed to become more community based.
- The number of people resident in hospital continues to decrease from 1821 in 2010 to 1441 in 2015.
- Mental ill health can have a significant impact on life expectancy and is a key cause of health inequalities. Research undertaken in the UK in 2011, found that people with severe and enduring mental health problems die on average 10 years earlier than the general population.
- Data from the 2011 census shows that in Wales there were 370,230 people providing unpaid care, reflecting 12% of the population, a slightly higher percentage than the overall UK average of 10.3%.
- Data from the 2011 Census shows in Wales that around 1 in 20 women were providing 50 or more hours of unpaid care a week to an adult relative, friend or neighbour that has a long-term physical or mental health problem
- Self-harm is a growing problem in Wales with approximately 5,500 emergency admissions to hospital each year.
- According to the Office of National Statistics suicide prevalence in Wales decreased from 14.7 per 100,000 in 2013 to 9.2 per 100,000 in 2014.
- Findings from the 2015 Welsh Health Survey (adult) found that there was poorer mental health in more deprived areas (8% in least deprived areas – 20% in most deprived areas).

The Western Bay Population Assessment (April 2017) identifies a number of challenges facing our area:

- GPs treat the highest proportions and numbers of people with mental disorders. The majority of people with mental health issues either live in the local community with minimal support from Adult Social Care (ASC) or from specialist mental health services, they either self-manage, have family/community support or access primary health care.
- There are also a significant number of people with serious mental health problems who are supported to live in the community by specialist community services
- Secure settings, residential care and nursing care are used more than they should be and service users can stay in them longer than is ideal.

- There is a lack of specialist mental health respite/short term crisis beds to use to stabilise a person during a mental health relapse so to be safe staff may choose to use residential care
- There is a lack of specialist mental health step down services to help people make the transition from hospital or from a residential care setting back to the community so there is a tendency to support people in residential setting for longer
- There is a lack of acute mental health beds which means there is significant pressure to discharge people from hospital as quickly as possible. Sometimes this is before people are ready to move back to their home in which case a safe place needs to be found
- There is a lack of specialist community mental health recovery / reablement service to continue to support people to recover in a community setting, and;
- There is a lack of community based support services that can meet the needs of people with complex mental health needs, notably behaviour that is challenging to services. This includes a lack of:
    - Mental health supported living services
    - Shared lives carers with mental health expertise
    - Housing (specialist and disbursed) that is suitable for adults with mental health needs
- Currently people with mental health needs can often only access generic support until they experience a mental health crisis that brings them into contact with specialist services. When this is the case, individual outcomes and wellbeing suffer and support costs escalate. Specialist mental health respite/short term crisis beds are used to stabilise a person during a mental health relapse which could lead to the use of residential care.
- It is expected that demand on all social care services will grow due to the anticipated demographic changes in Western Bay.
  Projections indicate that there will be an increase of people with a mental health problem.

4. Engagement Feedback

An engagement process was co-designed and co-produced with elected service user and carer representatives from the ABMU Together for Mental Health Local Partnership Board, loosely based on the “In Your Shoes” approach used by the Health Board previously. A total of 13 events were held across the Western Bay area, in different locations and

varying times, giving people the opportunity to tell us about their experiences. In each of these sessions one hour was spent with a service user / carer telling a member of staff or a facilitator from the voluntary sector (listener) about their experiences, good and bad, and identifying what would have made a positive difference to their experience. The second hour was spent grouping these issues. In addition the same questions were discussed in some established forums for mental health service users and their carers. Focus groups were also held in the Low Secure facility within ABMU and with the deaf community. The Western Bay Substance Misuse service user forum also discussed their experiences as a group and fed these into one of the above events.

In total 105 individuals gave their time to tell us in depth about their experiences of our services and in addition 170 people have been involved in giving their views either via an online survey or through discussions / submissions.

