Partneriaeth Ranbarthol Gorllewin Morgannwg | West Glamorgan Regional Partnership

WEST GLAMORGAN REGIONAL PARTNERSHIP

EMOTIONAL AND MENTAL WELLBEING STRATEGY

CHANGING THE DYNAMIC...
A MOVE TO **PREVENTION**
AND **EARLY INTERVENTION**

APRIL 2023

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1. INTRODUCTION

Emotional Wellbeing and Mental Health has been a strategic priority for the West Glamorgan Regional Partnership Board for several years, and a strategic framework for adult acute services was developed in 2018. This was supported by comprehensive underpinning work, including significant service user consultation and engagement, but predated covid. The pandemic slowed down or stopped many initiatives and as a result a scope review exercise was undertaken in 2021. A reboot of the programme was launched in 2022 with two supporting summits in June and October. The need to establish a strategy which builds on this work was confirmed and work commenced on this in November 2022. The aim was to explore a more preventative approach to the service - emphasising earlier intervention, emotional well-being and stopping or reducing a deterioration in people's mental health. This was coupled with a desire to develop more community engaged and focused ways of working which sought to reduce pressure on the already overloaded mental health system.

2. BACKGROUND

There has been a focus from Welsh government for some time around Emotional Well Being and Mental Health Services and a large pool of policy has been published in addition to the legislative framework of the Well Being of Future Generations Act (2015) and the Social Services and Wellbeing Act 2014.

The foundation document published in 2012 - 'Together for Mental Health' with a series of subsequent supporting Delivery Plans, recognises that the causes and effects of poor mental health are complex, challenging and multifaceted requiring an integrated, cross sector partnership approach. It goes beyond focusing on addressing the service challenges such as workforce supply and access to services and seeks to explore the wider issue of well-being of the whole population. This is further developed in 'A Healthier Wales: Our Plan for Health and Social Care' with a focus on cross sector preventative approaches. In addition, 'Prosperity for All' seeks to develop a cross governmental focus on the mental health and well -being of the population. It seeks to link economic vitality to the protective factors for good mental health in particular employment, education and housing.

Alongside these key strategic documents has been a policy focus around social connectedness and building emotional and psychological resilience within communities. Developing and protecting the social fabric of communities by growing and supporting local solutions, 'Connected Communities' describes a strategy to tackle loneliness and social isolation which supports the emotional wellbeing of the population through a series of priorities and commitments.

There has, therefore, been a strong legislative and policy backdrop to the work that has been developed by the West Glamorgan Regional Partnership Board and is contained within the Local Area Plan and this strategy.

In 2018, a strategic framework for adult mental health was developed on behalf of ABMU, NPT, Bridgend and Swansea Local Authorities, which drew on a wide ranging engagement exercise with service users. The document described a framework in which mental health services would be developed and identified key actions for the delivery of a new service model. Whilst many of these actions have been undertaken, a considerable number have not. This is in part due to the pandemic where the focus moved from strategic development to managing the immediacy of a covid response. It was also due to changes in leadership and focus and in part due to the population boundary change. This strategy seeks to build on this work and capture those areas previously highlighted but not addressed. The engagement undertaken to support this strategy builds on the work previously undertaken to support the framework and seeks to overlay the effects of the pandemic in the development of the priorities.

The demand for all services is growing and as is described later in this strategy there has been an increase in the complexity and volumes of people presenting into services. This is across all pathways and across all sectors. This has been exacerbated by the pandemic and there is concern that the latent demand is still not fully understood as the emotional and mental health implications of lockdowns are still emerging. In addition to the effects of covid, the economic outlook has altered with a growing concern around the cost of living and economic hardship faced by many. This is placing further pressure on services as people seek help as their mental health deteriorates as a result. A simple solution of providing more of the same in light of these pressures is clearly not the best outcome – if indeed is achievable or affordable in light of the workforce pressures facing the services. With this in mind, other areas of the UK have started to explore alternative and more preventative models. They seek to develop solutions which develop and build resilience in populations so that they are able to resolve issues for themselves without the need for services in the first place or by intervening earlier so that they get access to the right level of services before crisis interventions are necessary. This in turn allows easier access for those with enduring and sustained needs and enables them to gain support more readily.

This strategy seeks to build on these models and to explore in more detail how these solutions may be applied locally. The focus is not on secondary and tertiary mental health services, which from the engagement work described later, do have issues. Instead, it recognises these services are heavily impacted by the demand that is placed upon them and with it the need to properly prioritise and needs assess care within clinical criteria to ensure that the most at need receive services.

By developing strict criteria for access – completely appropriately, it does leave large gaps. This has led to growing waiting lists and in turn places pressure on Primary Care who are left with volumes of people requiring input but without the necessary services to support them. This is either because they don't exist or because the wait for existing services is too long. (We know from the engagement work described later, that people wait/explore other support options before seeking help and by the time they seek help the need is immediate). The net effect is that short term solutions develop at a local level to meet these needs without there being a comprehensive solution and overview.

This strategy does not look at mental health as a binary state, well and unwell. Instead it seeks to look at it as a continuum along which everyone travels. The focus is on maintaining emotional and mental health and well – being and intervening (if necessary) at a point to maintain self -care and social support, without the need to access more complex professional formalised care. The aim is to intervene upstream – if at all.

