GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Together for Mental Health in North Wales

Together for Mental Health in North Wales

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EXECUTIVE SUMMARY

This is a new strategy for mental health in North Wales, developed by Betsi Cadwaladr University Health Board (BCUHB)**.** This is an all-age mental health strategy, but does not encompass either substance misuse services or learning disability services. We will develop separate strategies for each of those two services.

This strategy has been coproduced with service user and staff involvement, and prepared in close consultation with our partners in North Wales. When the strategy is approved, we will prepare a detailed action plan for its implementation.

Responsibility for developing and implementing this strategy is shared across three levels, the Mental Health & Learning Disabilities Division [MH&LD], BCUHB and the wider health and care system including partners such as Local Authorities and Third Sector organisations. Much of what is planned here, to be implemented successfully, will need the active support and commitment of partners working together across North Wales, although, some actions can be taken forward by BCUHB independently.

The strategy commits us to adopting six key principles in everything we do:

- We will treat people who use our services, and their carers and families as equal partners – all of us must be seen as essential assets in improving the mental health and wellbeing of the communities of North Wales
- We will ensure everything we do is as integrated as possible – across disciplines, across agencies, across services – in both planning services, and delivering services. Fragmented care must be replaced by joined-up and continuous care.
- We will work to ensure **everyone** feels valued and respected
- We will support and promote the best quality of life for everyone living with mental health problems
- We will promote local innovation and local evaluation in how we provide services
- We will continually measure our impact on outcomes, within both national and local quality and outcomes frameworks – whether we have improved the lives of people for and with whom we provide services

The strategy confirms our aim to offer a comprehensive range of services which:

- Promote health and wellbeing for everyone, focussing on prevention of mental ill health, and early intervention when required;
- Provide evidence based interventions for people with common mental health conditions in the community as early as possible;
- Are community-based wherever possible, reducing our reliance on inpatient care

- Identify and provide evidence based care and support for people with serious mental illness as early as possible;
- Manage acute and serious episodes of mental illness safely, compassionately, and effectively;
- Support people to recovery, to regain and learn the skills they need after mental illness
- Assess and provide effective evidence based interventions for the full range of mental health problems, working alongside services for people with physical health needs;

The strategy therefore commits us to a wide range of specific actions and ambitions. Significant amongst those are:

- New services and approaches will be available to promote good mental health: promotion of the five ways to wellbeing; schools-based programmes; employer-based approaches; welfare rights and money advice
- A Family approach will be taken ensuring all are attended to and the assets of the family and community are valued
- Peer support and other services will be available as a step-down option from statutory community care
- Social prescribing will be more widely available, promoting access to education, exercise, personal and creative development
- There will be new integrated teams to manage very common co-morbidities between physical and mental health, for example anxiety and COPD
- The Eating Disorder Pathway for young people which focuses on early intervention and the family will be embedded.
- The self-harm pathway for young people developed with Education will be rolled out and implemented across North Wales.
- We will improve the availability of a range of psychological therapies, including online therapeutic interventions
- People experiencing first episode psychosis will have access to the full range of NICE-approved interventions, this is a joint model Adult Mental Health and CAMHS for young people aged 14 – 25years
- There will be alternatives available to inpatient admission for those able to manage safely in more intensive community situations
- All ward environments will be fit for purpose, safe and humane
- Information about patients' history, and care and treatment plans will be available in real-time to all staff working with them
- There will be a realistic and sustainable fit between our service commitments, and the numbers and skills of staff to deliver them
- We will ensure full and effective governance of both our commissioned services, and those we directly provide

We look forward to developing closer and stronger working relationships with our partners at all levels of our respective organisations to ensure the successful implementation of this strategy.

1. INTRODUCTION

1.1 Context and Purpose of Strategy

All mental health services in Wales have been working to implement the national strategy for mental health: 'Together for Mental Health' (2012). This national strategy identified 6 high level outcomes:

- The mental health and wellbeing of the whole population is improved.
- The impact of mental health problems and/or mental illness on individuals of all ages, their families and carers, communities and the economy more widely, is better recognised and reduced.
- Inequalities, stigma and discrimination suffered by people experiencing mental health problems and mental illness are reduced.
- Individuals have a better experience of the support and treatment they receive and have an increased feeling of input and control over related decisions.
- Access to, and the quality of preventative measures, early intervention and treatment services is improved and more people recover as a result.
- The values, attitudes and skills of those treating or supporting individuals of all ages with mental health problems or mental illness

The new Government strategy 'Taking Wales Forward (2016-2021)' identifies mental health in its priorities, particular emphasising the need to:

- Prioritise mental health treatment, support, prevention and de-escalation, including a pilot Social Prescription scheme and increase access to talking therapies.
- Work with schools, employers and other partners to improve well-being and promote better emotional health.
- Work to ensure that mental health discrimination is ended.
- Take further action to make Wales a dementia friendly country through developing and implementing a new national dementia plan.

Also at a national level a new delivery plan for Together for Mental Health has been published covering the period 2016 -2019. This sets out the specific actions required by local services over this period, and incorporates a monitoring framework to ensure delivery.

As with all agencies with responsibilities for mental health – and that is almost all public agencies – Betsi Cadwaladr University Health Board (BCUHB) needs to regularly review its strategy for mental health services, to ensure that, along with partners, it is meeting the expectations of Together for Mental Health.

This is therefore a new strategy for our mental health services, developed by Betsi Cadwaladr University Health Board. The strategy aims to:

- build on working in partnership with local public, private and voluntary sector organisations, recognising the contributions of each to improving mental health and wellbeing;
- be responsive to co-production work with people with lived experience of services, their families and carers;
- apply clinical models that help us to identify people's needs so that help can be offered at the earliest appropriate opportunity, to reduce the likelihood of escalation and distress and support recovery;
- deliver holistic evidence-based person-centred care, underpinned by evidence, which supports people to lead fuller lives;
- deliver the best value, efficient and high quality services, in line with the aspirations of the Together for Mental Health strategy and delivery plan.

The strategy will also support the Health Board's developing overall strategy for health and wellbeing, **Living Healthier, Staying Well**. This overarching strategy will set out the vision for the Health Board and will reshape how we promote good health and promote good health and wellbeing– physical, mental and emotional - and provide healthcare over the next ten years.

It is important to explain at the outset the nature of this document. No strategy, however well-prepared, can anticipate all of the changes and events which will happen over a 3-5 year period. Some things which currently seem important will become less so as time progresses; new events and opportunities will arise which we cannot currently anticipate. This strategy should not be read as a simple blueprint of everything which will happen over the next 3-5 years. It should be read as an indication of our planned direction of travel, and as a framework to support engagement, planning, partnership working, and service improvement over that period.

Our various services, pathways and partnerships are at very differing levels of maturity. Some are well established, with strong relationships, and a clear sense of direction. Others are only very recently beginning to consider their options for the future, and to develop new networks and partnerships. There are therefore differing levels of detail in the various sections of this strategy, reflecting these differing levels of maturity. Our ambition is, over the life of this strategy, to bring all of our services, pathways and partnerships to a position where they can demonstrate fully strong

This strategy is an all-age mental health strategy, but does not encompass either substance misuse services or learning disability services. We will develop separate strategies for each of those two services.

We will also ensure that this strategy supports the "active offer" as a key component of the More Than Just Words strategic framework for Welsh medium services. Within this strategy there is a commitment to deliver services in line with The Welsh Language Standards and the More Than Just Words framework as required of the Health Board.

Work will focus on implementing the components that the Health Board has already committed to with regard to setting the required level of language, planning and delivery:

- Strategic Intervention
- Behavioural Change
- Performance monitoring

Across Mental Health and Learning Disabilities we will continue to improve on delivery against these dimensions and the commitment to ensure the delivery of bilingual services to our patients.

We are determined that things **will** be different. We accept fully the responsibilities, and share the ambition, enshrined in the 'Together for Mental Policy and Delivery Plan (2016-19). There is a need to deliver joined up and recovery-focused mental health care across North Wales. We have taken an honest and open review of the current state of services, and worked closely with our partners on this. This strategy shows how the Health Board, working with partners, is planning to improve its services over the next few years. This new approach must be bold, so that our services reflect the very best evidence base and are developed in an innovative and creative way. Only by working together with all of our partners and with any individual who might have a role to play, will it be possible to make the progress that is required. Our strategic partnerships must become much stronger. The Health Board is committed to working to build relationships that are based on trust and shared values. Any new services must be sustainable. They must help individuals, families and the people of North Wales to become more resilient. This can only be done by using those assets.

This strategy has been prepared in close consultation with our partners in North Wales, and in particular listening closely to the experiences of people that have received services. Our ambition is that this new mental health strategy will help us to take this process further - towards a fully integrated partnership approach to mental health in North Wales, planned and prepared from conception to approval as a partnership process, and incorporating the actions and ambitions of all partners together

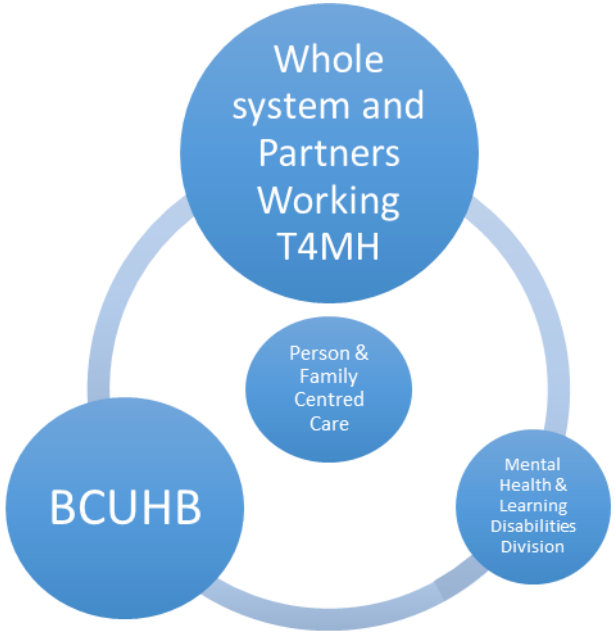
Immediately on formal adoption of this draft strategy, we will prepare a detailed joint action plan for its implementation. This will set out the steps required to ensure we achieve what is being proposed here, including:

- Who will do what, and over what timescales
- How we will measure the impact of what we will do – both as outcomes for people who use our services, and performance indicators for our work
- Financial and workforce plans
- How we will work with and strengthen relationships with our partners
- How we will continue to engage service users and their families
- How we will continue to support and engage with our workforce

The action plan to underpin the delivery of this strategy will be developed alongside the integrated service strategy to be launched in Autumn 2017. It will give full details of our plans for 2018-19, and an outline of the plans for the years beyond this**.**

1.2. Responsibility for strategy

- Consistent primary care offer and shared care arrangements
- Liaison in acute hospitals
- Devolved governance and resourced infrastructure
- Parity of esteem between physical and mental health
- Public health focus and early intervention, easy access
- Hold to account all elements of BCUHB (i.e. Primary Care, CAMHS, Acute Care - for delivery of the agreed workplan(s)



- Pathways that are trauma informed (ACE's)
- Five Ways to Wellbeing
- All support Recovery
- Housing, Police, 3rd Sector, Employment
- All age prevention

- Easy access
- Consistent Primary and Community Care approach
- Safe, humane and homely inpatient environments
- Consultancy, leadership and building capacity and capability across system partnerships and pathways

Responsibility for this strategy will have three levels. Much of what is planned here, to be implemented successfully, will need the active support and commitment of partners working together across North Wales.

1.3 So what will be different for?

There is much detail in this strategy. In this section, we draw out three simple lists:

- what will be different in our overall culture and approach
- what will be different in the delivery of our services, including people's health and care outcomes
- what will be different in our organisation

In each case, these lists contain our key commitments – the main things people who use our services, work in our services, and work with our services should notice as the strategy is implemented.

As we have said above and we repeat here, we are determined that things **will** be different – we are also enthusiastic and optimistic about the challenge ahead. These are our ambitions and we look to work with everyone and anyone who shares them with us.

What will be different in our overall culture and approach?

- We will treat people who use our services, and their carers and families as equal partners – all of us must be seen as essential assets in improving the mental health and wellbeing of the communities of North Wales.
- We will ensure everything we do is as integrated as possible – across disciplines, across agencies, across services – in both planning services, and delivering services. Fragmented care must be replaced by joined-up and continuous care.
- We will work to ensure **everyone** feels valued and respected.
- We will support and promote the best quality of life for everyone living with mental health problems.
- We will promote local innovation and local evaluation in how we provide services.
- We will continually measure our impact on outcomes, against both national and local quality and outcomes frameworks – whether we have improved the lives of people for and with whom we provide services.

What will be different in the delivery of our services – including people's health and care outcomes?

- Patients will see our values in practice in their interactions with us. For example, they will be more likely to agree that our staff:
    - Are respectful and compassionate
    - Listen to them and involve them
    - Are creative and innovative
    - Work with them in partnership
- The five ways to wellbeing will be promoted in all aspects of our work, across all ages and we will adopt the Public Health Outcomes Framework to monitor implementation and success.

- Information about patients' history, and care and treatment plans will be available in real-time to all staff working with them.
- Parents and carers of children will have access to targeted support to promote early attachment, bonding and parenting ability.
- All our maternity units will achieve full UNICEF baby-friendly accreditation.
- Perinatal mental health services, and general maternity and community services will support pregnant women and new mothers.
- Fewer children will live in families where there is domestic abuse, mental health problems, substance misuse or other forms of abuse or neglect.
- All schools will be supported to adopt evidence-based whole school approaches to emotional health, resilience and relationships
- BCU HB will promote anti-stigma and mental health discrimination messages, and a culture where employees can talk about mental health. It will adopt the 'Time to Change' campaign, and encourage stakeholder engagement in this.
- Individual placement support will be available to enable people to gain or regain employment
- An integrated welfare rights and money/debt advice service will be explored, targeted at people with mental health problems
- Peer support services will be available as a step-down option from long-term statutory community care
- Peer support and other approaches to post diagnostic support will also be available to individuals after a diagnosis of dementia
- Social prescribing will be more widely available, promoting access to education, exercise, personal and creative development
- No one will wait more than 28 days to access memory assessment services, and begin the process of diagnosis
- Programmes will be developed to reduce social isolation in older people
- Mild and common mental health problems, for people who also have a long-term physical health condition, will be managed as part of a single integrated package of care, without referral to specialist mental health services
- There will be new integrated teams to manage very common co-morbidities between physical and mental health, for example anxiety and COPD
- More Post Traumatic Stress Disorder services will be provided to veterans
- We will improve the availability of a range of psychological therapies, including online therapeutic interventions
- People experiencing first episode psychosis will have access to the full range of NICE-approved interventions
- People in crisis will have 24/7 access to effective crisis resolution and home treatment services, reducing the likelihood of being admitted to hospital
- There will be alternatives available to inpatient admission for those able to manage safely in more intensive community situations
- Out of area placements will be eliminated in acute mental health care for adults
- All ward environments will be fit for purpose, safe and humane
- A recovery college will be available to support people to gain or regain the skills and abilities to live more independently
- There will be a new integrated service with the Police, to ensure that we respond to needs and risks appropriately

- All our general hospitals will have access to psychiatric liaison services which comply with Core-24 standards

What will be different in our organisation?