Two feedback events were then held where all those who had participated in the engagement, service users, carers, voluntary sector and staff were invited back to hear the feedback from the engagement and asked whether they recognised the issues raised from their experiences. They were also asked whether there were any issues omitted and what their three top priorities for action would be.

In summary the engagement and feedback events highlighted the one key statement which service users and their carers wanted to underpin all that we did:

Work with us, not do to us

Their top priorities are:

- Change culture / attitudes:
    - Staff training / development
    - Leading to good communication, consistently, in an empathetic and compassionate way
    - People being really listened to and given support to address all the issues facing them, which in turn impact on their mental health
- Movement from medical to psycho-social model, with a true focus on them holistically and all their needs, not just their mental illness
- Enabling and empowering people to make their own decisions - coproduction real, not lip service

- Training / skills for service users, their carers and families to help them manage their mental health problems better and take more control
- Wider range of activities provided / low-level counselling and support to address issues which impact on mental health Detailed information on the range of issues raised through the engagement is contained as **Appendix A**.

5. Evidence / Rationale for Change

5.1 Based on Engagement with Service Users and Carers After presentation of the findings from the engagement to the four sponsoring organisations it was recognised these issues would only be addressed by a fundamental change to the existing pattern of services for adults with mental health problems. This will need to be a transformational change programme, with service users and carers and staff being central to the implementation of a new pattern of services. To achieve the requirements outlined below all the agencies believe that dedicated programme management on a multi-agency basis will be needed to achieve the key components of the new model of care outlined in section 6 below.

Fundamental to the proposed new model of services is the recognition that mental health services need to be formed using the same "building blocks" as other services provided within the Western Bay area. Currently teams do not share boundaries with other key services which they should link with and support, making it much more difficult than it needs to be for mental health services to be accessed.

Waiting times for some services, particularly counselling and outpatient appointments, have been identified as a key barrier to people getting timely support, and therefore their conditions deteriorating while they are waiting. The new model of services will need to be based on easily accessible services where waiting times are at a minimum.

Most services available to support people with mental health service users operate Monday to Friday and often 9-5. Service users and their carers highlighted that weekends and evenings can be times of heightened concerns and isolation. In order for the future model of services to be successful there needs to be services available 7 days a week and for extended hours, to prevent mental health problems exacerbating. The lack of services run by people with lived experience of mental illness and their carers, and funded appropriately was also highlighted as a significant gap

which should be addressed in any future model of service. The new model needs to ensure that services we provide or commission in future should give opportunities for people with lived experience of mental health problems to become peer support workers and gain access to paid employment and volunteering.
Fundamental to the new model needs to be the principle that support must be made available when the service user or their carers identify they need it, rather than having to wait for circumstances to deteriorate before meeting the criteria for support to be provided.

All services and their staff will work jointly with service users and their carers to provide a package of support co-produced with them, not just based on medication.

Another key issue which needs to be addressed are the transitions between services – from adolescent to adulthood and adulthood to older people as well as between services aimed at meeting different, cooccurring needs, such as substance misuse, learning disabilities and mental health.

Services in future need to be specifically designed to be responsive to the needs of those in rural areas and those with specific needs, such as the deaf community, the homeless, Veterans, travellers, ethnic groups, refugees, LGBTQ (lesbian, gay, bisexual, transgender and questioning) and those in prison.

In providing services in the future, we need to ensure that support is available to meet the mental health needs of staff within health, social care and other workplaces.

In order to support the new model of care, training and skills development for staff, volunteers, service users and their carers will be crucial. In addition pre-registration training for health and social care professionals will need to change to reflect the new model of care outlined here so that newly qualified practitioners can work effectively within it.

5.2 Based on Alder Advice Report for Western Bay on Unmet Mental Health Needs Service Development Review

In late 2017 the findings from Alder Advice were published. The aim of this report was to identify gaps in the system of care and support against the Western Bay vision of a future for mental health care and support as “having an integrated whole system of care and support that consistently focuses on enabling recovery and maximising independence, while keeping people safe during acute mental health episodes”.