3. STRATEGY DEVELOPMENT PROCESS AND ENGAGEMENT

The previous Strategic Framework was supported by a comprehensive engagement exercise which was undertaken over many months and was very detailed in its approach. This was reviewed in the development of this strategy and tested as part of the engagement work undertaken as part of this exercise. Many of the findings are still live and these are incorporated later in this document to form the new priorities going forward.

The summits undertaken in June and October 2022, were a useful backdrop and reboot of the previous Strategy work and provided the basis for the ongoing engagement work undertaken as part of this exercise. These provided a framework for the strategy development and have been used to design the engagement work described below.

4 engagement groupings were developed:

- General Public
- Service Users
- Third Sector
- Senior Stakeholders

Broad themes emerged from the summits and these were used as a focus for the engagement exercise – although these weren't rigid and the exercise allowed for additional comments, opinions and questions so there is fluidity in the ultimate findings.

The base themes were as follows;

- Prevention and Intervention
- Assessment and Diagnosis
- Treatment and Care
- Discharge and ongoing support
- Links between physical and mental health

The actual engagement was designed specifically for the target audience and took place between the beginning of December 22 and end of Jan 23 and took the following formats

- General Public - Survey and public events
- Service Users - Survey and public events
- Third sector - Survey and 1.1 interviews
- Senior Stakeholders -1.1 interviews

Alongside this engagement work, other further work was undertaken in parallel and built upon the emerging findings of the engagement exercise in an iterative way. This included;

- A review of Policy guidance
- A review of the needs assessment work that had been undertaken
- A review of Public Health reports/advice pertaining to the emotional wellbeing/mental health arena
- A review and exploration of UK wide best practice
- A review of the published evidence base for alternative models and best practice
- An examination of the existing service investment and the outcome measures being used to measure the benefits
- A review of the previous strategy work undertaken and any outstanding recommendations
- A review of locally commissioned service review work and findings

In addition, to ensure there was professional input into the exercise, a small Professional Advisory Group was established to test out findings from the engagement exercise and the emerging evidence from the review work described above. The group included social care staff and healthcare professionals including input from the 3rd sector. It was a small group of well- respected opinion formers who were able to formulate a considered professional response to the emerging

issues and critique potential solutions that were being generated to form the basis of the strategy.

4. FINDINGS OF THE ENGAGEMENT WORK

The findings of the engagement activity are highlighted below;

Service User/General Public

These two groups were treated separately during the engagement work, but there was significant overlap in the outputs from this engagement and are, therefore, combined below.

There was a good response to the survey with nearly 300 detailed responses. There were well attended organised engagement events and further more informal road shows e.g. in shopping centres, where the general public entered into discussion. A combination of these is drawn out below.

- Stigma associated with Mental Health is still very present and people are concerned about seeking support
- People seek help with issues first from friends and family
- Doing activities are a strong coping mechanism
- Seeking help from services is delayed until other coping mechanisms are exhausted
- Strong preference expressed for a move away from a medical model to a psychological/social model
- There needs to be more focus on raising awareness around the causes/factors which exacerbate poor mental health
- Waiting times for services are very long and by the time support is sought it is often a long time until they get help, by which time other factors such as employment have been affected.
- Medication is often the first and only solution available because waits for other options are long
- There is a lack of clarity over what other options are available
- The ‘system’ is very complex and interagency working is a major problem
- There were many examples of poor care/communication described when services had been accessed with staff training highlighted as an issue frequently
- Once services are accessed, difficulty with getting out of services – being held on to and a lack of empowerment to make own decisions

Some comments are included:

“I felt embarrassed to ask for help as outwardly I come across as happy and positive and have a good job, nice home, happy marriage etc."

“Your mental health should be seen as being just as important as your physical health “

“Not taken seriously by ANY NHS mental care provider from GP to Crisis team. Crisis team handed out leaflets for charity based support (MIND) and told to do deep breathing when actively suicidal. Six week counselling sessions are by 'basic' counsellor, not specific/ personal e.g.: childhood trauma. Told 18 months to 2 years waiting list when crisis is current.”

“CBT counsellor appointment took 12 weeks to arrange. I was reaching crisis point having been signed off work for depression and anxiety (undiagnosed post-natal depression until son reached 1 yr. old)”

“I needed encouragement from my family to speak to my GP and assurance that I wouldn't lose my job”

“Invest in community interventions and community psychology. Prioritize children and young people - they nearly all grow up to be adults. Ensure psychological support is available across physical health services. Ensure psychological wellbeing is addressed at all levels of care and across the community.”

“By being more proactive, promoting healthy change of lifestyle and talking about it so that it becomes less taboo.”

Third Sector

Engagement with third sector organisations was undertaken with the support of Swansea and NPT CVS. Discussion also took place with the Regional Health, Social Care and Wellbeing Network before engagement commenced. The process included a survey monkey with structured questions specifically to third sector organisations and 1.1 interviews with a randomly selected cross sector of organisations. These included organisations with links to both Swansea and NPT and were deliberately chosen to represent a range in size and complexity. A combination of these is drawn out in the outputs below.

Overall, the sector is very vibrant and engaged with strong service provision and an ambition to develop. There is evidence of imaginative and creative approaches to strategic development and service delivery with a desire to develop solutions which are deeply needs led. There is strong understanding of the needs of clients/population and advocacy for emotional wellbeing and mental health is clearly

evident. The third sector represents a real strength for the West Glamorgan partnership and one which needs to be built upon.