- There will be a realistic and sustainable fit between our service commitments, and the numbers and skills of staff to deliver them
- We will have effective internal and joint governance arrangements, to ensure that the quality, safety and organisation of services are both maintained and improved in a continuous and sustainable manner.
- We will ensure full and effective governance of both our commissioned services and those we directly provide.
- We will have modern information systems to record and share data about our services.
- Our services will reflect the ambitions within national strategies such as Together for Children and Young People and the National Dementia Strategy.

2. CURRENT CONTEXT

2.1 Our local community

The BCUHB was formed in 2009 and is the largest of the seven Health Boards in Wales. It provides the full range of health services to a population of about 695,000 people across the six local authority areas in North Wales, as below:

Anglesey	69,979
Gwynedd	122,864
Conwy	116,218
Denbighshire	94,691
Flintshire	154,074
Wrexham	136,647
Total	**694,473**

Source: ONS 2015 mid-year estimates

North Wales has an increasing and aging population. The population is expected to increase to 729,100 by 2030; the percentage of the population aged 65 years and over is expected to increase by 26% and persons aged 85 years and over are expected to increase by 80%. The findings of the population needs assessment undertaken for the Social Services and Wellbeing Act will be used to understand local needs and targeting of resources and interventions.

2.2 Engagement

Since 2015, we have conducted a wide range of engagement exercises, to ensure that the views of a wide range of people inform and influence our thinking. Most recently, this has included:

- Engagement events with service users conducted by Caniad (a local service user-led organisation who supports people who want to have their voices heard, influence decisions and help shape the services they use) in October 2016 across North Wales. There were five open events for adult service users; with six areas for contribution at each event. There were two separate events focussing on CAMHS. 153 people attended the workshop events or gave one to one feedback, and 71 people responded to an on-line survey issued as part of the same process.
- A multi-agency mental health summit was held in January 2017, to stimulate and draw together leaders of a wide range of local agencies. Details of this event are given at Appendix 1.

Across the patient journey, the Caniad engagement process reported the following main perspectives and concerns:

Primary Care

"There was a general view across the engagement workshops that people who use mental health services often feel excluded from wider health promotion activities, do not have fast and easy access to primary care support services, and frequently get defined and labelled as a result of their mental health problem or illness.

People spoke about the need for greater awareness and better training in mental health for staff in all those front line services that are likely to be accessed by people with mental health problems, and about the need for further work to be specifically undertaken to raise awareness and understanding about mental health within GP practices.

A common concern expressed across almost all of the engagement workshops was the lack of co-ordinated and joint working across front-line services. This came out as a clear priority area that needed to be addressed within the new mental health strategy, along with the need to make it easier for people with mental health problems to access a range of front-line services."

Community Services

"Across BCUHB there are many good examples, at both a strategic and operational level, of where different organisations and groups have come together to discuss and plan service delivery. There was though, a consistent message coming out of the engagement workshops that on a day-to-day basis there is often poor communication and a lack of joined up working across agencies, and in particular across health, social care and housing services.

Despite existing policies, strategies, and legislation emphasising the importance of joined up and collaborative working, the experience of many people who took part in the engagement events and who use mental health services was that this is not happening enough in practice. Many people spoke about how they had been pushed back and forth between services, and of being passed from pillar to post – the ping-pong effect!

A strong message that came out of the workshops was the need for more collaborative working to happen across agencies that are more person-centred and focused on recovery. Many people also spoke about the need for services to adopt a more holistic approach and to not solely focus on medication but to be more tailored around the needs of the individual."

Crisis and out of hours services

"Many concerns were expressed at the engagement workshops about the need for people to be able to access services early enough to prevent a crisis occurring in the first place. Views were mixed about whether A&E units are the most appropriate settings for people in crisis to access, but there was a clear consensus that the environment within A&E units for people with a mental illness needed to significantly improve."

Inpatient services

"The experience of people attending the engagement events who were in hospital was varied, but there was a strong view that both the physical and therapeutic environment of hospital wards needed to be improved as well as some of the behaviour and attitude of staff.

Some people commented that staff were professional and displayed a genuinely caring attitude. However, worryingly many people described being afraid of staff, and of feeling uncomfortable and frightened. Many people spoke about there being a lack of privacy on the ward, and that some psychiatric wards felt more like a prison than a hospital.

There were also lots of comments about food being of poor quality with a lack of healthy eating options, and of poor hygiene across a number of wards. Many people also spoke about a lack of meaningful activities, having nothing to do, and feeling bored."

Below is an example of the "Rich Pictures" produced in these engagement events:

2.3 Current services – description

All of our services – not simply our specialist mental health services – play a part in maintaining and improving the mental health and wellbeing of our communities in North Wales. This includes the "universal" services available across the community, such as primary care, health visiting and school nursing. It also includes the roles that other specialist and acute services take in supporting the wellbeing of people who use them, particularly services which have long-term relationships with their patients and clients.

The role of our specialist mental health services is therefore to work with the smaller number of people who have more serious and complex mental health problems.

Our mental health services include primary, community and therapy services within localities across North Wales, and from inpatient services from four hospital sites. As such we make an important contribution to improving the health and wellbeing to a population of around 695,000 people. This encompasses prevention of mental ill health as well as treating illness and providing healthcare services.

We currently provide the following services for adults, based across North Wales:

- Community mental health teams for adults
- Home treatment teams
- Community rehabilitation teams, and mental health services for offenders
- Community mental health teams for older people
- Memory clinics for older people with dementia
- Day hospitals for older people
- Specialist community-based substance misuse services
- Specialist community-based learning disability services
- An acquired brain injury service
- A range of specialist psychological therapy services
- Inpatient wards, including services for:
    - Adults
    - Older people with functional mental health problems (a range of serious mental health problems, such as schizophrenia, bipolar disorder, or severe depression)
    - Older people with organic mental health problems (dementia and related conditions)
    - Rehabilitation
    - Rehabilitation within a locked, secure environment
    - A medium secure unit (a service for people with serious mental health problems and a history of criminal offences)

In addition, there exist smaller specialist teams such as Complex Cases (for people with trauma and attachment problems), a small Early Intervention in Psychosis Team, Criminal Justice and Forensic Team and Primary Care Mental Teams.

The Primary Care Mental Health Teams cover all localities, are linked to General Practices, and bridge the divide between primary and secondary care. They are subject to Part 1 of the Mental Health Measure, and performance of these teams is comparable to other Health Boards.

There are also well developed multi-disciplinary specialist child and adolescent mental health services based in each county in North Wales. This includes inpatient facilities providing specialist care for those most vulnerable and at risk.

Our services for children, young people and their families are delivered from 3 area community Teams – West, Central and East:

- Universal Services (Midwifery, Health Visiting, School Nursing)
- Enhanced (Community Paediatrics, Flying start, Families First, Tier 3 CAMHS , integrated disability teams)
- Specialist (Tier 4 outreach – the Kite Team, Eating Disorder Clinics and 12 bedded inpatient care at the North Wales Adolescent Unit).

The Betsi Cadwaladr Mental Health and Learning Disabilities Division operates out of 43 properties across North Wales. The main inpatient facilities are located in the Ablett Unit on the Glan Clwyd hospital at Bodelwyddan, close to Rhyl (38 adult and old age beds); the Heddfan unit adjacent to the Wrexham Maelor Hospital Site in Wrexham (71 adult and old age beds); the Hergest Unit on the Ysbyty Gwynedd hospital site on the outskirts of Bangor (38 adult beds), and; the Bryn y Neuadd site in Llanfairfechan (57 beds, predominantly learning disability and forensic).

There are two isolated wards for older people: the first is located in the Cefni Hospital at Llangefni, Anglesey (16 older people's beds); the second in the Bryn Hesketh Unit in Colwyn Bay (16 older people's beds.) There are also two rehabilitation units; Coed Celyn in Wrexham (10 beds) and Tan y Castell in Ruthin (8 beds.)

2.4 Strengths

We are very conscious of the risk of our strategy focussing on the problems with our services, and what we need to do to address them. We are far from complacent about those problems, as the following section 2.5 will show. We want to apply the same philosophy to our services as we do with our service users – to work hard to focus on our strengths, goals, assets and opportunities, and to seek to maximise those. We know that this approach is essential to good care and treatment planning; we think it will be equally essential to planning changes to our mental health services. We think our mental health services have the following key strengths and assets:

- The overwhelming majority of our staff, both within BCUHB, and across our partners, are dedicated and committed to doing the best job they can to provide care and treatment for people with mental health problems. The engagement work we have done in preparing this strategy has reconfirmed that we are fortunate to have many staff with ideas and ambitions to improve our services.
- BCUHB offers a fully comprehensive range of health and care services, and is therefore in a position to develop much more integrated services, unhindered by organisational boundaries, unlike other parts of the United Kingdom.
- We serve a range of local communities across North Wales, with a strong sense of local identity, and many networks within and across communities.
- We have access to excellent local training, development, and research facilities. The University of Bangor has recently been rated as 3rd out of 68 UK-wide institutions offering nursing and midwifery training
- North Wales is an attractive place to live and work, and we therefore have much to build on as we look to improve our recruitment and retention of staff.

BCU HB are proud to have achieved the Gold award for Health at Work: Corporate Health Standard. This is the national quality framework and award for employers to improve health and well-being in the workplace. Mental health and wellbeing is a key component of this.

Our aim in taking forward this strategy will therefore be to keep these assets constantly in mind and to look to develop our services in ways which build on them.

2.5 Concerns

We are committed to using this process to build upon the progress made and continue to strengthen our partnership working, focus on developing compassionate care cultures and deliver high quality outcomes with people. With any service, there is a risk that problems with the organisation and quality of services lead to difficulties in recruitment and retention of staff, which in turn exacerbate problems in the delivery of safe, high quality care. We are determined to use this process to drive improvement. We recognise that we will therefore need to address the following main issues:

- Demand for our services regularly runs ahead of our capacity to respond. This leads to:
    - Waiting lists for services, and longer waits than we would wish even for people with acute needs
    - Some people having to go out of area for services, sometimes a long way out of our area
    - Pressures on staff to manage caseloads and risks at levels above those we would wish
    - Some people not having their needs met or fully addressed
- The boundaries of our services' responsibility are not well enough defined, with unclear specifications and agreements as to what is and is not possible within the resources we have available
- Problems of capacity and demand will be aggravated by demographic change – we have a growing and ageing population, which will in particular increase demand for services for older people
- Our services are insufficiently holistic in approach – both within mental health care, and across the wider services of BCUHB. People have medical, psychological and social needs; they also have needs for both physical and mental health care. Our services are too fragmented, and we need to do more to offer services in an integrated and holistic way
- Our services are insufficiently focussed on recovery, by which we mean emphasising active rehabilitation rather than simply longer-term indefinite care
- The very limited availability of modern information and communication systems is a real problem. We have deficits in physical hardware, in patient information systems, in business intelligence systems, and in staff training and expertise to use existing and proposed ICT. This hinders both the practicalities of care delivery (such as sharing of care and treatment plans), and means we know too little about community services' overall

performance, and the way our pathways link together for individuals across our services. It is also a serious clinical governance concern
- We have persistent difficulties in recruiting and retaining staff in some disciplines and areas
- Delivery of improvements and changes to service models requires us to work in partnership with a wide range of partner organisations: local authorities, criminal justice agencies, voluntary organisations, independent sector providers. There is a complex network of relationships between these many partners, such that agreeing and delivering change can sometimes prove difficult.

These problems interconnect; and our strategy for addressing them is therefore equally interconnected.

3. STRATEGIC VISION

3.1 Our Shared Values

The following statement of values has been co-produced with CANIAD.

The statement has been prepared with consideration of values statements from other Health Boards, as well as the draft Mental Health Service Charter - Dignity Pledge, and Caniad's Involvement Framework. We will undertake further work on our shared values to ensure they are relevant to all age groups and all communities. We will ask Caniad to coproduce any changes and in particular, ensure they reflect the needs of children and young people.

Our Values	Our behaviours – how we are with people, including those who use our services and their families, and our colleagues. This means that we:
We will respect each other and be compassionate	• Put the people who use our services at the centre of everything we do – we are respectful and responsive • See people as individuals, do the right thing for every person and treat people with dignity • Are kind, patient and person centered in every human contact wherever we work • Will be approachable and helpful to all • Will be sensitive and thoughtful about how we meet the needs of each person • Treat other people as we would wish to be treated.
We will listen and involve you	• Will listen closely to what is being said and to gain your trust • Communicate openly, honestly and explain things clearly • Listen, understand, involve and value everyone's contribution • Let people know what's happening now and next

	• Give constructive feedback and be open to, and act on feedback we receive. • Encourage a culture of honesty and openness
We will be creative and innovate	• Work with you to try new things to support you • Look for the best ideas and most positive practice to share and develop services of the highest quality • Aim for excellence in all we do, and provide evidence of how we are doing • Ensure our services will be safe, positive, efficient and timely • Will actively find ways to reduce delays and waste, and to join up services for others • Look for opportunities to learn, enthusiastically share ideas, find new solutions and ways to improve.
We will work with you in partnership	• Consider others views, and include people (patients, families and colleagues) in decisions about things that affect them • Be appreciative and be supportive and acknowledge this in our behaviour and by saying 'thank you' • Be open with you about what the options are, and what you can expect from our services • Plan with you, be prompt, responsive and reliable • Speak in a language that people understand • Will be professional, responsible and accountable.

3.2 Our Strategic Goals

We aim to ensure that service users have an excellent experience of services – and that our mental health system is safe, sustainable and affordable.