The scope of the report covered 430 people from Western Bay who have complex mental health needs and are either jointly supported by adult social care and ABMU Health Board's multidisciplinary community mental health teams or are supported in NHS low or medium secure settings. The report states that "the current care and support system was considered to be a long way away from the vision for the future". To assess the impact of this difference front line staff were asked whether the current support for each individual service users was "ideal" and if it was not we asked how it could be improved so it was "ideal". This found that staff considered 24% to 33% of people had support that was not ideal. The support that was considered "not ideal" was concentrated in the more intensive end of care and support with 90 out of 104 people with support deemed "not ideal" being supported in 24/7 and accommodation based models.

The main shifts identified by staff were from residential care and from secure settings to various supported living or community support models. This highlights the need for step down services and improved community support options to reduce the over reliance on 24/7 models.

Key priorities for improvement were identified in the Alder Report as:

- Improved transition planning (from children & young people's services into adult mental health services)
- Improve the fluidity and flexibility within the system, notably within and between existing services so support can more easily be adjusted up or down as the mental health needs of individual service users fluctuate
- Reduce reliance on 24/7 care models by resettling people where possible when their existing placement is no longer fully appropriate and use the savings achieved to fund: ○ Improvement in early intervention services so mental health crisis are minimised
    - ○ Developments to community support infrastructure capacity as an alternative to 24/7 support models
    - ○ Prevention activities

6. Outline of Proposed New Service Model

The Health Board and Local Authorities within the Western Bay region have agreed that their mental health services need to be transformed to provide modernised, integrated services, aimed at earlier intervention with a focus on prevention.

6.1 What does good look like?

The aim is to support people of all ages to live as full a life as possible with community based help and support seen as the norm and hospital care the exception.

This would be achieved by delivering a range of services which are available to everyone experiencing mental health problems, irrespective of the severity, aimed at prevention and earlier intervention. The new model aims to stop problems occurring or getting worse which will affect people's mental health as well as providing earlier support for people whose mental health is deteriorating. This will include options to easily help people be confident to deal with problems themselves as much as possible and more complex interventions and approaches reserved for addressing more complex needs.

The Health Board and Local Authorities within the Western Bay region have identified the following priorities:

- Increasing partnership/integrated working across Western Bay (pooling budgets, aligning services, jointly planning, commissioning and procuring services)
- Ensuring up to date, easily accessible information is available for service users, carers and professionals on help and support available
- Developing a single point of access for people requiring mental health services
- Strengthening progression pathways that prevent hospital admissions and promote early hospital discharge
- Delivering a strategic approach to ensure individual outcomes are met
- Strengthening the transition process
- Supporting people and carers in ways that promote independence
- Developing localised community support networks
- Developing a range of preventative services within the community
- Developing modern accommodation models
- Ensuring help and support packages are tailored to the needs of the individual and are reviewed appropriately
- Modernising day services
- Promoting and increasing the uptake of Direct Payments where appropriate

- Developing and strengthening support for people with substance misuse issues, particularly our prison population
- Developing clear pathways for people with dementia
- Promoting mental wellbeing and helping to build resilience for people, families and communities
- Working with people, families and communities to develop and provide mental health help and support

6.2 The New Model of Care

Outlined on the next few pages are the components of the new model of care we are proposing, based on what service users and their carers told us needed to be different in future. Key to the new model is that anyone who has mental health problems, irrespective of the severity, has the right to receive help and support which aims to prevent problems and intervene earlier to stop problems escalating.