- A struggle to join up with the statutory sector, but are developing creative ways of working with each other (3rd sector organisations)
- A concern that they are perceived by the statutory sector as not providing the same level of quality or capacity
- Short termism is a problem. The approach to developing projects and pilots as proof of concept leads to difficulty with strategic planning and organisational development
- The short term nature to initiatives exacerbates workforce challenges – recruitment and workforce development are problematic
- Funding arrangements which don't recognise the challenges – short term, uncertain with no response to inflationary pressures
- Tendering and commercial approaches have caused difficulty for some
- Infrastructure requirements of responding to bids, tenders and monitoring are seen as problematic/costly and hamper organisational development
- Demand on services has grown dramatically
- Complexity of referrals is causing difficulty for some – the services were not designed/resourced or staffed to support
- The number of people presenting at crisis point when they are finally seen by services is growing
- A feeling that the third sector are filling gaps in provision which are being left by the statutory sector as the manage demand on their services
- A need for a more imaginative, strategic approach – joining things up to respond to growing need

Some comments are included;

> 'We could work more strategically together – all of us – to provide critical support'
>
> 'We need to provide a more inclusive approach to support individuals'
>
> 'Running costs are high – and getting higher, we have to have these recognised in our funding'
>
> 'The waiting lists for our services are very long and we are early intervention. The level of complexity and need is getting higher all the time'
>
> 'It's all about funding, no other agencies have any funding for the services we provide and therefore we seem to get referrals when they are really complex and often at the point of being stepped up to social services or are in crisis and need

more in depth support for their mental health. These people need a longer more intensive service than we can provide and they need it sooner'

'Our vision is to enhance our work with partners and to respond to growing needs'

'The short term nature of commissioning projects can be a barrier to developing programmes of support when dealing with longer term needs such as mental health and wellbeing'

'The financial envelopes that must be operated in when having short term work does not meet the needs of the population. Yet outcomes and expectations of outcomes are often unrealistic in such a tight turn – around'

'Help us to be sustainable – successful work should be supported on an ongoing basis financially. Many of our clients are some of the most traumatised people you might meet'

'Employ link people who can forge trusting relationships between the third sector and public services. They are difficult at the moment'

'The public services need to look at and understand the third sector more. There are lessons to be learnt on both sides'

Senior Leaders

Senior leaders spanned both health and social care and included executives, senior managers and system leaders. They also included senior politicians from both Swansea and NPT. 1.1 interviews and some group discussions formed the basis of the findings.

- Were very cognisant of the demand and strain on existing services
- Were seeking sustainable solutions, with a clear view that the present approach wasn't sustainable in the medium to long term – financial/workforce pressures were stressed
- Wanted to see 'transformation' as a solution to the pressures, varied opinion about what this may mean
- Recognition that the system wasn't working together as well as it might
- Need to join up things up more was supported – how far this should go differed. Ranged from 'cautious' through to those who 'were ready to implement'
- Strong emphasis on prevention and early intervention as a direction of travel
- Holistic approaches were stressed as important

- Desire to tackle the causes of poor mental health as a way of developing future provision
- Consistent agreement that population needs should be central to the solutions, but recognised that these weren't always as well understood as they might be
- Were ambitious for the future and committed to providing excellent services
- Were concerned about implementation – maintaining services today whilst transforming services into the future
- Varied on the speed that change should be implemented
- Believed that there was a part of the population for whom need wasn't being met – they described it as the 'missing middle'.
- Recognition that access to services is difficult and that waiting times are too long
- Appreciative of the need to develop more person centric care – felt services were designed too much around organisational ease rather than around those who accessed services
- They believed there wasn't parity in the way mental health and physical health was funded or prioritised – there needs to be a shift
- Recognised that whilst stigma around mental health still existed – that this was improving and discussion was more open. Described it as a journey that would take time.
- Felt that as organisational leaders they had an important part to play in raising awareness of emotional well-being and mental health and as employers how staff with needs were supported.

5. ASSESSING THE SCALE

The proportion of UK disease burden due to mental health ill health is 23.8% compared to 16% each for cardiovascular disease or cancer. Even this level is seen as an underestimate. This has an estimated cost to the UK economy of £105 billion a year.

Mental Health ill health affects 1 in 4 of the adult population at any one time and over a third of adults during the course of a year. Lifetime risk varies from 1 in 4 to 1 in 2 in different settings. It is estimated that only 32% of those of clinical levels of mental illness receive treatment. This is dwarfed when one considers those who never come forward for help. This is in stark contrast to cancer where almost everyone receives some intervention.

The number of people experiencing mental ill health is projected to increase by 14% by 2026. The largest increase is predicted to be in the adolescent group (17-19 years old) with a disproportionate prevalence in women of all ages.

The majority of lifetime mental health disorders arise before adulthood and there is strong evidence that the impact of early years disadvantage (whether this is economic, social, relational or educational) has a significant impact in later years. These include poor parenting, childhood adversity (e.g. abuse, loss of parents), poverty, bullying, poor educational attainment and a lack of social relationships.