The outcomes we are seeking are:

- For the person using services, either recovery from illness, or the best possible quality of life and independence, despite continuing illness
- For family and friends, the best possible quality of their own lives, whilst caring for a person with mental health problems
- For the whole community – irrespective of age, gender, sexuality, ethnicity - people with experience of mental illness contributing positively to community life – through work and other social roles
- Improved mental wellbeing and resilience for the whole community

We therefore aim to offer a comprehensive range of services which:

- Promote health and wellbeing for everyone, focussing on prevention of mental ill health, and early intervention when required
- Provide effective interventions for people with common mental health conditions in the community as early as possible

- Are community-based wherever possible, reducing our reliance on inpatient care
- Identify and provide effective interventions for people experiencing serious mental illness as early as possible
- Manage acute and serious episodes of mental illness safely, compassionately and effectively
- Support people to recovery, to regain and learn the skills they need after mental illness
- Assess and provide effective interventions the full range of mental health problems, working alongside services for people with physical health needs

The services that we deliver are underpinned by the same values and principles as all other services provided by the health board.

This is also consistent with expectations of prudent healthcare, whereby, as defined by Welsh Government, any service or individual providing a service should:

- *"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 using evidence-based practices consistently and transparently"*

3.3 Partnership Working

To achieve our goals our leaders at all levels will continue to work closely with partner organisations: to identify and address avoidable health inequalities; promote community engagement; and exploit joint working opportunities. The bodies include:

- The six Local Authorities in North Wales;
- Public Health Wales;
- North Wales Police;
- Universities and education providers;
- Welsh Ambulance Services Trust;
- Local voluntary and independent sector organisations;
- North Wales Fire and Rescue Service;
- Betsi Cadwaladr Community Health Council;
- Neighbouring NHS bodies in England and Wales; and
- The County Voluntary Councils.

To help us do this we propose to support the development of a forum that is accountable to the system wide Together for Mental Health Partnership Board which:

- Helps develop and strengthen relationships across the sector

- Clarifies the commissioning framework and respects the 'business process' whilst enabling 3rd sector providers to respond to ideas and existing services gaps with innovative and joined up solutions
- Helps people share positive practice and build trust and respect across organisational boundaries
- Helps to develop sustainable integrated pathways that support people across North Wales.

Such a forum will provide an opportunity for BCUHB to share and involve key third sector organisations in its policy decisions, service planning and service engagement on areas of work that potentially have an impact on existing and new care pathways. We will ensure that issues important to the Voluntary and Community Sectors are brought to the attention of BCUHB and vice versa, always acknowledging that a diversity of views may exist and be valued.

These arrangements will be established in the context of the statutory Public Services Boards which were established by the Well-being of Future Generations (Wales) Act 2015. These are tasked with assessing the state of economic, social, environmental and cultural well-being in each area and with setting objectives that are designed to contribute to the development of local well-being. The Regional Partnership Board, established under Part 9 of the Social Services and Wellbeing (Wales) Act 2014, requires local authorities to make arrangements to promote cooperation with their relevant partners and others, in relation to adults with needs for care and support, carers and children will play a key role. Mental Health is a priority area for the Regional Partnership Board, and will provide additional impetus, and opportunity, for system partners to work together on areas within this strategy.

4. PLANNED CHANGE AND DEVELOPMENT

This section includes both commitments which relate to specific age-groups across the course of their lives, and commitments which relate to specific groups of needs. We recognise that these inter-relate in often complex ways; individuals' needs are not necessarily typical of either their age-group, or their formal diagnosis. Throughout this section, therefore, we would stress our intention to meet needs as flexibly as possible, and for individual services to work together to meet those needs.

All of our work will be underpinned by our intention to promote, for all age-groups, the five ways to wellbeing, these were developed by the new Economics Foundation and published in 2008 by the UK Government.

- ***Connect*** *– connect with the people around you: your family, friends, colleagues and neighbours. Spend time developing these relationships.*
- ***Be active*** *– you don't have to go to the gym. Take a walk, go cycling or play a game of football. Find an activity that you enjoy and make it a part of your life.*
- ***Keep learning*** *– learning new skills can give you a sense of achievement and a new confidence. So why not sign up for that cooking course, start learning to play a musical instrument, or figure out how to fix your bike?*

- ***Give to others*** *– even the smallest act can count, whether it's a smile, a thank you or a kind word. Larger acts, such as volunteering at your local community centre, can improve your mental wellbeing and help you build new social networks.*
- ***Be mindful*** *– be more aware of the present moment, including your thoughts and feelings, your body and the world around you. Some people call this awareness "mindfulness". It can positively change the way you feel about life and how you approach challenges."*

We will encourage and support all staff to be knowledgeable about the Five Ways to Wellbeing, and in turn to actively encourage people to learn more about them and put them into everyday practice.

As a specific commitment within this intention, we have agreed a programme of joint work across CAMHS and adults. This will have the following elements:

	Item	Notes on content
1	Developing a whole-family approach to mental health and wellbeing	• Family interventions • Parents with mental health problems • Young carers • Looked-after children
2	Improving the care and support of individuals as they move between services	• Transitions between services for children and young people, and those for adults – ensuring these arrangements are flexible and centred on the needs of the young person, not on arbitrary age cut-offs • Perinatal mental health services

3	Promoting wellbeing / preventing ill-health	• all-age approaches to:
		  ○ the five ways to wellbeing
		  ○ training in support to people who self-harm
		  ○ training in supporting emotional resilience
		  ○ books on prescription
		  ○ other forms of social prescribing, including the role of the Recovery College

4	First-episode psychosis	• agreement and implementation of new service model
5	Managing crises	• shared resources for managing crises • community alternatives and inpatient admission
6	Model for psychological therapies	• consistent/coherent approaches to delivery of specific psychological therapies

In considering the age-group-specific sections here, this commitment to joint development should be kept in mind.

We begin, however, with looking beyond our mental health services, to our wider role in public health and wellbeing.

4.1. Public Mental Health and Wellbeing

Public mental health focuses on wider prevention of mental illness and promotion of mental health across the life course. Public mental health is fundamental to public health because mental health is a determinant and consequence of physical health as well as a resource for living. Mental health is now recognised as being profoundly important to growth, development, learning and resilience and protects the body from the impact of life's stresses and traumatic events.

The aim of the public mental health component of the Health Board's mental health strategy is to champion mental health for all, to promote and improve public mental health and wellbeing across the life course, from childhood to old age, and reduce discrimination for people with mental health problems, across the Health Board and partner organisations in all work areas. These are all consistent with the Welsh Government Strategy 'Together for Mental Health' which outlines three outcomes to promote better mental wellbeing and prevent mental health problems:

- *Population wide physical and mental wellbeing is improved; people live longer, in better health and as independently as possible for as long as possible.*
- *People and communities are more resilient and better able to deal with the stresses in everyday life and at times of crisis.*
- *Child welfare and development, educational attainment and workplace productivity are improved as we address poverty.*

Public mental health supports the delivery of the strategy through the following means –

More people will have good mental health and wellbeing.
Targeted and universal interventions will be delivered to those at higher risk. This will result in a greater proportion of the population having better mental health and wellbeing and a reduction in the proportion of the population experiencing mental disorder.

More people with mental health problems will have good physical health.
Targeting appropriate public health interventions to promote physical health and prevent physical health problems from developing will promote wellbeing and recovery.

More people with mental health problems will recover.
Interventions will be targeted at those who have or previously had a mental disorder to promote recovery and prevent relapse. Improved screening, detection and earlier intervention will result in fewer people going on to develop more complex mental disorders.

More people will have a positive experience of care and support.
Interventions will be integrated into secondary care, providing a holistic and health promoting environment which supports recovery.

Fewer people will suffer avoidable harm.
Improved mental health and reduced mental illness across the population will result in a reduction in associated different forms of harm including self-harm and suicide attempts, harm to others, health risk behaviour including smoking, alcohol, drugs, physical illness, premature mortality and a range of inequalities.

Fewer people will experience stigma and discrimination.
Promoting wellbeing and social cohesion will result in reduced discrimination to higher risk groups including those with mental disorder

Evidence and benefits from effective public mental health interventions –

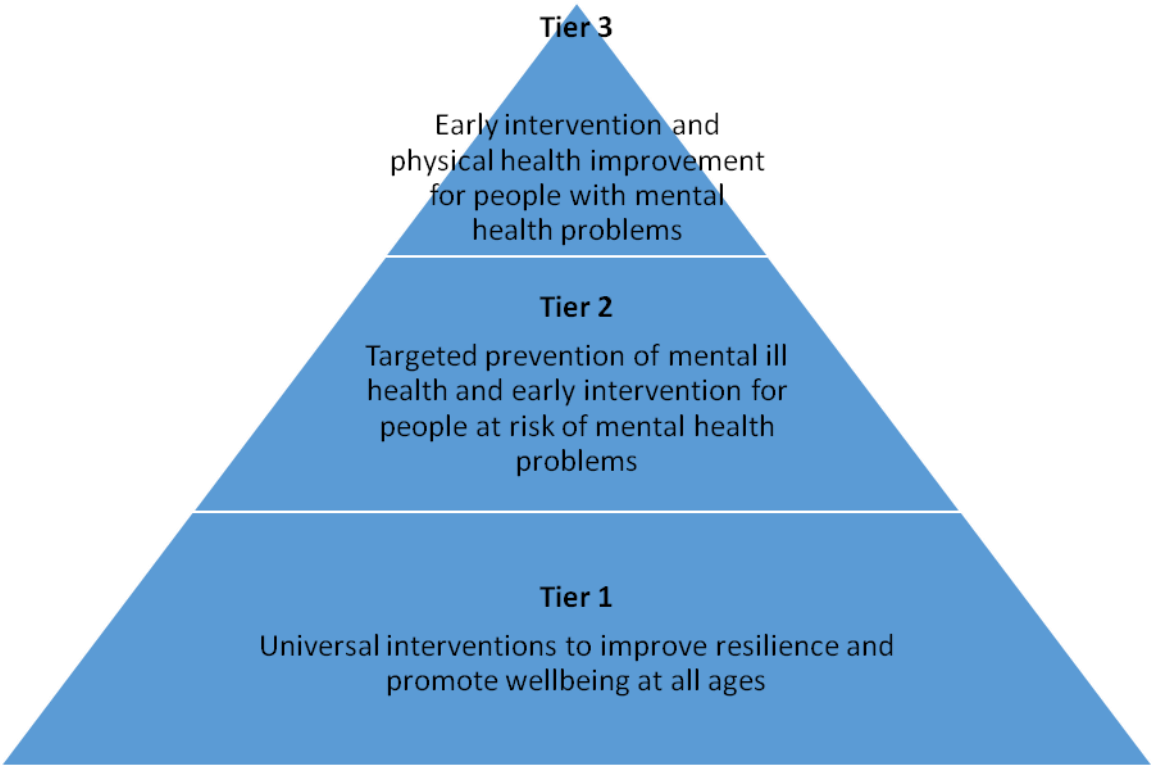
Good evidence exists for a range of public mental health interventions. These can reduce the burden of mental disorder, enhance mental wellbeing and support the delivery of a broad range of outcomes relating to health, employment and education.

There is also good evidence that public mental health interventions deliver large economic savings and benefits. Improved mental health leads to both direct and indirect savings in health service costs e.g. reduced use of primary care and mental health services, improved physical health and reduced use of alcohol and tobacco. Improved mental health also leads to savings in other areas: reduced sickness absence and reduced spending in education, welfare and criminal justice, as well as increasing the overall economic benefits of wellbeing for individuals and families. An influential report (Department of Health, 2011. *Mental health promotion and mental Illness prevention: The economic case*) found that for every £1 invested, the net savings were:

£84 saved	–	school-based social and emotional learning programmes
£44 saved	–	suicide prevention through GP training
£18 saved	–	early intervention for psychosis
£14 saved	–	school-based interventions to reduce bullying
£10 saved	–	work-based mental health promotion (after 1 year)
£10 saved	–	early intervention for pre-psychosis
£8 saved	–	early interventions for parents of children with conduct disorder
£5 saved	–	early diagnosis and treatment of depression at work
£4 saved	–	debt advice services

Three Tier Approach to Public Mental Health

Both the promotion of mental wellbeing and prevention of poor mental health can be undertaken on a three tiered approach:



The following elements of this strategy will promote public health and wellbeing

Tier 1: Universal interventions to improve resilience and promote wellbeing at all ages

- Ensure that parents and carers of children have universal and targeted support to promote early attachment, bonding and parenting ability, including vulnerable families, children and parents experiencing domestic violence; providing a more integrated approach to supporting vulnerable families, with a strong emphasis on prevention and early intervention. The role of midwives, health visitors, school nurses and primary care teams are key
- All maternity units and community providers should achieve full UNICEF baby friendly accreditation as a minimum standard in order to maximise initiation and maintenance of breastfeeding
- Ensure that all partners act to reduce the number of children living in families where there is domestic abuse, mental health problems, substance misuse or other forms of abuse or neglect. Providing safe and nurturing environments for every child in North Wales to reduce the number of Adverse Childhood experiences (ACEs) is the best way to raise healthier and happier adults (promote ACEs informed services)
- Explore the joint development of a programme to promote good mental health to more children and young people. This includes prevention and early intervention initiatives to prevent emotional health and wellbeing issues escalating , such as enabling schools, colleges and universities to build children and young people's resilience and wellbeing; help young people to look after their own mental health and that of their peers; support parents in the care and development of their children's mental health and emotional

wellbeing; enable primary care to identify problems early and respond positively to support young people's mental health

- Support all schools to adopt evidence based whole school approaches to emotional health, resilience and relationships, and work with partner agencies to ensure implementation fidelity; also be ACEs aware
- Promote the use of a Mental Wellbeing Impact Assessment tool enabling organisations and communities to engage with and improve mental health and wellbeing and to assess and improve a policy, programme, service or project to ensure that it has a maximum equitable impact on people's mental wellbeing
- Build upon the widely used evidence-base programme "Five Ways to Wellbeing" within the Health Board and partner organisations
- Encourage individuals and organisations to join the 'Time to Change' and mindful employers campaigns. Encourage large or small organisations to participate in the Health at Work: Corporate Health Standards. This includes actions to support public mental health at work
- Improve mental health training – awareness, support, signposting and first aid – for frontline staff to develop their awareness and ability to signpost to other services. Develop the capability and capacity within the wider workforce to deliver services which support and promote public mental health e.g. through the Making Every Contact Count (MECC) programme
- Develop a local suicide prevention strategic plan based on national guidance
- Explore how interventions for older people can be extended to address social isolation, increase social interaction and promote greater, safer independent lives
- Support the development of befriending schemes for older adults and enhanced opportunities for older people to become physically active. This includes work aimed at tackling rural isolation and loneliness
- Ensure services promote equality and are accessible and acceptable to all. Public bodies should meet their obligations under Equality Act in relation to mental health and ensure quality and access and outcomes for groups with particular mental health needs, which may include the most vulnerable in society

Tier 2: Targeted prevention of mental ill health and early intervention for people at risk of mental health problems