These generic services will include:

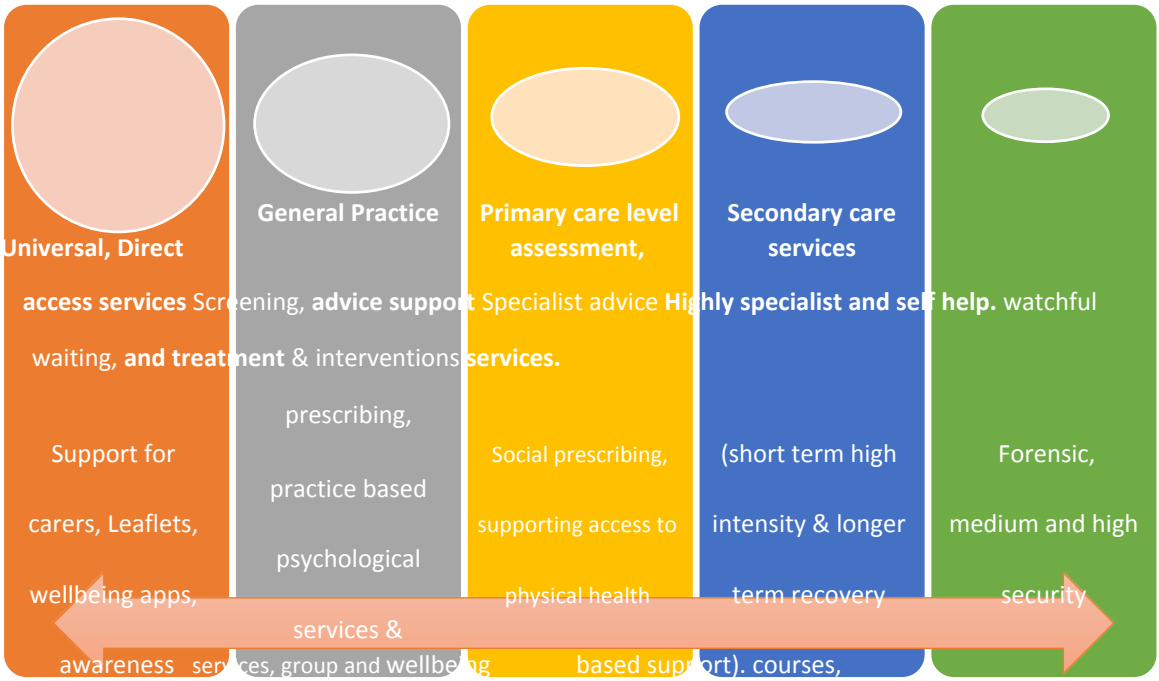
- Citizens advice and similar information / advice services
- Housing and benefits advice
- Access to leisure (A discount scheme for people with disabilities, low incomes or in full-time education to take part in leisure and sports activities at reduced rates)
- Access to Primary Care and generic physical healthcare services
- Mental Health website and accessible, up-to-date information on help and support available
- Employment and education support to access and sustain work
- Emotional Health drop in hub providing wellbeing services to maintain and improve their mental health (without referral)
- Drug and alcohol drop in hub
- Training and support for carers
- Spiritual and pastoral support
- Self-help and Self-care recovery college to help people to become experts in their own self-care and enable family and friends, carers and staff to better understand mental health
- Range of third sector peer / activity groups and support networks through a Clubhouse approach, based on a non-clinical co-production approach giving its members a place to go, meaningful work, meaningful relationships and a place to return

As well as these generic services, a range of services will be in place to ensure that people can receive support specifically for their mental health problems, aimed at earlier intervention and prevention of problems getting worse. These will include:

- A single point of contact for a local area, where the services sort out the range of support required for an individual and their family, rather than them being required to navigate multiple access points to get this support
- Integrated (health, social care and voluntary sector) teams which will:
    - Take responsibility for the full range of needs of individuals in a geographical area (rather than a range of separate teams meeting specific needs)
    - Be coterminous with GP Clusters so as to ensure clear relationships and support arrangements from primary care to more specialised services and back as required, including where there are dual diagnosis issues (be it substance misuse or learning disabilities)
    - Have access to a full range of support services, as outlined in the previous section, for people who need assistance to avoid their mental health deteriorating, including when people are in crisis, – such as spiritual and pastoral support, housing, benefits, financial advice and work and volunteering opportunities
    - Have access to crisis beds / safe places for service users when their needs can't be effectively met in the community
- A range of community based facilities which are open to all, and wherever possible without age restrictions, which would assist with transitions
- A range of services available to support people 7 days a week, for extended hours, rather than the traditional 5 days a week, 9-5pm
- Drop in services which are available for extended days and at weekends
- Information which is readily available for service users and carers in accessible formats and other professionals on the range of services available to help and support them
- Crisis cards / discharge advice numbers for the local integrated teams to access support irrespective of the issue
- Services which are user led and which support service users and their carers to take more active control of their mental health and wellbeing