Poor mental health has a broad range of impacts including health risk behaviours such as smoking, alcohol consumption, poor physical health, reduced life expectancy as well as broader issues such as poorer education and employment outcomes, poor housing and antisocial behaviour and discrimination.

Risk factors for poor mental health include:

- Demographics – such as age and gender
- Socio economic – household income, debt, housing
- Poor Childhood experiences/mental health
- Low self esteem
- Workplace experiences including bullying
- Unemployment
- Poor health behaviours e.g exercise, diet
- Physical ill health – especially chronic conditions
- Social isolation and loneliness
- Life events (e.g. divorce, bereavement)

Conversely, protective factors experienced by a population can have a major impact on wellbeing levels and there is evidence that these can prevent mental ill-heath and suicide.

These include:

- Socioeconomic
- Good parenting/childhood
- Personality
- Education level
- Good social capital including quality and quantity of social relationships
- Living environment
- Having leisure time/activities
- Sleep
- Access to culture and the arts
- Being able to take actions for others e.g. volunteering
- Self- compassion
- Meaning

- Autonomy

Whilst not all these factors are measured at a local level, many are at a national one in the Wellbeing of Wales report. The 2022 report highlights that mental well -being is lower than prior to the pandemic.

Using the Warwick, Edinburgh Mental Health Score (WEMWBS), people were asked about their mental wellbeing. The score ranges from 0 to 70, with the higher the score the better.

Overall the 21-22 score was 49 compared to 51 in 2018-19. On average, younger people had lower scores, with the over 75s having the highest.

People who described themselves in good health had higher scores than those in less well health. Similarly those who described themselves as lonely (39) scored lower than those who described themselves as sometimes lonely (53) or never lonely (49).

Average life satisfaction had been increasing since 2011-12, with slight reductions in anxiety levels. However, the year prior to the pandemic saw a slight deterioration in levels of both life satisfaction and anxiety. This downward trend continued in 2022 data.

The West Glamorgan PNA provides a helpful backdrop to the local area and describes growing pressure on the majority of existing services with significant increases in demand and complexity of referrals. It also explores the potential impact of the pandemic and whilst not at this stage categorical it does conclude that the pandemic has had a significant impact on mental health across the population.

It highlights the work undertaken by The Wales Centre for Public Policy Report ‘Wellbeing and the impact of COVID-19 and Brexit’, which identified:

- That there was evidence pointing to the worsening of the Welsh population since the start of the pandemic, with increased reporting of depression, anxiety, and loneliness and social isolation (Green et al., 2020; Public Health Wales, 2021).
- Predictions of an increase of up to 20% in the proportion of the population needing new or additional mental health support, a significant proportion of these are predicted to be children or young people under the age of 18
- That COVID-19 had dramatically decreased mental well-being across Wales and this has particularly affected young people, women and those in deprived areas.

- That the experience of loneliness has increased, particularly for those who already felt the loneliest.

In conclusion, there is a good understanding of the drivers for poor mental health, this is well documented in much of the literature and is well researched. Measurement of these drivers within the population is less well developed. The Wellbeing in Wales reports attempts to do this at a national level but there is a need to supplement this in a much more granular way locally to support the West Glamorgan PNA. It is also clear that demand for mental health services both locally and nationally is growing. The impact of the pandemic is less clear but there is an understanding that latent demand is present – the expectation is that this will manifest in the next year or two and that demand is likely to be stoked as a result. Waiting lists are already high and there is increasing pressure on primary care in particular as a result, as people in distress try to access services. In addition, there is a recognition that many who would clearly benefit from services don't currently receive support. This is evidenced in the Adult Psychiatry Morbidity Survey and is supported by the findings of similar work undertaken by Public Health Wales. The engagement work undertaken as part of this strategy's development echoes this.

This all supports the need for a different approach focusing on prevention and early intervention if this current growingly pressurised picture is to be addressed and the needs being expressed by the population are to be met.

6. WHAT DO WE KNOW WORKS (from the published evidence)

There is good evidence for a range of interventions which reduce the impact of poor mental health these are summarised below. Some of these are policy interventions, some are evidenced in more practical programmes.

These-

- Prevent mental ill health arise in the first place
- Detect mental ill health at an early stage
- Prevent relapse where ill health has already occurred
- Promote well being

Prevention of ill health in the first place

- Addressing socio- economic inequalities and the development of the Marmot principles.
  - giving every child the best start,
  - enabling all children/young people and adults to maximise their capabilities,
  - creating fair employment, ensuring a healthy standard of living,

    - creating and developing healthy and sustainable places and communities,
    - strengthening ill health prevention

- Perinatal parental interventions
    - Smoking cessation
    - Breastfeeding promotion
    - Reduce alcohol and drug misuse

- Addressing parental mental disorder
- Parenting programmes
- Prevention and addressing childhood adversity
- Prevention of violence and abuse
    - Alcohol associated harm
    - Family intervention
    - School based programmes

- Prevention by addressing particular risk factors
    - Social isolation
    - Physical inactivity
    - Dietary
- Early intervention in childhood mental ill health
- Suicide prevention programmes

Detect ill health early

- Early detection and implementation of evidence based treatment for child and mental health disorders (NICE guidelines)
- Early detection and implementation of evidence based treatments for adults (NICE guidelines)