- Ensure that at every contact mental wellbeing is discussed and opportunities that strengthen mental wellbeing, relevant to the pregnant woman's individual circumstances
- Ensure that women are offered a mental health assessment in the antenatal and postnatal period by appropriately trained health professionals, and there should be access to specialised follow-up support services if needed
- Extend the development of wellbeing hubs across North Wales which enable opportunities to offer low level support, one-to-one counselling, signposting to other services and outreach for people at risk of common mental health problems. Link with practice nurses and other frontline staff to ensure effective signposting for people with long-term conditions to wellbeing hubs and other wellbeing support sessions

- Explore local provision of social prescribing options to include arts on prescription, leisure on prescription, learning on prescription, computerised cognitive behavioural therapy, books on prescription and exercise on prescription
- Support carers in their caring role enabling them to have a life of their own and stay mentally and physically well
- Improve opportunities for people experiencing mental health issues or who may need extra support to access and retain employment, a place in education or training or other meaningful activity in the community
- Ensure health and social services consider the impact of domestic violence on mental health and wellbeing and provide support appropriately
- Explore the provision (for example with Citizens Advice Bureau) of an integrated welfare rights and money/debt advice service targeted at people experiencing mental health issues
- Coordinate services to increase the physical health of people with poor mental health through the promotion of healthy lifestyles and reducing health risk behaviours. This includes improving access to stop smoking and weight management services within the community for people with poor mental health

Tier 3: Early intervention and physical health improvement for people with mental health problems

- Ensure that for any woman with an identified mental illness of any severity, an antenatal and postnatal care and treatment plan is made which must include: any particular intra-partum concerns; how a mental health problem and its treatment might affect parenting; providing the interventions and agreeing the outcomes with the woman involved
- Ensure that treatment of mental illness is managed with the same urgency and importance as physical illness. Develop more effective integrated physical health pathways for people with mental illness
- Improve access for individuals with mental illness into support and recovery through early provision of activities such as supported employment, housing support and debt advice

4.2 Children and Young People

CAMHS services sit within the integrated Children's Service of BCUHB. In developing an all age, bio-psycho-social and trauma informed mental health strategy for BCUHB it is appropriate and important to include CAMHS within the remit of this strategy. A separate Children's Strategy is to be developed and having a consistent 'read-across' for both strategies will be important to ensure key service initiatives, developments and accountability for delivery is clear.

The overarching framework for understanding children's services requirements falls under the remit of Together for Children and Young People (T4CYP) which was launched by the Minister for Health and Social Services in February 2015. Led by the NHS in Wales, this multi-agency service improvement programme has been

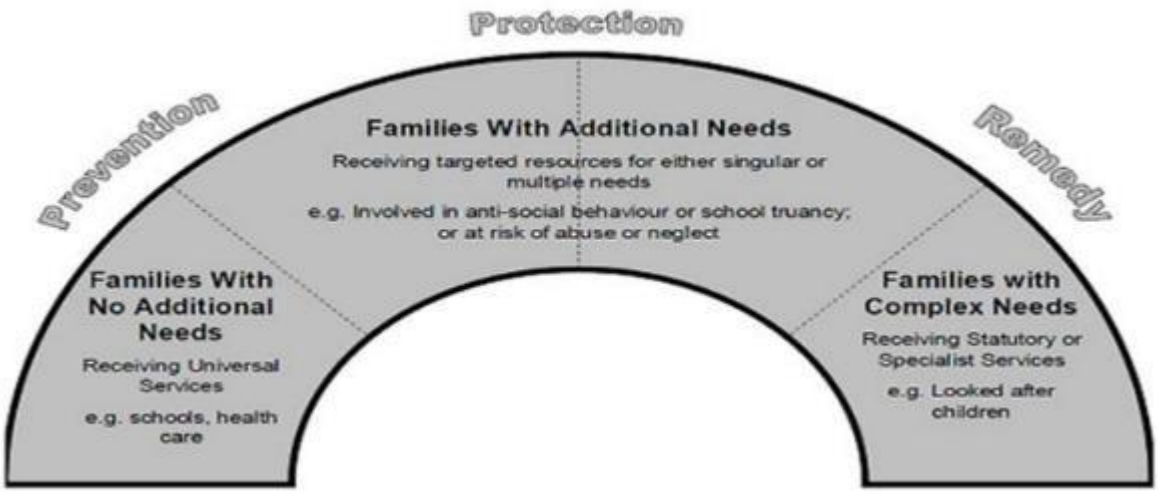
established to consider ways to reshape, remodel and refocus the emotional and mental health services provided for children and young people in Wales, in line with principles of prudent healthcare.

Partnership with families and with Social Services, Education Authority, Schools, Youth Justice, Team around the Family is fundamental to the delivery of services with children, young people and their families.

Partnership begins with partnership with children, young people, and their families. All of our local specialist CAMHS teams will fully adopt the Choice and Partnership approach (CAPA), with the aim of putting children, young people and their families at the heart of our decision making. This will also enable us to take an evidence-based approach to managing capacity and demand. This is in keeping with the commitment made by CAMHS across Local Health Boards in Wales.

We will also work at all levels with our partners in local authorities to develop a shared understanding and shared approach to working with children and young people. This begins with good working relationships between local CAMHS teams and local services teams. We will support this by developing regular meetings and learning events between clinical leaders and senior managers from health and social services in each area. It will be further supported by regional collaboration bringing together Heads of Children's services, clinical service managers, and clinical leads to ensure an overall North Wales approach, where there can be learning across counties and authorities.

This section sets out our proposed approach in North Wales, beginning with early intervention and prevention, then our referral based intervention services concluding with our approach to managing and delivering highly specialist regional services (Inpatient and intensive outreach.) This approach is consistent with the "Windscreen" model adopted nationally across Wales in Together for Children and Young People.



4.2.1 Early Intervention, Prevention and Primary Mental Health

This responsibility is not limited to specialist mental health services. Universal services (health visitors, school nurses, midwives and others) also have an important role in contributing to the emotional and mental wellbeing of children, and in early intervention when problems arise. Effective perinatal mental health services also have a part to play here.

CAMHS has a key role in promoting good mental health for children and young people and reducing stigma. By working with partners, in particular education, we can actively help children, young people and their families to build resilience, improve their mental health and maintain good mental health.

We will promote our North Wales Book Prescription Scheme and the National Better with Books Scheme together with a range of resources that enable children and families to be more knowledgeable about mental health. The resources will be of good quality, carefully reviewed and tailored to individual children, young people and their families' needs.

We will ensure that there is easy and quick access to dialogue leading to advice and consultation with trained professionals about mental health concerns in children and young people. We will do this via the Single Point of Access for CAMHS in each county. We will work to build confidence in the professional networks in having early conversations about children and young people who have mental health difficulties, so that the following options are routinely considered:

- Signposting to appropriate services
- Brief time limited interventions in the community
- Provision of written materials, resources and guidance through the book schemes
- Specialist Mental Health assessment and treatment
- The offer of ongoing consultation to professionals working with children and young people

CAMHS will maintain an outward looking stance towards all professionals working with children and young people encouraging dialogue and striving to avoid arbitrary thresholds for referrals to cross. The aim is for there to be joint decision making between professionals and CAMHS when there are concerns about children's mental health. A multi-disciplinary approach to assessment, planning and provision of interventions for children, young people and their families is essential, ensuring flexibility of services and joint client care.

We will develop, in partnership with our colleagues in education, social services and other agencies, targeted early interventions for the treatment and prevention of anxiety. These will be delivered through the ‘Friends for Life’ suite of interventions.

We will work with all frontline staff involved with children to develop a safe and supported response to helping children and young people who self-harm. This will involve senior leaders and the unions in education and social services and will lead

to the development of a clear pathway and protocol with training at a range of levels for all staff working directly with children.

We will routinely offer consultation from trained CAMHS staff to any professional working with children. The aim of this consultation is to enable a wide range of professionals to assist children with tackling mental health problems early before they become established and also to assist children to access the right service promptly where concerns are more serious.

4.2.2 Referral based intervention services

These have been significantly enhanced following the Welsh Government's announcement of investment in CAMHS in 2015. Children and young people requiring a routine mental health assessment are seen for their first appointment within 28 days. Children and young people who require an urgent mental health assessment are seen within 48 hours.

In order to achieve this some of our existing services are now organised differently. Some elements of our service are provided on a 7 days per week basis:

- Assessments of children who have been admitted following episodes of self-harm at the three acute hospital sites
- The provision of urgent mental health assessments when required
- Section 136 Assessments carried out by Consultant Child and Adolescent Psychiatrists between the hours of 9 am to 5 pm, 7 days per week
- Urgent psychiatric assessments provided by Consultant Child and Adolescent Psychiatrists between the hours of 9 am to 5 pm, 7 days per week
- All children and young people who have been admitted to hospital with a mental health crisis will have a mental health assessment the following day and where necessary a psychiatric assessment

All specialist CAMHS staff will be supported through supervision and training when required to deliver timely mental health assessments with a development of broad based formulations. We will constantly develop CAMHS capacity and skills in developing Care and Treatment Plans, together with children and young people.

Our commitment to developing good quality psychological therapies will continue with the focus on:

- Cognitive Behaviour Therapy
- Dialectical Behaviour Therapy
- Family and Systemic Therapy
- Interpersonal Therapy
- Psychodynamic Child Psychotherapy
- Evidence based approaches for children aged 0 - 7

We will continue to build a culture of timely multi-disciplinary review of all interventions. This will be with the aim of:

- Supporting sound and effective therapeutic relationships between our CAMHS staff, children, young people and families they work with
- Choosing the most appropriate and effective therapy / intervention in partnership with children and young people
- Making sure that therapy / intervention is effective
- Ensuring that improvements happen as quickly as possible

4.2.3 Neurodevelopment, including Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD)

We have reorganised our provision of assessment and intervention for this group of children, placing Community Paediatrics at the heart of this service, as part of multidisciplinary teams. Both of these conditions are enduring and have long term implications for children's education and broader future.

Any child or young person who requires a neurodevelopmental assessment will first be seen by a Community Paediatrician. Community Paediatricians are best placed to take a long term overview with education and schools. They are also best placed to ensure there is appropriate physical evaluation, particularly for younger children. Specialist CAMHS staff will continue to play a very significant role in the provision of assessments and also in providing treatment where there are significant mental health difficulties. By establishing this service we will be able to ensure that there is sufficient time and focus for this work and establish a closer working relationship between education, community paediatrics, therapies, and CAMHS. It is expected that this in turn, together with the new investment, will enhance the capacity of CAMHS to provide specific interventions where there are mental health problems.

4.2.4 Early Years (children age 0-7 years and their families)

All of our specialist CAMHS services will be available from birth when required. We will review our models for working with very young children and their families together with our partners.

4.2.5 Paediatrics and Mental Health

We will continue to develop our service for children and young people with physical health problems by building an integrated service with and alongside the specialist CAMHS teams across North Wales. This is with the explicit aim of responding quickly and flexibly to the needs of children by increasing skills in managing the emotional health components of physical health conditions across broader CAMH services and providing seamless access to specialist CAMHS when required.

4.2.6 Crisis and Urgent Care

We have recently developed a 7-day service, to ensure that children and young people are assessed in a timely manner, outside of core hours. This includes support to paediatric wards at weekends, and self-harm assessments. Consultant Psychiatrists provide an out of hours telephone on-call rota supporting the assessment and care of children and young people admitted to paediatric wards or the section 136 suite. Paediatricians assess all 15 year olds who are detained on a section 136. It is intended that these workforce changes will result in reduced admissions to paediatric wards, shorter lengths of stay on paediatric wards, reduced admissions to Tier 4 inpatient care at the North Wales Adolescent Unit and fewer out of area placements.

Partnership working with the police, social services, adult mental health, acute paediatrics and CAMHS is essential to meet the needs of young people and their families who find themselves in crisis. Currently many of these young people are on paediatric wards, and often have delayed discharges due to their home environment needing to change; a growing number of young people are being detained under section 136. We are reviewing these models of care, to ensure that future pathways are developed in partnership with the Police, Social Services, CAMHS, Paediatrics and Adult Mental Health, that safeguards children.

4.2.7 Tier 4 Services

We will continue to take a whole systems approach to managing our intensive regional services. The inpatient unit at the North Wales Adolescent Service (NWAS) Kestrel Ward is now fully operational with 12 beds. The intensive outreach team (Kite team) is also now fully operational, with the aim of supporting families, avoiding admission, and supporting early discharge. We aim to further enhance the capacity at NWAS and within Kite by putting community Care and Treatment Co-ordinators at the heart of treatment throughout community and intensive and inpatient care. We will enable our Care and Treatment co-ordinators to maintain frequent, regular contact with children and young people who are inpatients. We will consider the possibility of offering a health-based place of safety for Children and Young People detained under Section 136 of the Mental Health Act at NWAS.

We also expect that by developing a regional approach to eating disorders that we will reduce the length of stay for children and young people who have eating disorders and reduce the requirements for admission.

As the Kite team gains experience it is anticipated that we will be able to help children leave NWAS and go back to the community more quickly, ensuring further capacity for admissions when they are required. By investing further in the Kite team, we will enable the Kite team to undertake assessments for admission 7 days per week following urgent assessments by the community teams.

One of the strengths of being in one Health Board is our capacity and ability to manage our community services and Tier 4 services as one completely integrated service.

4.3. Adults

In this section, we consider mental health services for adults in three groups:

- General primary and community mental health services
- Services for people in acute mental health crisis
- Services to support rehabilitation and recovery

At the outset of this section, we wish to state clearly that older people have many similar needs to those of adults. We therefore wish to see older people having access to the same services, or services of equivalent quality, to those for adults. The principles set out below for community, crisis, and rehabilitation services should therefore all be read as also applying to older people, within an all age service model.

4.3.1 General primary and community mental health services

We think there are four main areas of change and development required in this service area.

Firstly, we want to ensure that psychologically informed community services are at the heart of what we do. Our commitment to developing good quality psychological therapies will continue with a focus on:

- Making sure the psychological intervention/ therapy is evidence based and effective
- Ensuring a timely and multidisciplinary approach to psychological therapies
- Making sure the intervention happens as quickly as possible
- Maintaining the importance of the therapeutic alliance
- Choosing the most appropriate and effective intervention/therapy based on a collaborative and individualised formulation of that person's difficulties
- Encouraging all services to be trauma informed.