- Opportunities within the services we provide and commission for people with lived experience of mental health problems to become peer support workers and gain access to paid employment and volunteering
  • Support being made available when the service user or their carers identify they need it, rather than having to wait for circumstances to deteriorate before meeting the criteria for support to be provided
- A range of housing options available for people with mental health problems, both in facilities with others with lived experience of mental health problems, and where this isn't the case, dependent on their preferences and how best their needs can be met
- Floating tenancy support to assist those with mental health problems who need practical support with budgeting and home management
- Provision of direct payments, where appropriate, to tailor support for people with mental health problems
- Employment and education support for people with mental health problems to enable them to access and sustain work
- Local clinics to meet specific needs (e.g. lithium, health screening)
- Care coordination, assertive outreach and intensive support, accessed through the local integrated teams
- Where required, forensic community support, prison and criminal justice liaison
- Range of specialist services (e.g. psychological therapies) which can be accessed through the local integrated teams
- Small number of acute assessment beds, provided within local areas, accessed by the local integrated teams when a person's mental health issues cannot be managed through the crisis beds or safe places
- Access to low secure, medium secure and specialist placements as required to meet the specific high level needs of a small number of people within our population

The diagram below shows these different services, which can be accessed by people depending on their needs:



Wellbeing and universal services available to people across all services

In order for this new model to become a reality the following will be required:

- Detailed planning of an implementation programme which over time sees the introduction of the new model
- Dedicated project management to oversee this implementation, with service users, their carers and families being involved throughout
- Staff training and development so that existing and new staff have the skills and values to deliver this new model
- Education on mental health needs to be provided in schools, colleges and workplaces to reduce stigma and increase people's ability to manage their own mental health
- Training and skills for service users, their carers and families to help them manage their mental health problems better and take

more control by being enabled and empowered to make their own decisions

- Funding to increase the level and range of services available to help and support as part of the generic services described in Section 6.2 above

7. Next Steps

This draft Strategic Framework has been co-developed and co-produced with the group of service users and carers elected to the Together for Mental Health Partnership Board and the joint Health Board and Local Authorities' Optimum Model working group. The draft Strategic Framework was considered by the Western Bay Regional Partnership Board on 7th December 2017 and the Health Board on 8th December 2017 for approval to:

- Undertake further work on the implementation of the framework with the Optimum Model Working Group;
- Identify resources needed to support the implementation of the framework;
- Incorporate the findings of the Alder Advice Report on Unmet Mental Health Needs Service Development Review into the Framework;

This work has now been completed and this revised Strategic Framework is the result. It is intended that the Framework will go through the following approval processes prior to being adopted by partner organisations:

- Mental Health / Learning Disabilities Commissioning Board on 21st September 2018 - approved
- Together for Mental Health Local Partnership Board on 27th September 2018 - approved
- ABMU Health Board's Senior Leadership Team on 3rd October 2018
- Western Bay Programme Team on 11th October 2018 - approved
- Bridgend, Neath Port Talbot and Swansea Local Authority Cabinets October 2018 - approved
- Western Bay Regional Partnership Board on 30th October 2018 - approved
- ABMU Health Board on 29th November 2018

- Local Authority Cabinets in November / December 2018

A Project Manager has been financed from the Integrated Care Fund and this post is currently out to advert and will be in place to support implementation of the Framework once approved.