Prevention of relapse once ill health has occurred

- Implementation of evidence based treatments for mental ill health (NICE guidelines)
- Monitoring and intervention for physical health conditions
- Addressing health risk behaviour – smoking, alcohol, drug use
- Interventions to address socio-economic and housing impact
- Prevention of stigma/discrimination
- Suicide prevention interventions

Mental Wellbeing Promotion

- Starting well
    - Parental mental health and physical health promotion interventions
    - Infant attachment promotion

    - Parenting programmes

- Developing well
    - Pre-school and early education programmes
    - School-based mental health promotion interventions
    - After school programmes
    - School mental health policy

- Living well
    - Promotion of social interactions, (e.g. volunteering, enhancing community engagement, adult learning, social group membership)
    - Physical activity promotion (e.g sports participation)
    - Diet
    - Financial interventions (e.g debt advice)
    - Neighbourhood interventions (e.g. neighbourhood facility regeneration)
    - Housing Interventions (e.g. energy efficiency improvements, green space)
    - Arts and Creativity (e.g. art therapy)
    - Positive psychological interventions
    - Mindfulness, yoga, spiritual interventions

- Working well
    - Flexible hours
    - Training
    - Welfare to work interventions
    - Promoting well- being at work

- Ageing Well
    - social isolation interventions
    - physical activity
    - reablement

There is a strong emphasis within the literature that early approaches which target children and young people have the highest impact and longevity. These are both at pre- birth (interventions during pregnancy) and post birth, through parenting programmes, school based interventions and early detection and treatment of mental ill health.

The next highest impact comes from work based interventions and socio-economic interventions which seek to target the causes of ill health and promote wellbeing.

7. SOME PRACTICAL EXAMPLES FROM ELSEWHERE

Lots of areas of the UK have recognised that continuing to provide services in light of the universal increases in demand that is being experienced, is problematic and

have explored different approaches. All these examples seek to encourage people to take greater control of their health and wellbeing and change the dynamic from 'doing to' to 'working with'. There are different strategies employed and different levels of engagement and none would claim to have resolved all the issues or indeed provide blueprints for this strategy. Indeed some were not set up specifically to improve the emotional and mental health of the population but in practice when measured as an outcome, have done. These are used as examples and provide practical approaches to support the published evidence.

- **Wigan – A citizen-led, system wide approach to health and care**
- **Born in Bradford – A research based approach**
- **Gwent – a psychological approach**
- **Derbyshire – a community engagement approach**

Wigan

Wigan have developed a system wide approach. Faced with significant financial challenges in 2011 Wigan began to look at the way services were delivered and sought to strike a new relationship between public services and local people. Whilst not specifically targeted at emotional and mental health improvement – the outcomes demonstrate an improvement in both. Starting first with different approaches to the way social care staff worked and then morphing into a council wide (and subsequently a system wide) strategy, it became known as the Wigan deal.

The Wigan Deal was truly transformational and worked at a whole system level:

- Developed asset based working – recognising the existing strengths of individuals, families and communities and to build independence and self-reliance and building solutions from these, 'doing with' not 'doing to'.
- Gave staff the permission to innovate. Developing positive risk taking and learning from what didn't work into the culture.
- Investing in Communities. Wigan invested heavily in local voluntary sector organisations and community groups through a dedicated community investment fund. Developing collaborative commissioning arrangements and partnership arrangements (rather than contractual approaches), there has been a focus on growing citizen leadership through things such as community health champions and social prescribing
- Place based working. Neighbourhoods form the basis for integrative working across health and social care teams and other statutory and voluntary partners. Everyone works to the same boundaries which are developed from natural communities.

At the heart of the approach is a positive belief about the potential of frontline staff and local people to bring about improvement. It presents a bottom up approach to

both the development and delivery of services and seeks to build on the existing strengths of the population. The Deal provides key service principles which are encapsulated in a written commitment describing the responsibilities of the council and the public and of the council and its staff. It provides a framework for everything that happens in Wigan.

Bradford

Bradford have developed an academic approach. Whilst there is good empirical evidence of what influences the Health and Wellbeing of families, this is often at a global, national or regional basis. Rarely is it locally understood. Bradford took the view that tracking the lives of over 30,000 Bradfordians would enable them to develop new practical ways to work with families and health professionals to improve the health and wellbeing of communities.

They have developed a comprehensive research programme examining environmental, psychological and genetic factors that impact on the development peri-natally, during childhood and subsequent adult life as well as those that influence their parent's health and wellbeing. It is backed by the Wellcome Trust.

This programme is supported by two things – good data and an innovation hub.

The data is linked using BiB4All as an integrator and links up all health, social care and educational organisations information. It has recently taken this further by accessing information from Voluntary organisations, other research studies and Dept of Work and Pensions to form a live data base. There is a clear understanding of need in Bradford and this research is used to inform the delivery and development of services.

The Innovation hub is also an important supporting function which –

- Supports the development of practical projects emanating from the research
- Brings together academics to evaluate the effectiveness of projects
- Acts as a catalyst for further research and spread of effective projects

Whilst this programme goes beyond Emotional and Mental Well -being into physical health it provides an academic/research based approach to the development of holistic services – tracking the needs of the population and providing a strong base to develop services from and shape new ways of improving their mental health.