The main approaches, supported by the Matrics Cymru (2016), and which will be the focus for consistent delivery of services for both adults and older adults are:

- Cognitive Behavioural Therapy, including CBT for complex cases
- Dialectical Behaviour Therapy – full programme
- EMDR
- Other evidence based approaches as appropriate including Schema Focused Therapy, Mindfulness Based Cognitive Therapy, Acceptance and Commitment Therapy
- Life review, Solution Focussed, Systemic and other interventions for carers and their relatives

Secondly, we want to develop much more integrated approaches to the management of common mental health problems – and common mental health

problems occurring with physical health problems. Anxiety and depression are the most-experienced form of mental health problem; almost all of us will know of a friend, colleague, or family member with experience of depression or anxiety. Whilst symptoms are often mild, and many people do not seek any form of treatment, they can also be much more serious, and have a significant impact on health and social functioning.

This will need clearer and improved care pathways across primary and secondary care, ensuring primary care teams are both supported to manage most common problems within primary care, and have access to rapid advice when needed. This will see the development of improved links between GP clusters, and our local teams. It can also be improved by improving local supported access to online therapies (for example, web-based tools to guide people through treatment of depression or anxiety, with access to some face-to-face support.)

It will also need the development of more integrated approaches across the Health Board, as we explain below.

Problems such as depression and anxiety are commonly experienced alongside long-term physical health problems, such as diabetes, COPD, chronic pain, or neurological disorders. Integrated, collaborative treatment of both the mental and physical health problems can produce much better outcomes. A 2012 report from the King's Fund and the Centre for Mental Health on this topic ("Long term conditions and mental health") cites case studies of such services producing both better outcomes and cost reductions over a five year period – in one example (co-morbid diabetes and depression) a reduction of 14 per cent over a five year period.

We therefore think it is essential that the care and treatment of depression and anxiety are no longer seen as being simply the responsibility of specialist mental health services. Across health and social care, statutory and voluntary services, all clinical/professional staff should have the skills to manage mild depression or anxiety – and to integrate that care with the other services they are providing. This would mean that in the future we:

- Have greater accessibility to a range of evidence-based psychological therapies and interventions – including DBT and CBT. We will develop a new model of psychological therapies, which will set out approaches which can be the responsibility of generic services, those which can be provided by mental health specialists, and those which need the skills and expertise of highly trained psychological specialists – such as, for example, services to treat PTSD and complex trauma for those most at risk including veterans.
- Build capacity for the delivery of mental health interventions through our acute and general healthcare services. Management of relatively mild common mental health problems, for people who also have a long-term medical condition, should not require referrals to specialist mental health services, but should form part of a single integrated package of care. There are some innovative examples of Primary Care models (such as in Wrexham and Bets-y-Coed) which are focussing on whole community asset based approaches and trauma informed care.

- Create new roles within more integrated teams to manage very common co-morbidities. This could include, for example, the management of anxiety and COPD. There are examples of this already with Health Psychology that could be extended.
- Seek to integrate lifestyle behaviour change into the management of mild depression and anxiety, and long term conditions. Resources available online such as Dewis Cymru will help support this.
- Ensure there is the capability of medical oversight of care (where required) to sit within primary, rather than specialist secondary mental health services. We do not envisage this creating a significant new burden for GPs – most patients will require no specific medical oversight. For patients who have a mix of physical and mental needs, their GP should in any event be aware of and involved in the oversight of their care and treatment. We envisage that this involvement of primary care in management of milder or stable mental health problems will be an important responsibility of our developing primary care clusters.
- Make greater use of online therapeutic interventions, guided by staff. Many people prefer the flexibility and anonymity of such approaches, and evidence of effectiveness is good.
- Undertake a whole system workforce needs assessment to understand where the priorities lie, and inform our intent to improve the workforce, including how system partners could lead or co-lead the above developments
- Work with new integrated models of care that are adopting holistic and integrated approaches to managing care in the community.

Thirdly, we need to develop systems to ensure appropriate delivery of early intervention in psychosis; this may or may not be via standalone teams. We will, within whatever structure, be working to ensure that the service meets all of the intended functions of an Early Intervention in Psychosis service:

- Active treatment of first episode psychosis
- "Watch and wait" – monitoring of uncertain symptoms, and following up people who have not engaged for at least 6 months
- Management of people at risk of suicide or self-harm, or serious deterioration
- (Often) support to the management of linked problems of substance misuse

Specialist services for children and adults will therefore work together to develop a shared and consistent model of care for children and young people presenting with psychosis aged 14 to 25 years. CAMHS staff involved in this area of work will contribute to a service that extends up to the age of 25 years and Adult Mental Health staff will contribute down to the age of 14 years.

We also plan to invest in additional staffing, across a range of disciplines, to develop a consistent model of care for this group of children, young people and young adults.

Fourthly, we want to consider the organisation of our services into teams. Given the large geographical area we serve, with many very rural communities, it may be that some areas would be better served by more generic community teams, including within their remit a range of responsibilities and functions. This does not need to be

identical everywhere across North Wales, and it may be that different solutions will meet the needs of different areas. We are conducting a census of caseloads within our community teams to inform this process.

To help us understand this in more detail, the Pathway Delivery Groups will become the main vehicle of change to agree the best models of care that seek to create the most effective and efficient joined up approach to meet local population needs. This approach will continue to adopt coproduction as the vehicle for enabling teams to determine the best solutions for their problems.

4.3.2 Services for people in acute mental health crisis

Acute and urgent care services deal with the most serious of mental health problems, which cause great distress to service users, their families, partner organisations, and (sometimes) the wider community. It is therefore a considerable priority to ensure these services work effectively.

The Commission to Review the Provision of Acute Inpatient Psychiatric care for Adults, led by the Royal College of Psychiatrists, reported (2016) that there are eight key national problems in acute care:

- *"Inadequate availability of inpatient care or alternatives to inpatient admission when needed.*
- *Many patients remain in inpatient beds for longer than is necessary in significant part because of inadequate residential provision out of hospital*
- *Variable quality of care in inpatient units, reflecting the environment, the interventions available and the number and skills of health and care workers*
- *Variation in terms of access to evidence-based therapies across the entire acute care pathway*
- *A lack of clarity as to the quality of outcomes expected and how these should be reported in a transparent way*
- *Variable involvement of patients and their carers in both the care received and in the organisation of services*
- *Significant differences in the quality of leadership and the culture of organisations*
- *A fragmented approach to the provision of services providing inpatient care."*

This national commentary is relevant to North Wales, where we recognise that many of these difficulties apply. We should also recognise that:

- The model for crisis response in BCUHB is under-developed and inconsistent. Access to Home Treatment Teams (HTT) is not equitable, with an absence of HTT service for people aged over 65 years old, and with reports that HTT is often above capacity and unable to take referrals.
- We have no crisis houses, or safe havens to offer a short-term alternative to inpatient admission. Models for such services vary, but the most effective are rigorously gatekept by statutory services, and focus on offering stays of only a handful of days to people whose needs are relatively straightforward,

but who otherwise might have been admitted to hospital. This can include the needs of people at an early intervention stage.

- There are persistent problems of people having to be admitted to beds outside North Wales. Our acute wards very frequently have occupancy above 100% (including patients on leave) i.e. beds are allocated to more than one patient at the same time, when someone is on temporary leave from the ward. Delayed transfers of care are also a persistent problem.
- The interface between mental health services and criminal justice services does not work as well as we would want it to at present. As well as the lack of alternatives to admission, as identified above, targeted diversion services such as street triage are not well developed in North Wales. In consequence, too many incidents are being managed by the police (the North Wales Police Efficiency Review (2016) found 12.5% of reported incidents relate to mental health) with insufficient mental health support and advice; this is also leading to high use of section 136 of the Mental Health Act, with a very low conversion rate to longer-term assessment or treatment sections of that Act.

Fundamentally, we want to see an acute and urgent care system within which:

- No-one, anywhere in North Wales, waits more than 4 hours for mental health assessment in crisis
- Once assessed, people are placed immediately in accommodation suitable for their needs. For most people, this should be their own home, with sufficiently intensive home treatment support. For some, it could mean a short-stay crisis house. For a minority, it will mean acute inpatient care
- All admissions to hospital will be 'purposeful'
- No-one stays longer than they need to in acute inpatient care. There are no "delayed transfers of care" due to lack of step-down support
- No-one is admitted to an acute mental health bed outside North Wales

We therefore propose the following steps:

Partnership with North Wales Police

We will continue to work closely with the North Wales Police. The Police Transformation Fund will be used to support improvements in services. Right Point – Right Time - Right Support (RP-RT-RS) is intended to be a socially responsible tiered approach to enable mental health needs to be identified and acted upon at the earliest opportunity.

RP-RT-RS will be driven by need and presenting risk. As risk increases, the response becomes incrementally more comprehensive. Our proposal is intended to:

- Advise the most appropriate mental health support pathway following receipt of first call contact
- Refer the vulnerable person (identified on a call out) to a Central Referral Unit; the Unit to include a mental health practitioner with links to community mental health teams

- Extend the Vulnerability and Risk Management Panel to the whole area and consider extension to include at risk children/young people with mental health problems
- Divert a vulnerable person at risk of being detained (under s136) to one of three Sanctuaries provided by the 3rd sector; Sanctuaries will have outreach workers. These could in practice be shared functions with crisis houses or safe havens
- Change the nursing model in custody to increase the staff numbers with mental health qualifications
- Add a mental health practitioner to the Welsh Integrated Offender Management Service to ensure continuity of mental health care and help reduce re-offending
- Train frontline professionals in referral pathways
- Develop a pathway to support 'App' for people with mental health problems, their families and frontline staff.

Home treatment

In the future our HTTs will be sufficiently resourced to operate 24/7, and with protected caseloads that allow teams to fulfil their core functions of a community-based crisis response and intensive home treatment as an alternative to admission in line with the best evidence. We will evaluate the models against best practice and the CORE Fidelity Criteria to assist in identifying positive practice and establishing clinically owned improvement plans for each team.

Crisis café / safe haven

We will develop the crisis café / safe haven model to offer community-based "safe space" alternatives to inpatient admission. Such models are relatively new, but have been trialled very successfully in Aldershot, in Bradford and in Leeds. The key features of our approach will to include:

- gatekeeping of access;
- a mix of voluntary and statutory sector delivery;
- availability during the evenings and weekends.

Early evidence from the Aldershot model suggested that as many as a third of inpatient admissions could be prevented by diversion to a crisis café and whilst we clearly cannot be certain that such a substantial effect could be achieved in North Wales, even a small proportion of this diversion rate could have a major impact of our local acute system's ability to function effectively. Integration of day services and CRTs may address the criticism that patients receiving CRT care may be spending much of their days alone between team visits and may have relatively little structure to their days or activity (Allen 2009)[1].

1 Allen, D., Blaylock, W. and Mieczkowski, S. (2009) Local implementation of the crisis model: the Buckinghamshire community acute service. The Psychiatrist 33: 252–4.

A&E / psychiatric liaison

Although we will aim to divert as many people as possible from unnecessary visits to A&E departments, it will remain important to ensure good quality psychiatric liaison within our acute hospitals. Three levels of mental health liaison services have been identified nationally: core, core 24, and enhanced 24. We will use this evidence base to set out the expected levels of staffing, service availability, and performance, specifically:

- Team consultants available beyond office hours and for some periods at weekends
- Outside of these hours, rapid access to consultant support provided by on-call services
- Substantial time given to supporting and training mainstream hospital staff to improve their ability to assess and treat people with mental health problems
- Single point of contact for all patients (16+) in hospital with diagnosed or suspected mental health conditions
- Co-ordination with out-of-hospital care providers and housing services.

We will also explore models which additionally improve the integration between mental health liaison and:

- Community based crisis assessment services
- Community based services offering urgent opinions to referrers
- Services aiming to reduce high use of Emergency Departments by patients not known to any other services

Finally in this section, there is the question of the number and configuration of our inpatient beds. In the long-term, this question can only be answered in the context of a clear understanding of alternatives to admission, and it is on the latter that we propose to focus in the first instance. We will also address the environmental issues raised by the Health Care Inspectorate to make our services safe.

4.3.3 Services to support rehabilitation and recovery

These services support people who have serious mental health problems outside the acute phase of illness. They can work to prevent deterioration in people's mental health – and reduce the risk of acute care ever being needed. They can also work to reconnect people with their lives before they developed those mental health problems. This will mean different things for different people.

Delivering improvements in this area will be the responsibility of many agencies working in partnership – health, social care and the third sector.

People who are in employment should expect to keep it. Employers should be supported to keep on, or take on, people with experience of mental health problems. People who have been in education should expect to be supported to resume education. People whose role is in the home and family should be supported to

maintain those responsibilities – or to take up those responsibilities again. People whose lives have been difficult for some time may have no stable life to return to, and will need longer and more complex support to gain and regain the skills and the structures their lives will need. Some people may need support to secure stable housing.

This emphasis on employment will require not only individual casework, but also general development work with employers – encouraging employers to retain and recruit people who experience mental health problems, and reassuring them as to the support which will be available if problems do arise. The Centre for Mental Health[2] have reviewed the evidence on this topic, and estimate that Individual Placement Support could save as much as £20,000 per person over a five year period.

Rehabilitation and recovery therefore requires a wide range of skills and services. Many of these do not need to be limited to people with mental health problems – indeed, there is a great deal to be said for services whose specialist function is housing, benefits, family support, employment support catering for <u>everyone.</u>

For a minority of people who have serious mental health problems, support will need to be over a very long period: many years, sometimes a lifetime. We understand this, and this strategy will not change that. **If people need indefinite support to manage their mental health problems, that is what we will provide.** For all people using services, it will be important to identify factors which could lead to relapse, and for care coordinators to ensure things are in place which can minimise the risk of relapse.

However, for most, services' ambition should be very clearly towards gradually moving people out of specialist mental health support – and into the structures which provide social support for all of us: jobs, homes, friends, work, a role in the community.

Access to appropriate, affordable and safe housing is key to a person's recovery. This is recognised in the national mental health policy:

> '*Professionals need to work together to ensure that people with mental health conditions have full access to and are given appropriate consideration under housing allocation systems.'*
>
> *Together for Mental Health (2012-2016).*

The 'North Wales Supported Living (Mental Health) Commissioning Statement' has been produced which is a partnership between BCUHB, Welsh Government, and North Wales Social Services Improvement Collaborative who have worked together in response to the 'Together for Mental Health strategy for Mental Health and Wellbeing in Wales'. The statement recognises that:

2 Priorities for mental health – economic report for the NHS England mental health taskforce (Centre for Mental Health, 2016)

- We need to encourage partners and Providers to use housing services differently and be innovative with their design.
- We need a collaborative approach across the North Wales region to ensure that partners and Providers can facilitate and achieve creative, innovative developments in an era of declining budgets.
- Through working together we want to formulate plans for future development and the regeneration of supported housing in North Wales and focus on key services that are not currently available for people living with Mental Health problems in Supported Living environments.
- There are certain client groups whose needs are not currently met. This is resulting in a dependence on out of area placements with unclear pathways to step down / move on facilities.
- It is deemed that many services accept complex issues presented but fail to respond to them adequately and that the transition from service to another is hindered by lack of appropriate models of care and appropriately trained staff to offer the support.
- There is a need to develop care pathways and timescales for movement between services and to develop services that are flexible in their delivery. This includes ensuring a clear role for our directly provided inpatient rehabilitation services
- We need to ensure that there is active offer of Welsh language service provision for people living with Mental Health problems in Supported Living environments during their journey of recovery.