A similar, but not identical process, is employed in the Academic Health Science Networks which have been established in England. These innovate service delivery through research and development, including commercial approaches, to gain traction on transformation. They have worked across sectors and have driven

initiatives e.g. ADHD assessment, eating disorder access, which provide solutions through adoption and spread underpinned by academic processes and rigour.

Gwent

Have developed a psychological approach. They work specifically with the Child and Adolescent population and have been enhancing their service since 2014. Wanting to work with communities to support resilience they have developed approaches with communities where solutions come from within. Where the whole community operates in a psychologically informed way.

They work on the basis that young people don't live in isolation and are part of a wider network. This may be family, school or their local community. With this approach in mind they have partnered with a variety of local organisations including third sector, local community clubs and other local anchor points e.g. schools, and developed a service which operates in a 'hold on' not 'refer on' way. They offer a range of skills based activities, such as consultation, training, and programmes of group work, reflective practice and staff wellbeing sessions.

They are taking their psychological skills to the communities, developing those within the communities and by doing so, spreading the ability of communities to prevent the need for psychological referral in the first place.

Whilst they do offer direct consultation, this is not the norm. Preferring to work in a consultative way so that solutions are developed where they are best delivered. This may be at home (through enhancing parenting skills), in the sports club (by working with coaches) or in the school environment (by developing solutions with teaching assistants). The principle is to hold onto the child not to refer them on to psychological services.

They have also developed a number of projects which seek to fill gaps where they see them from the referrals they receive. They form part of the Gwent Emotional Wellbeing panel, led by the Local Authority, which provides an anchor structure for access into services. It is multidisciplinary and multiagency and reviews and agrees the best way to support those being referred into services. Where gaps emerge these are supported with agreed projects such as those below which seek to test and spread alternative service models.

These projects include

- Stronger Roots, psychology in the forest. A specific programme to use nature in a group intervention for referred children
- Parent/Carer workshops. Requested intervention to support a church group
- Parenting with the Family Change team. Developing specific interventions with the statutory sector

- Raglan Football Club. Skills based development of coaches
- Kids4U. Skills based development of 3rd Sector

A similar approach has developed in Manchester with Just Psychology. This has further evolved the model and developed into a social enterprise to form a collective organisation where third sector organisations formally partner with the CIC. This provides an interesting structural possibility for bedding this approach more formally and collectively with communities.

Derbyshire

Derbyshire have developed a community engagement approach. Derbyshire reviewed the delivery of their social services during 2011 and specifically wished to improve their personalisation programme. They had growing demand on services and a lot of complaints about how services didn't work in partnership with individuals but 'did to them'. They wanted to develop a way of involving individuals and working with the strengths of Derbyshire. There was a vibrant 3rd sector and actively engaged communities where volunteering and community spirit was very present. They looked to a model which had developed in Western Australia and which was developing in a small number of local authorities in the UK with varying success – Local Area Co-ordination.

It provided a practical assets based approach which operated in a way which developed strong partnerships with specialist, statutory and funded services as well as local people, families and communities. Starting with 2 wards which were seen as the most fertile, the service has spread across Derbyshire. It works with communities to strengthen existing activities and grow new ones at the same time as working with individuals who have been referred or introduced to them including health practitioners, schools or people themselves concerned about an individual in their community. A big feature of the referrals are around social isolation (75%) with financial difficulty also prevalent (35%). It takes a holistic approach and seeks to work with individuals and develop specific plans to help them, working with the existing range of options available within the community. It is much more than a signposting service as it continues to work with individuals until the goals are met. It also seeks to work with communities to develop solutions where gaps are being identified through the casework.

The service has been academically evaluated and demonstrates a reduction in social care packages, demand for secondary mental health services, reduction in crisis health interventions (mental and physical), sustainment of tenancies and improved wellbeing scores.

Local Area co-ordinators are embedded within a community and work in partnership with local people, services, organisations and statutory partners. They do not solve

people's problems for them –their aim is to build individual, family and community capacity so that there is less dependency on services.

Similar, third sector delivered approaches have developed through ReCoco and by the NHS through the Grenfell Health and Wellbeing Service set up in response to the Grenfell Tower disaster.

Social prescribing which is being spread throughout the UK is a not dissimilar model but operates more as a signposting service rather than growing and developing local assets. A good example of where social prescribing and Local Area co-ordinators have formed a collaborative arrangement is in York where they operate complimentary approaches with one offering short term/signposting intervention taking referrals from GPs and the other more deeply embedded into the wider community offering longer term support. The key is the relationship that exists between the two is excellent and the social prescribing service is seen as one of the many assets available within the Local Area Co-ordinator catchment.

8. WHERE IS SWANSEA/NPT POSITIONED – THE CASE FOR CHANGE

The features of the system at present are summarised below;

- **Integration is fragile**

This is between the statutory sector organisations and the statutory sector and 3rd sector. The third sector, whilst frequently competing for resources due to the bidding processes which form the basis for RIF funding, do work together more cohesively, but not to the degree of those highlighted above. This results in complexity and confusion for those using services and makes strategic planning difficult. It also leads to distrust, a lack of overall ownership, conflict and at worst service design which is defensive (i.e. to protect my budget, my staff, my organisation), rather than offensive and seeking to address the needs.