We are therefore planning work to develop:

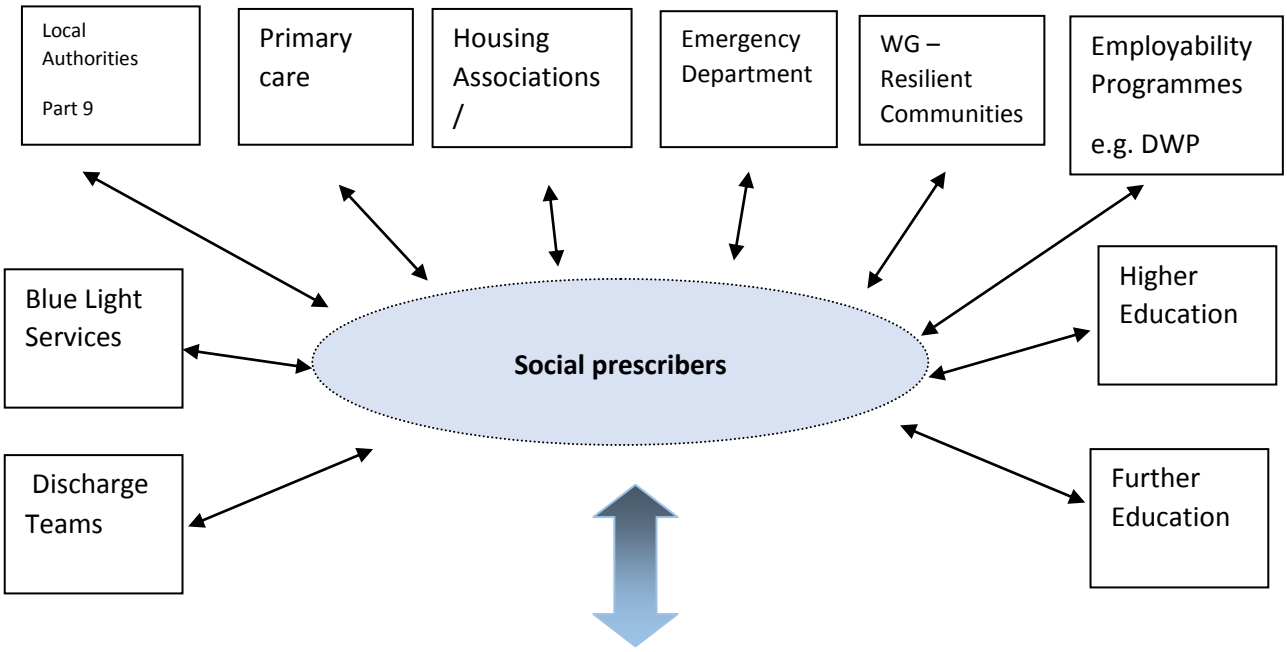
- An increased emphasis on peer support. There is considerable evidence that many people do not just equally well, but better, if the main focus of their ongoing support is from their peers, rather than professional services. In addition to the effect on individual service users, impacts have also been observed on the wider mental health system (reducing costs, improved outreach and engagement, improved provider attitudes and quality).

We are considering promoting this model by the expansion of supported networks of peer support workers. This will, of course, need to incorporate proper arrangements for the governance, support, and supervision of peer support workers, and of peer supporters themselves. Initially, we intend to work with an independent organisation (such as Caniad) to develop a model of peer workers to 'in-reach' into our services and to help embed a peer worker role into all pathways.

- A significantly strengthened focus on the importance of employment. We seek to invest in services which secure employment, and support work placements - to extend the community of support for people with mental health problems to their work colleagues and employers. We will recruit and implement individual placement support workers within the psychosis pathway initially, and then roll this out to CMHTs to focus on support people back into employment.
- An increasing emphasis on recovery, and on positive risk-taking. The concept of 'positive risk-taking' developed in adult mental health services in the mid-

1990s (Morgan, 1996)[3]. It emerged as a way of describing thinking that goes into decision making process. The idea is that: 'we are going to take risks to achieve our own personal 'positive outcomes'. In other words, it is weighing up the potential benefits and harms of exercising one choice of action over another. Identifying the potential risks involved (i.e. good risk assessment), and developing plans and actions (i.e. good risk management) that reflect the positive potentials and stated priorities of the service user (i.e. a strengths approach). We will work with partners to review our assessment and response to people at risk of suicide and co-produce safety plans and harm reduction approaches across services. We will ensure that people receiving care are fully informed of all potential and actual harms to their wellbeing and work with them to maximise their full potential.

- Support for "social prescribing" – promoting access for people with mental health problems to services intended to promote education, exercise, personal and creative development. Work is already under way to develop a local model for social prescribing, based on the networks below:



Many of these initiatives can be brought together and delivered via the means of a "Recovery College," of which many examples now exist. This is a physical or virtual hub for coordinating developmental support aimed at promoting and maintaining

3 Morgan, S. (1996) Helping relationships in mental health. London: Chapman & Hall

individuals' recovery. We need to ensure that an appropriate, sustainable model of recovery is implemented.

4.4 Older People

Older people have many similar needs to those of younger adults. We therefore wish to see older people having access to the same services, or services of equivalent quality, to those for all adults. The principles set out above for community, crisis, and rehabilitation services should therefore all be read as also applying to older people, within an all age service model.

This section addresses the group of mental health problems which affect older people very disproportionately: organic mental health problems – dementia, and its various causes. Such problems do of course also affect a small number of adults; consistent with the principles above, we would expect people with early onset dementia to have access to the same services, or services of equivalent quality, to those for older people.

Estimations of the numbers of people with dementia vary. Following substantial efforts nationally, more people are being diagnosed with dementia, both in absolute terms, and as a proportion of the numbers believed to have dementia. Whilst there is evidence emerging that the overall rate of dementia in the UK population may be falling, the facts that we are living longer, and diagnosing more, mean that our mental health services are aware of steadily increasing numbers of people with dementia. The prevalence of dementia among people living in care homes has increased, from 56% of residents of care homes to around 70% over the past 20 years.

We do know that lifestyle changes, such as diet and exercise, can reduce the risk of dementia, and we will continue to encourage healthy living, for this as well as many other reasons. Once launched, we will support the newly developed Together for Dementia Friendly Wales (2017-2022).

Rising demand is creating a pressure on specialist mental health services for people with dementia. We are increasingly aware of the complex patterns of comorbidities which frail elderly people experience. A patient with a cognitive impairment and in a hospital bed is much more likely to be in an acute hospital bed than in a psychiatric hospital bed. And any admission to hospital, for a person with dementia, creates a serious risk of a dislocating effect, such that they may never return home.

Managing dementia well cannot currently mean an expectation of recovery. Effective care and treatment mean managing the process of increasing frailty over as long a period as possible, and whilst maintaining the highest possible quality of life – for the person with dementia, and for their carers and family. This process needs to begin with post-diagnostic support, and continue through to end-of-life care. Effective support of carers is essential.

As well as our direct provision, we spend substantial sums on continuing care with a wide range of independent providers. We are keen to make best use of this

investment via a clearer and more managed relationship with those providers. This should also form part of a wider reconsideration of the location and organisation of bed-based services.

We have begun work on developing a new local strategy for people with dementia, addressing the wide range of services required. In this, we are developing commitments to ensure that:

- People know where or how to access reliable and accurate information about the signs and symptoms of dementia, and who to turn to for advice
- Where people do present for help or advice, they are welcomed, taken seriously, listened to, allowed more time if necessary, and given the choice of being referred on for specialist assessment
- Carers of people with dementia are positioned as the expert in who that person is, and in how many of their care needs can best be met. This could be enhanced, for example, by increasing the offers of support and education to carers
- No-one will wait more than 28 days from the referral being received to be seen and assessed by a memory service – and to begin the process of diagnosis
- Dementia is managed effectively within acute general inpatient wards
- People will have access to post diagnostic support, including peer support
- People are supported to identify those aspects of life that have meaning to them, and to retain control for as long as possible
- If resources permit, we hope to explore the possibility of offering home-based alternatives to admission via some form of crisis support for people with dementia
- If people have to be admitted for inpatient care, it is provided in an environment which is suitable for people with dementia
- Support is offered to enable people with dementia to die with dignity, including access to hospices and palliative care where relevant

4.5 Learning Disabilities

In working to prepare this document, it has become very clear, following feedback from clinicians and practitioners working within learning disability services that it is important that people with learning disabilities and mental health problems are able to have their mental health needs met appropriately and in the least restrictive environments. However, the development of the whole learning disabilities pathways (residential and community) will not be met simply by incorporation within a strategy whose main focus is mental health.

Given the separate policy framework, with different drivers and enablers than T4MH, including a strong focus on a rights based philosophy of care, but similar in that the focus should be on early access, prevention and be all-age, we recognise that a separate process of strategy development will be needed to ensure that plans for learning disability services are developed in an integrated way with local authorities, people who use services, and their families.

4.6 Substance Misuse

The position of substance misuse services is similar to that for learning disabilities. Here too, the policy framework, commissioning and reporting arrangements are different, and whilst there are co-morbid or dual-diagnosis issues to be addressed, the future development of substance misuse services will not be met well simply by incorporation within a strategy whose main focus is mental health. Our response will therefore also be a similar one.

4.7 Forensic Pathways

Our forensic provision is primarily concerned with the assessment, treatment, rehabilitation and aftercare of patients who suffer from a mental disorder, and who have or are alleged to have offended, or are considered likely to offend / re-offend.
Forensic services currently comprise a 25-bedded Medium Secure Unit (MSU) - inpatient care (male) and specialist community team provision, including Forensic Outpatient, Out of area care coordination, and Criminal Justice Liaison.

Both clinicians and managers responsible for these services have made substantial efforts to improve the sustainability of local services, including development of training, and participation in research and professional networks. There are, however, a number of challenges still facing the service including:

- The clinical model is not well defined in terms of it focussing on a specific client group or speciality (such as long term complex care, female specialist, personality disorder or enhanced MSU care) which provides an opportunity to meet future identified needs
- It is based in the West of North Wales, on a relatively isolated site, which has potential for development and regeneration
- There are no NHS low secure beds for North Wales, resulting in regular out of area placements for men and women. Access to NHS low secure provision would be a significant benefit
- It is unclear to what extent there is sustainable demand for a MSU of this size in North Wales
- There has been under-investment in the skills and development of forensic teams.

Via the new Pathway Development Group for these services, we will prepare a workforce development plan, coproduced with the teams and people using the service.

We will also develop forensic teams with the right skills, experience and confidence to support people with high risk and complex needs safely in the community.

5. IMPLICATIONS OF VISION

5.1 Workforce

5.1.1 Current workforce

The mental health and learning disability workforce is around 1650 WTE, and accounts for 11.5% of the overall BCUHB workforce. The following headline issues inform the actions outlined in our strategic priorities.

- There has been little change to overall workforce numbers since August 2015
- There have been changes to the skill mix, Band 2 and Band 5 have reduced whilst Band 3 and Band 6 have increased.
- The cumulative sickness rate is typically around 6%, which is higher than we would wish
- Overall turnover rates are low, however, there are high rates amongst some groups e.g. consultant psychiatrists at 25%.
- 21.5% of the workforce are aged 51 to 55 and trend analysis indicates many retire soon after reaching the age of 55.

5.1.2 Culture

We have heard through staff engagement events the following experiences of staff:

- There is a committed and loyal workforce
- Staff are keen to develop new services and new ways of working
- Staff recognise the need for stronger partnership and Multi-Disciplinary Team working There is a real commitment to working more closely with local authorities
- They welcome devolved decision making as part of the new leadership and governance arrangements.
- They are passionate about making a positive difference to people's lives
- Staff want to make North Wales the best place to receive mental health services

However staff also expressed concerns in relation to:

- An excessive focus on targets and number-counting in the absence of a coherent strategy, performance framework or vision for integrated care
- The residual impact of financial efficiency savings have left people feeling disempowered, demoralised and over worked
- There is a perceived over-dominance of a ‘medical model’ approach where other professional groups have too little voice or sense of influence over quality and safety
- There is too little emphasis on recovery – characterised by long periods on caseloads, risk averse practice and processes, negative attitudes experienced by service users and carers, and lack of investment in new models of care
- There is a lack of management ‘grip’ on basic processes (such as purposeful admission, use of person centred care planning, communication, and outcome measures.)
- Paper based systems result in risks to patient safety and continuity of care,
- There is a lack of audit capability for reviewing pathways and caseloads and limited involvement of patients in care plans.

Ballet and Campling (2011), both psychiatrists, reviewed the literature on organisational learning following the publication of the Francis Report in 2009 into the failings in patient care at Mid Staffordshire NHS Foundation Trust. They remind us that, when health systems are overly focused on targets, numbers and inspection, they are likely to result in the worker having divided attention. This results in, at best, distraction, disempowerment and anxiety – and, at worst, coercive and brutal systems. Organisations that have systems characterised by strong alliances, trust and compassionate care cultures lead to skilful and compassionate work, and better health outcomes.

Our aim is therefore to shift our culture to support the development of 'Enabling Environments' (EEs), which are workplaces that can demonstrate 'relational excellence' and will be expected to confer the following benefits. Enabling environments (which have been implemented in all prisons across Wales and some Health Boards) can be expected to:

- Improve quality of care and thus measurable patient outcomes
- Promote wellbeing of patients, optimising conditions for recovery
- Enhance workforce engagement
- Reduce staff sick leave
- Reduce the risk of adverse outcomes
- Support positive mood; positive mood promotes more flexible problem solving, robust decision-making and enhanced analytic precision
- Nurture the collaborative ethos that is fundamental to effective teamwork
- Result in more productive workers who are better at handling adversity.

The fact that job satisfaction, organisational commitment, turnover intentions, and physical and mental wellbeing of employees are predictors of key organisational outcomes such as effectiveness, productivity and innovation means there are multiple reasons to encourage such positive employee attitudes. This applies even more so in health services, where the attitudes of employees are likely to directly affect the quality of the patient experience.[4] We will utilize the 'Health at Work : Corporate Health Standard'. In so doing we will use this as the framework to promote 'mental wellbeing and the management of pressure' in the workplace; and address issues associated with 'mental ill-health' and in so doing support a wider how BCUHB ambition to retain our employees and help them to reintegrate back into the workplace following a period of absence.