- **Criteria based care management is very tight**

Demand on the system is such, that secondary care services have increasingly focused their resources on the most at need and most complex. It is described as 'core services'. This is wholly understandable and is a feature of many under pressure systems. In order to maintain safe and effective care, waiting lists have also grown - which means access for those with lower needs becomes problematic. They either deteriorate until they become unwell enough to gain access or they create pressure for primary care, try direct access services provided by the third sector, ring 111 or seek private support. We can see this in the responses to the engagement work. There is a gap.

- A lot of services have developed to address this lower level need

There are a plethora of services in place which are often small, short-term funded (projects or pilots), not linked across the system and struggling to recruit and maintain themselves. There is quality oversight by commissioners and RPB, but there is little 'professional' join up, such as there is in Gwent. As seen in the Gwent 'hold on not refer on' model it enables other services to meet higher acuity needs, improve quality, helps to recruit, ensures professional development is in place and provides a quality framework which reduces the bureaucratic burden of reporting and develops measurement tools which are dynamic.

- **The third sector fills gaps**

As is described earlier in the outputs of the engagement work, the third sector is high quality, vibrant and engaged within the region. They are, however, increasingly struggling to meet the level of complexity and could, with more join up with both the statutory sector and each other support, flourish and really innovate. There are a number of examples of exciting and potentially ground breaking projects which are ripe for development but currently work on a project basis. Their philosophies are such that they are well placed to work in and with communities. The model in Wigan emphasised the third sector in its Wigan Deal, and developed long term joint commissioning and delivery arrangements which reduced the burden on this sector and enabled them to truly form part of a system based model

- **Information is difficult**

Understandable, granular data/information which drives needs assessment and truly measures emotional wellbeing is not really in place at a local system level. Where information exists it is organisationally based, not joined up and makes it difficult to easily plan at system level.

The PNA does an extremely good job of bringing this together, but can only work with that which is currently available. As seen in Bradford – which in fairness is a well -supported and developed research project; data and research has been used to develop services. It has supported this in dynamic way and uses it to fully understand the needs of the population and apply rigour to the evaluation and design of services.

- **Anchor structures are not in place**

Access into services is confusing. There are multiple access routes, different criteria, 111 isn't really a single point of access as it only covers health and third sector services each have different access arrangements. This leads to people ending up in services which may have not been the most appropriate for their needs but the easiest to access or worse gaining access when their needs are so high that they reach crisis points – and their emotional and mental health has deteriorated. It also means that they require services, when there may have been simpler solutions

available. In Gwent, where there had been similar complexity – an Emotional Wellbeing Panel is in place. This is multi agency/multidisciplinary and spends a significant amount of upfront effort on getting the best solution for individuals. The principle is not to pathologise and to get the most simple, most effective response in place at the start. They also use this process to recognise gaps and seek to develop solutions to these.

9. TAKING THIS FORWARD – A STRATEGIC FRAMEWORK

Building on the engagement feedback and needs/evidence base, coupled with examples of successful models from elsewhere the following presents a strategic framework for taking this forward in the Region.

VISION

To have vibrant, diverse and individually focused services which promote emotional and mental wellbeing, are delivered and commissioned in a dynamic and integrated way, adopting innovative models and promoting the strengths of communities to improve the lives of those in the Region.

AIMS

- To focus and promote emotional and mental wellbeing (rather than illness)
- To enable communities to generate solutions for themselves, work from their strengths supported within a dynamic multiagency environment
- To truly join up commissioning and provision of services to support service design around the individual not the organisation
- To work to a common set of values and service model principles which permeate everything we do and the way that we do it
- To underpin this with a good understanding of the need supported by granular data/information
- To develop and deliver services which are supported by the evidence and ensure that there is a strong underpinning emphasis on research and development within the Region to add to the evidence base

VALUES

- We design services around the individual
- We operate in an enabling and dynamic way
- We develop community resilience and move away from service dependence
- Our overall strength comes from each other's strengths – we work together to achieve the best outcome for our population
- We underpin everything we do with information and evidence
- We recognise that we each have a unique contribution and seek to use these to support the development and delivery of services

THE SERVICE MODEL PRINCIPLES

- Move from crisis to preventative focus
- Intervene early and quickly
- Are provided on a multiagency/multidisciplinary basis
- 'Hold on, not refer on' individuals so that help is provided at the lowest and most appropriate level
- Minimise the need for complex care by supporting individuals early, appropriately and with the correct level of support
- See relationships as the vehicle for resilience and emotional wellbeing
- Have anchoring structures which provide cohesion, e.g panels, MDTs
- These anchor structures are dynamic and work with the membership components to ensure that the optimum solution is reached on an individual basis but also seek to fill gaps in provision where these emerge
- Are open and empowering with service users and other professionals. They skill and information share
- Equal partnerships form the bedrock
- Don't pathologies or start with the problem, but build on the strengths either of the community or individual
- Are holistic and person focused – believe physical and mental health are one and that service users are the expert in their experience
- Work as part of a system of care
- Innovate and evaluate but aim to mainstream
- Devolve and evolve, to and with communities
- Provide strong integrated leadership at service and system level
- Seek to build solutions with communities
- Don't bureaucratise, but still measure
- Work with evidenced based solutions – or where these are less clear, seek to evidence themselves.
- Rigorously evaluate everything they do and develop new approaches from this evaluation
- Are data hungry and use this to develop information to evaluate themselves
- Are inquisitive and seek to evolve

10. TAKING THIS FORWARD – TAKING IT INTO PRACTICE

Moving the strategic framework forward into a clear plan for action, the following represents the delivery approach. There are 4 themes:

- Joining it up
- Cementing it together
- Filling the gaps
- Truly understanding the need and evaluating what we do

These are supported by a 3 phase delivery process spanning the next 3 to 5 years.