5.1.3 Workforce vision

Our vision is:

4 West M, and Dawson J (2012). Employee Engagement and NHS Performance, The Kings Fund

"To recruit, develop and retain appropriately skilled, qualified and experienced staff to deliver compassionate, safe and excellent care while demonstrating our values and behaviours."

Within this, the division is aiming to:

- Strengthen leadership and capability
- Undertake workforce planning to accurately forecast our future staffing requirements, and review the structure and size of our establishments
- Recruit to our agreed establishment levels and maintain levels to ensure safe staffing.
- Support and develop staff to deliver expected standards of care and deal with performance that falls short of expectations
- Be flexible in the deployment of our workforce to deliver appropriate levels of activity and reduce the need for overtime, bank and agency staff
- Aim to be a centre of best practice for learning and development
- Develop a culture in which our values support compassionate care, openness and honesty
- Encourage innovation by encouraging discussion about how we do things at ward and departmental level
- Support staff health and wellbeing to enable them to fulfil their roles
- Improve staff engagement and experience to build staff confidence in the Division as an employer of choice and provider of excellent care

We will also underpin all of this by working towards signing the "Time to Change" organisational pledge, committing BCUHB to demonstrate our commitment to change how we think and act about mental health in the workplace and make sure that employees who are facing these problems feel supported.

5.1.4 CAMHS

Beyond the mental health and learning disability division, this is a time of significant change and investment in Specialist CAMHS. We have recently reviewed our overall workforce and developed a blueprint for CAMHS teams across the region. This is based on an analysis of current demand, need, population and deprivation data. We will consult with our workforce and following this develop and implement a workforce plan that leads to an equitable provision of services across North Wales. This plan will seek to meet the challenge of both increasing our commitment to early intervention, prevention and promoting good mental health as well as reducing our waiting times to 28 days for mental health assessments and interventions and 48 hours for urgent assessments. In developing the workforce we will consider the language needs of the population and recruit staff who can offer services in the language of choice.

5.1.5 Partnerships

As with all aspects of this strategy, we will need to work in partnership with other agencies to deliver fully on our workforce change ambitions. Specific initiatives on which we envisage partnership working will be:

- The identification of staffing structures and skill mix arrangements for new services, where teams include social care or third sector members
- Training, development, and culture change initiatives, where it will be essential that these are designed, delivered, implemented and participated in by cross-agency teams
- Implementation of healthy workforce initiatives, where we will be keen to share learning across partners
- Recruitment and retention initiatives. Staff are more likely to be attracted to and retained by services with strong multi-disciplinary teams; staff can be supported to "passport" between agencies locally in ways that keep them in North Wales; we can promote together the advantages of living and working in this area.

5.2 Estates

5.2.1 Condition of our existing inpatient estate

There are a range of problems with our existing inpatient estate. Many of our facilities do not comply with modern standards and expectations. Specifically:

- The Hergest Unit at Bangor is not designed to modern standards and is of an age where upgrade to elements of the fabric and services are required. The patients have little circulation and lounge space, poor privacy and dignity due to the shared dormitory and bathroom facilities and many of the recreational and therapy facilities are located away from the ward area. No steps have been taken to make the ward environments dementia friendly despite the fact that people with a dementia are admitted to these wards (as well as other vulnerable people with similar needs.) This unit requires upgrade and reconfiguration to meet the needs of the patients in a modern Mental Health Service as well as addressing the address the backlog maintenance issues in a building of this age.
- All of the wards at the Ablett Unit are out-of-date in design, with cramped facilities, lack of en-suite provision, narrow corridors, and design limitations. This unit is unlikely to provide a sustainable option for long-term provision.
- The Heddfan unit at Wrexham has been built to modern standards, with good facilities for the patients and staff. The unit does however suffer from significant long standing building defects, poor component specification and poor design detail that result in high levels of maintenance and repair. The condition of the unit will deteriorate without these issues being resolved or maintenance management control plans being put in place. The older persons' wards do not incorporate many of the dementia features expected in this type of environment.
- Bryn Hesketh has limited bathroom facilities, no ensuite facilities, and significant backlog maintenance problems. It is also isolated from other services.
- Coed Celyn rehabilitation unit is dated, cramped in its design and dated and requires upgrade of the facilities for patients.

- Cefni Cemlyn is in a reasonable state of repair, but the unit provides care for dementia patients, and the internal and external facilities require improvement to meet the needs of this group. The shared bedroom facilities and lack of en-suite provision also require addressing.

5.2.2 Planned estates programme – existing programme

The inpatient anti-ligature and environmental programme within Betsi Cadwaladr University Health Board involves the removal of very high risk ligature points and improvements to the general environment across 21 wards. These improvements address many of the quality and safety issues, including dementia, raised by Health Care Inspectorate Wales (HIW), the Delivery Unit (DU) and the Community Health Council (CHC) in their inspections; these changes will enhance the patient, relatives, carer and staff experience.

By the end of the 2016/17 financial year we will have expended the full allocation for the year and undertaken some form of improvement in 20 of the 21 ward locations in the programme; with full completion in 12 areas.

5.2.3 Planned estates programme – potential programme

The current configuration of mental health inpatient units does not provide the right environment to deliver high quality services that meet the privacy and dignity requirements of a modern day mental health facility. The limitations of the current units do not provide the opportunity to deliver any flexibility for changing the size and configuration of each ward that would allow for new pathways to be implemented, almost immediately, improving the flow of patients through the system.

We are therefore developing an approach which will make use of existing building envelopes, where practicable, and to generate new ward/unit designs that support future service requirements. We would expect to close more remote and isolated units, and incorporate their services in larger hubs.

5.2.4. Community estate

Detailed estates review work has so far concentrated on our inpatient estate. We are conscious, also, of the need to review the large and diverse estate of premises from which community services are provided. This is work which we intend to do over the lifetime of this strategy. We intend to approach this as a partnership exercise, with local authorities and other organisations with whom there might be suitable opportunities to share premises. This is not simply (or even primarily) a financially-driven intention – our aspiration to improve the integration of local community-based services will often be supported by delivery from more integrated local premises.

5.3. Information and Communication Technology

Local data to inform our understanding of local services' delivery and performance are very limited at present. Data on mental health inpatient services is available, but with many gaps in our recording of diagnoses; there are also problems with the

structure of our data such that we cannot easily link together individual patient episodes.

This problem is greater in the community, where many services are wholly reliant on paper records and booking systems, such that there is little or no central understanding of their caseloads or activity. The large majority of our mental health services' activities do not feature at all in BCUHB's activity and performance reporting systems. The systems for managing and archiving our paper files are inadequate.

This matters, not simply for the purposes of service management, but more importantly for the purposes of the management of individual patients. Staff across our services cannot readily access information about work that colleagues have done in other parts of our area, or even in the same team. This limits significantly our ability to ensure effective care and treatment planning.

We are therefore very pleased to be seeing the first stages of implementation of the WCCIS - the new Welsh Community Information System – beginning in 2017. This will begin to address these deficiencies, and start a process which should enable much better communication across our staff and our teams – and better information for strategic planning.

Successful implementation of the WCCIS will require the development and implementation of a shared strategy in partnership with local authorities – to ensure that we secure the full advantages of this system for both individual care and treatment planning, for shared business intelligence, and for shared governance of our mental health services.

We would wish to use the improved information arising from this process to enable us to undertake, for the first time, a robust service capacity assessment, which:

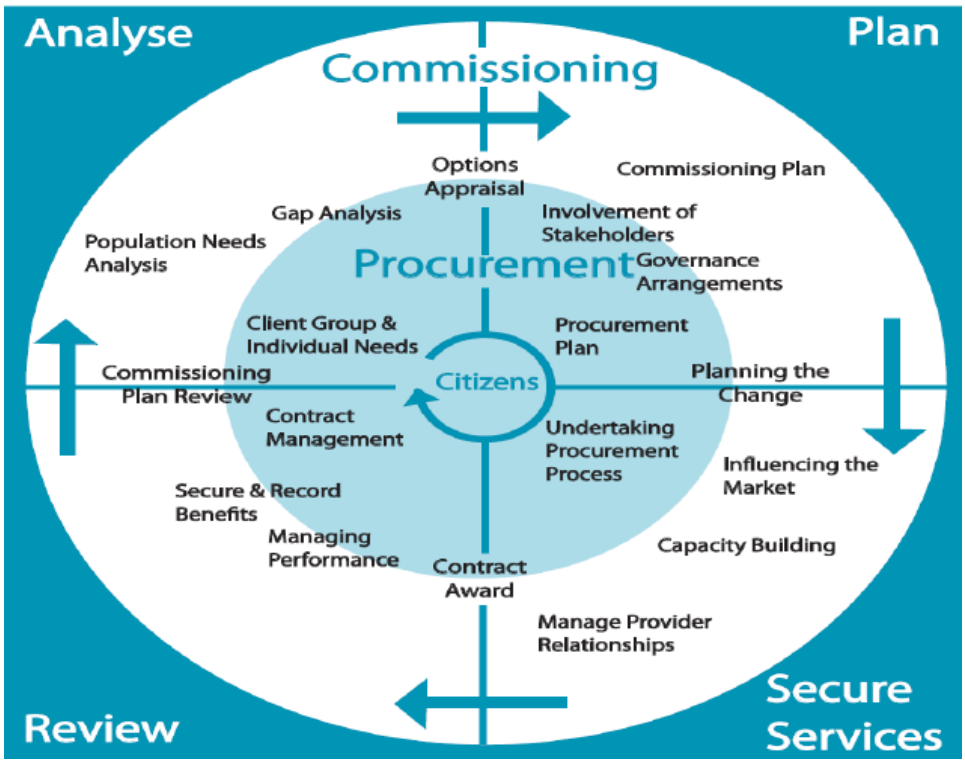
- Draws on a wide range of local quantitative data about flows through services, so that the assessment is based in the reality of local services and their context
- Takes account of the relationship between community and inpatient services, and not plan each in isolation
- Takes account of expected demographic change
- Uses a robust modelling technique, which takes account of the full range of variance in the way people move through services, not simply averages
- Considers change scenarios, and draw the expected impact of those scenarios from reliable sources of evidence, wherever possible
- Ensures that a wide range of stakeholders has the opportunity to contribute, both to validate data inputs, and to contribute thinking about scenarios for change

5.4 Commissioning

BCUHB spend approximately £60 million a year on commissioning both continuing health care, and a range of other health care from other providers, across the range

of mental health, learning disability, and CAMHS. This includes both long-term placements, and short-term fees for local residents being cared for elsewhere. This is a very substantial sum, and our intention, over the life of this strategy, is to significantly improve the way in which it is spent.

By establishing a significantly strengthened specialist commissioning unit within the mental health and learning disabilities division, we will establish a function to manage the full commissioning cycle for the use of this money, i.e.



Whilst some of these activities are currently undertaken, we do not have a connected commissioning cycle which ensures best value for money and best outcomes from this substantial investment; nor do we systematically determine the range of services which BCUHB should provide directly, as against external commissioning; nor do we ensure that commissioned services form part of coherent pathways with directly provided services. We intend that all of this should change, and we will create a dedicated and specialist team with the responsibility of ensuring that it does.

6. GOVERNANCE ARRANGEMENTS

We have undertaken a focussed review of our governance, as part of the development of this strategy. This has identified the following main findings:

- BCUHB's mental health and learning disabilities division is, in itself, very large. The Division (because of its relative size, complexity and risk profile) warrants an internal performance and accountability framework across the Division which needs to be developed to support the implementation of the strategy.

- There is a need to re-establish the Together for Mental Health Board in North Wales. Meeting should take place bi-monthly and be supported by clear terms of reference which clarify the role, purpose and authority of the Board. The Board should be supported with a leadership concordat with a shared vision which has been developed by partners. The inter-relationship between the Together for Mental Health Board and the Regional Partnership Board [Social Services and Wellbeing Act], will be subject to further discussion to confirm assurance and reporting systems.
- The Board should take responsibility for the various Pathway Development Groups (PDGs – see below in this section), defining expectations, gaining insight into their progress, holding them to account for delivery and keeping oversight on programme risks. The PDGs will need ongoing, senior multi-agency support to ensure that plans are delivered and outcomes achieved.
- Assurance reporting within BCUHB regarding progress with the implementation of the strategy will be overseen by the Strategy Partnerships and Population Health Committee on behalf of the Health Board.

A key vehicle for delivery of the mental health strategy will be a series of Pathway Delivery Groups (PDGs). These groups are not exclusive to BCUHB and are intended to be a key plank in strengthening our partnership working with local authorities and the third sector.

Ten PDGs will form the basis for delivery of this strategy:

- Primary care and wellbeing
- Children and young people (including transition)
- Acute care pathways, including in patient care, home treatment, liaison
- Rehabilitation and complex case pathways
- Community mental health teams, and recovery
- Forensic pathways
- Learning disabilities services
- Older people's mental health
- Substance misuse services
- Commissioning

There are of course many sub-specialities and client groups within mental health services, and some will not fall neatly into one or other group. The best pattern of groups will be kept under review, and may change over the lifetime of this strategy.

Each PDG is expected to work to understand how current care pathways across North Wales operate, including their strengths and weaknesses, agreeing a clinical case for change, and producing options for a multi-disciplinary model that improves people's recovery outcomes.

Each Pathway Delivery Group will therefore be expected to:

- Work together within the following principles:

  - Actively engage with and support the co-production process, providing time, in-depth service knowledge and access to critical information in a timely fashion.
  - Support the values and 'model' the expected behaviours arising from these values.
  - Support a recovery and strengths based ethos to designing pathways and new service models.
  - Receive and incorporate the views and experiences from a patient and carer perspective.
  - Foster and model strong partnership working and multi-agency engagement as part of the coproduction process.
  - Foster a culture of continuous quality improvement and patient safety.
  - Promote the leadership required at all levels for all partners and agencies.
  - Promote patient-centred care.
  - Wherever possible, adopt a health and wellbeing perspective to support early intervention and self-management to promote independence from services.
- Determine, review and agree issues for any proposed improvements in a case for change.
- Put forward all options that have been considered regarding the preferred clinical model.
- Consider clinical, future operational and financial implications of options and any further work required.
- Determine a process for evaluating all options.
- Receive and take into account data and information provided, and consider future data requirements such as clinical outcomes and measures of recovery and wellbeing.
- Advise the SMT as to alternative models and test underlying assumptions for the delivery of sustainable models for the future.
- Monitor progress and achievement of key milestones, in line with the agreed actions contained in the mental health strategy and the Together for Mental Health Delivery Plan (2016-19), and to report to the Partnership Board as required.
- Consider the partnerships and links with the local and regional planning and commissioning processes to be able to support the SMT to influence a positive political environment with regards to mental health services.
- Understand and have links with the partnership processes with external agencies and organisations as required to deliver a whole system approach to mental health strategy development and delivery, which is reflected in a communication and engagement plan.
- Escalate risks and issues through the strategy governance framework.