Phase 1 represents the establishment of the project structures, the framework, the governance, operating principles and project plan (and business case, where necessary)

Phase 2 represents the implementation phase with milestones and identification of risks to delivery

Phase 3 represents the evaluation phase and reframing the priorities in light of implementation, which will form the basis of the programme refresh

The following represent the actions to support each of the themes;

Joining it up

- Integrating statutory commissioning, supported by a joint framework based on the vision, aims and service model principles
- Integrating community based statutory provision – to develop a joint community service with one management structure
- Encouraging the development of a 'chambers model' (led by CVS) for all community counselling and psychological therapies to provide a single offer which meets the 'service model principles'. The aim is to develop a loose organisational structure which brings together services into a more cohesive model.
- Pooling statutory budgets for emotional and mental well- being, within agreed parameters/governance, with a view to devolving to an enhanced LAC structure over the lifetime of the strategy

Cementing it together

- Developing anchor structures to support access into services (a truly integrated front door and extending 111 beyond its current remit as well as establishing emotional and wellbeing panels)
- Using these anchor structures to provide individual care planning at a multiagency level (getting it right at the start)
- Enhancing and developing the existing Local Area Co-ordinator structures, jointly with CVS, to provide the focus for asset development and community responses to emotional wellbeing.

Filling the gaps

- Develop a community psychology service led by SBUHB. In the first instance focusing on children and young people with the aim of extending this,

supported by the need and evaluation model described below, into adult services. This needs to be achieved within the timeframe of this strategy.

Understanding the Need and Evaluate what we do

- Establish a joint programme specifically on emotional wellbeing, supported by Public Health and Swansea University to
    - develop research into practice methodologies
    - develop a granular information base which assesses the regional need
    - develop an academic evaluative process for service development/delivery

11. TAKING THIS FORWARD – A PRIORITISED TIMETABLED PROGRAMME

The following section seeks to place the themes into a timetabled programme using the phased approach described above. This is indicative at this stage. Some pieces of work have interdependencies and have, therefore, been timetabled together. Others are more standalone but have a level of urgency attached to them.
A programme approach is suggested, which would re-orientate the existing RPB structure for emotional and mental wellbeing. Given the very nature of the work however, this will need to be strongly owned and in some cases, led, by all organisations involved in the programme.

Theme 1. **Joining it up**

Action	Phase 1	Phase 2	Phase 3
Integrating statutory commissioning	June 23 - March 24	April 24 – March 26	April 26 – April 27
Integrating community provision	April 24 – March 25	April 25 – March 26	April 26 – April 27
Encouraging a ‘chambers’ model	September 23 – March 25	April 25 – March 26	April 26 – April 27
Pooling Budgets	June 23 – March 24	April 24 – March 26	April 26- April 27

Theme 2. **Cementing it together**

Action	Phase 1	Phase 2	Phase 3
Develop anchor structures	June 23 - March 24	April 24 – March 26	April 26 – April 27

Develop individualised multiagency care planning	June 23 – March 24	April 24 – March 26	April 26 – April 27
Enhance the Local Area Co-ordinator Structure	September 23 – March 24	April 24 – March 26	April 26 – April 27

Theme 3. **Filling the gaps**

Action	Phase 1	Phase 2	Phase 3
Develop Community Psychology Service	June 23 – September 24	September 24 – March 26	April 26 – April 27

Theme 4. **Understanding the Need and Evaluate what we do**

Action	Phase 1	Phase 2	Phase 3
Establish a joint programme specifically on emotional wellbeing	June 23 - March 24	April 24 – March 26	April 26 – April 27

Given the step change in approach, careful thought on the programme support needs to be given – including organisational development input and overall programme leadership.

12. CONCLUSION

In summary, this strategy represents a shift in approach. It looks at mental health as a continuum along which each of us travels and seeks to shift focus from ‘illness’ to ‘well-being’. Services for people who have enduring mental illness will continue to be a priority but the vast majority of the population need differing levels of support as they travel through life and this strategy focuses on their emotional wellbeing. It seeks to develop earlier and more preventative approaches. It aims to support people to live their lives in the communities they inhabit. It aims to develop a focus on enabling people to access help when and where they need it, but predominately it seeks to support people to live their lives without needing access to services in the first place.

The general public have told us that they only access services after they have exhausted their immediate sources of support. When they do seek help they need

that help quickly and to be able to access it simply. They need the right help and they need it for only as long as necessary.

We need to reformulate the way we approach this and design services which are joined up, hold on not refer on, develop dynamic approaches to individuals needs and ensure these are within an evidenced based environment. We need to fully understand this need at a population level and continuously strive to meet this in the most appropriate way.

There is work now to translate this strategy into a programme of work which delivers it. There needs to be a commitment to do things differently and to evolve services which support people to live their lives not ‘do things to’ them. This is a shift in approach which will need to be carefully implemented and delivered, but which begins to meet a need the public have described.