The work of these groups, and other work streams will be overseen by a Delivery Group which in turn reports directly to the Mental Health Partnership Board. A description of their role and purpose is set out below:

Mental Health Partnership Board

The North Wales Mental Health Partnership Board (NWMHP) will be chaired by the Vice Chair of the Health Board and provide regular reports to the National Together for Mental Health Partnership Board. It will be responsible for the strategic development of multi-agency partnership working and will oversee the delivery and implementation of the Together for Mental Health - North Wales Strategy and the Delivery Plan (2016-19) for all ages. This will include; setting and agreeing the strategic direction, guiding and monitoring progress, encouraging innovation, holding partnerships to account and facilitating co-ordination of the cross-cutting approach required across the Health Board, North Wales Local Authorities, Statutory Agencies, and the Third Sector. As the formal delegated body acting on behalf of the BCUHB Board the NWMHP will be expected to provide an annual report to the BCUHB Board outlining progress against the strategy.

Delivery Group

The Delivery Group, accountable to the NWMHPB, is responsible for the professional advice, planning, oversight and delivery of service transformation and redesign. Its membership will comprise of partnership agencies and encourage the development of innovative and needs based, locality driven services to meet the needs of local populations across North Wales. The sub-groups reporting into it comprise of:

- Criminal Justice Mental Health Group
- Pathway Delivery Groups
- Estates
- Talk to Me
- Third Sector Partnership Forum

7. FINANCIAL ASSUMPTIONS

The direct budget of BCUHB's mental health and learning disabilities division, in 2015/16, was just over £97.6 million. This overspent, meaning an actual expenditure at the end of the year of just over £100 million. This spend included the following items:

	Outturn spend (£000, rounded)
Divisional management	2,290
Medical staff	14,377
Psychology staff	5,724
Mental health services - West	10,260
Mental health services - Centre	11,887
Mental health services - East	23,312

Rehabilitation services	4,002
Forensic services	3,477
Learning disability	21,803
Substance misuse	3,405

There are differences between funding per head which are essentially historical, and not necessarily reflecting current needs.

The equivalent budget for CAMHS was £11.3 million.

In addition to this direct expenditure, BCUHB invests in a wide range of other providers' mental health services. We also receive income from other areas whose residents make use of our services. Across mental health, learning disability and CAMHS, this "commissioned" expenditure broke down in 2015/16 as follows:

(£000, rounded)	Mental Health	Learning Disability	CAMHS
Primary Care	14,781	499	1,568
Continuing Health Care	31,893	14,823	1,537
Other contracts with other providers	10,864	94	4,066
Provider contract income	(8,417)	(125)	(3,273)

There are a range of other overhead costs charged to local mental health services, and not listed separately here.

We will be developing a series of business cases to secure capital funding (with associated revenue consequences) to support capital investment within the life of this strategy. We are also expecting additional general revenue investment within mental health services. In addition, we are optimistic that the large sums currently identified as commissioned costs could provide opportunities for review and reinvestment.

A full breakdown of our current expenditure on services across all relevant services is given below. As overheads for some of these services inter-relate, we include here services not otherwise described in this strategy.

		Mental Health	Learning disability
BCUHB Hospital Services			
Learning disabilities	£6,680,912		£6,680,912
Mental illness	£29,192,529	£29,192,529	
Child and adolescent psychiatry	£5,760,020	£5,760,020	
Medium secure Forensic Psychiatry	£4,109,241	£4,109,241	
Psychotherapy	£85,764	£85,764	
Old age psychiatry	£14,844,639	£14,844,639	
BCUHB Community Services			
Learning disabilities	£5,683,727		£5,683,727
Psychology Services	£68,254	£68,254	
Child and adolescent psychiatry	£6,363,559	£6,363,559	
Drugs and Alcohol (Substance Misuse)	£2,268,481	£2,268,481	
Old age psychiatry	£6,566,044	£6,566,044	
Other mental illness	£15,773,968	£15,773,968	
Specialised mental health services	£1,199,333	£1,199,333	
Partnership Schemes	£2,251,154		£2,251,154
Home Delivery Drugs Acute Mental Illness	£339,908	£339,908	
Home Delivery Drugs Forensic Psychiatry	£23,058	£23,058	
Total Provider Budgets	**£101,210,592**	**£86,594,798**	**£14,615,793**
BCUHB Commissioner Budgets			
Primary Care	£16,849,206	£16,350,236	£498,970
Continuing Health Care	£48,253,794	£33,430,497	£14,823,297
Commissioner Contracts	£15,024,000	£14,930,000	£94,000
Provider Contract Income for Non BCUHB Residents	-£11,815,000	-£11,690,000	-£125,000
Total Commissioner Services	**£68,312,000**	**£53,020,733**	**£15,291,267**
Total BCUHB Budgets	**£169,522,592**	**£139,615,532**	**£29,907,060**

….and in conclusion

We want to end this strategy by reiterating the commitments we made at its outset. If this strategy is implemented as we intend, we aim for everyone involved to recognise the progress we will make against these commitments:

- We will treat people who use our services, and their carers and families as equal partners – all of us must be seen as essential assets in improving the mental health and wellbeing of the communities of North Wales
- We will ensure everything we do is as integrated as possible – across disciplines, across agencies, across services – in both planning services, and delivering services. Fragmented care must be replaced by joined-up and continuous care.
- We will work to ensure **everyone** feels valued and respected
- We will support and promote the best quality of life for everyone living with mental health problems
- We will promote local innovation and local evaluation in how we provide services
- We will continually measure our impact on outcomes, within both national and local quality and outcomes frameworks – whether we have improved the lives of people for and with whom we provide services

We are determined that things **will** be different, within a service which is more community-focused, more outcome-focused, more wellbeing-focused. We look to work with everyone and anyone who shares these ambitions with us.

Appendix A

Outcomes of Mental Health Summit

In January 2017, we organised and held a mental health summit in Llandudno, with 18 workshops and plenary sessions, attended by over 180 people from a very wide variety of stakeholder groups. This very successful event considered the issues arising from the interim report, and contributed many ideas towards the finalisation of the strategy. The main points arising from the various workstream strands were:

a) Public wellbeing – mental wellbeing beyond mental health services

This group identified a range of possible indicators for our communities becoming more resilient, including changes in the profile of conditions with which people present, and falls in referrals to services. They identified measures which could encourage self-help and self-management, including sharing knowledge of community assets, work in schools and in early years, and making use of the five ways to wellbeing. And they discussed how partners could work together to develop a learning culture, with information-sharing, including with and for service users.

b) Services for children and young people

This group discussed how to improve the experience of transition for young people between CAMHS and adult mental health services, and wanted to see the sharp dividing line removed, with a much more flexible approach. Current investment in new services should increase support for ADHD and ASD, as well as improving seven day working, and promoting preventative measures. The group looked for Early Intervention Psychosis services operating without any age boundary, and developing in an integrated way with other services.

c) Improving services for common mental health problems, and in primary care

This group discussed how to raise skills across all agencies, looking for a wide range of types of training initiative, beginning with a shared training needs analysis. Within primary care, the group looked to improve access to psychological therapies, with more co-location of services, and more consistency of standards. The group sought clear priorities on the development of mental health services in primary care, with more clarity as to pathways and approaches available, and more cross-sector work.

d) Improving the acute, crisis and rehabilitation pathway

This group discussed how to make services more recovery-focussed, supporting positive risk-taking. Positive examples were identified in local learning disability services, and it was clear that this will require a process of culture change – at all levels in local organisations, with training, development, and changes in governance and supervision required at all levels. Patients' expectations will also sometimes

need to change. More support must mean less blame. The group looked for services to develop a focus on trauma, not just symptom management, and on evaluating in detail current practice. All of this requires a more integrated approach, common management of teams, with clear pathways into and out of CMHTs, and a 24/7 multi-agency response to crises. Electronic records will be essential. Better community-based alternatives should be offered to inpatient admission.

a) Services for older people, including all people with dementia

This group discussed how urgent home treatment could also be offered to older people. Better support for carers was identified, including telephone support, as was the good service model in Anglesey for home support for physically unwell people. The group noted the many differences across North Wales, and looked for investment in services to address some of these differences. The group supported a whole-community approach to supporting people with dementia, and recognised the important work done by third sector partners. Education and awareness would continue to be important, as would a fully holistic biopsychosocial view to the care of older people. The group hoped to see improved assessment approaches, and a rapid dementia service, such as that available in Sheffield.

f) Integrating services across health, social care, and the third sector

This group discussed how trust can be improved between local agencies. Many ideas emerged: joint projects, new ways of meeting, co-location, engagement events with the third sector, agreed local outcomes, and a general permission to act. Personal contact was stressed, to break down barriers, with shared goals, shared budgets, joint training, and a "one team" ethos – with regular and reflective feedback. The group identified existing positive examples, in health liaison nurses, the self-harm pathway, the Criminal Justice Mental Health Partnership Board, and in the Quay Medical Centre – and in this event. Effective leadership will be required, and the group looked for stability, respect, initiative, and an acceptance of the challenges.

g) Developing our workforce: improving mental health recruitment and retention

This group discussed how the workforce can best be developed to meet service needs. There was much emphasis on cultural change – honesty, openness, modelling good behaviours, compassionate care. 'Candid disclosure' needs to be encouraged and supported in any organisation, and staff need to be empowered to make decisions. The group looked to maximise the impact of local universities, and rethink approaches to skill mix, including use of peer support workers, and better support of carers. The group stressed that staff who feel invested in will deliver good care. To attract and retain staff, all of this needs to be done, within a system which delivers effective, evidence-based services.

h) Working towards a recovery culture in mental health

This group discussed the need for training, for close working with the third sector, and for cultural change. Care planning should re-focus on clients' assets, rather than their deficiencies. The group supported the implementation of a Recovery College, recognising that local geography means that it will need to have "virtual" elements to be accessible across the area, with access points in many settings. Service users will need to be supported to tell us what they want and allow us to feel safe to follow that; clinical supervision and reflective practice will also be essential.

i) Commissioning

This group firstly considered needs assessment. Many local agencies will have a perspective on needs, and need to work together to consider gaps and approaches to fill them. Good quality data will be essential, and the WCCIS will be an important source of data. The group looked for better clarity as to who makes commissioning decisions and how, with more engagement discussions, and wide involvement in those. All services can play a part in stimulating the provider market.

Finally, all groups considered changes required in approaches to governance - to ensure all partners work together to support the implementation of the Together for Mental Health Delivery Plan (2016-19). A great many suggestions were made, with an emphasis throughout on: comprehensiveness of involvement, openness of information-sharing, prioritisation, wide communication, a firm focus on outcomes, and clear schemes of delegated authority.

Appendix B

Cost Drivers – estimate list

We have identified the following cost drivers within this strategy. As we develop full implementation plans, we will be drawing out these cost implications in more detail.

"Invest to Save" initiatives are expected to show a time lag between investment and benefits, in some cases a long-term time lag. "Costs" and "benefits" relate to BCUHB only – not full economic costs and benefits.

It will be seen that there is intended to be a significant "invest to save" effect from this strategy; in its first year, we expect to work in detail on the necessary business cases, and long-term financial plan.

Initiative		Estimated potential cost effect					
		Non-recurrent benefit	Recurrent benefit	Non-recurrent cost	Recurrent cost	Neutral	Invest to Save
Public Health and Wellbeing							
1	Ensuring access to universal and targeted support for parents / young children		x		x		x
2	Partnership working to reduce children living in troubled families, number of adverse childhood experiences		x		x		x
3	Improve information sharing between partners					x	
4	Promotion of good mental health for children – evidence-based school-focussed approaches		x		x		x
5	Support for women at risk of perinatal mental health problems		x		x		x
CAMHS							
6	Develop CAMHS SPA					x	
7	Targeted interventions for anxiety				x		
8	Better response to self-harm – training and pathway		x		x		x
9	Wider consultation and advice				x		
10	Care Coordinators in Tier 4				x		
11	Target of maximum 48 hours wait for specialist assessment – 24/7 services				x		
12	Reduce length of stay of OATs		x				

Initiative		Estimated potential cost effect					
		Non-recurrent benefit	Recurrent benefit	Non-recurrent cost	Recurrent cost	Neutral	Invest to Save
Across CAMHS and adults							
13	Full service for Early Intervention in Psychosis		x		x		x
14	Promote 5 ways to wellbeing					x	
15	Promote book prescription scheme				x		
Adults							
16	Implement Talk to me 2 action plan		x		x		x
17	Improve access to psychological interventions				x		
18	Improve quality of care and treatment planning					x	
19	More integrated management of common mh and physical health		x		x		x
20	Effective CRHT service – 24/7 alternative to admission		x		x		x
21	Elimination of unjustified OATs		x				
22	Crisis houses / cafes		x		x		x
23	Street triage		x		x		x
24	Core 24 psychiatric liaison		x		x		x
25	Improve housing offer			x			
26	More peer support		x		x		x
27	Employment support services		x		x		x
28	Financial support services		x		x		x
29	Recovery culture and practice		x	x	x		x
30	Review eating disorder services				x		
31	Improve PTSD services for veterans				x		
32	Develop prison inreach services				x		
33	Review and reconfiguration of community teams					x	
Older people							
34	Review of continuing care / commissioned services				x		
35	Training and awareness				x		
36	28 day target for memory assessment				x		

Initiative		Estimated potential cost effect					
		Non-recurrent benefit	Recurrent benefit	Non-recurrent cost	Recurrent cost	Neutral	Invest to Save
37	Post-diagnostic peer support				x		
38	Better inclusion of carers				x		
Forensic							
39	Review of future of Ty Llywelyn					x	
Workforce							
40	Develop workforce plan					x	
41	Reduce bank, agency, overtime spend		x				
42	Leadership and cultural change			x			
43	Sickness absence management		x				
44	Healthy workforce initiatives		x				
Estates							
45	Programme to raise environmental quality; eliminate small isolated sites – inpatient services			x			
46	Programme to review community services sites – develop co-location opportunities			x			
47	Longer-term strategic review- towards end of mental health strategy period			x			
ICT							
48	Benefits realisation for WCCIS			x			