NHS

Bath and North East Somerset,
Swindon and Wiltshire

Integrated Care Board

Mental Health Strategy

2025 - 2030

Introduction

Introduction

We are delighted to share the Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (BSW ICB) mental health strategy with you. It is a transformational roadmap for the next five years and covers all ages and localities in BSW. Whilst this strategy is focused on the responsibilities and requirements of [ICB] mental health commissioning, it makes strong commitment to operating within the BSW Integrated Care Partnership to ensure we support and enhance an integrated system approach across ever level of need and sector of provision.

Led by the BSW ICB, the vision, strategy and our ambitious commitments have been co-produced with people from across our geography. This includes people with lived experience of mental health, their families and carers, and the professionals who deliver and lead the array of mental health services we offer.

BSW ICB has drawn upon the expertise of the National Institute for Health and Care Research Applied Research Collaboration West (NIHR ARC West) to help develop the strategy.

We have looked at existing and emerging national policy and evidence, including Lord Darzi's report into the state of the NHS in England, and welcome the ongoing national conversation about a 10 year health plan that will help further shape the delivery of our strategy.

The ARC West team analysed population health data, alongside holding extensive engagement and co-production with stakeholders. This included interviews, focus groups, workshops, patient and public involvement meetings and reviewing recent pre-existing co-production work.

This strategy is the cumulation of that work.

It takes a lifespan view of mental health. Where we refer to people in our strategy, this means all people – so children and young people, adults of working age and older adults. Where possible, it is deliberately age-agnostic. Over the course of the next five years, we will commission our services to embed and deliver the co-created conceptual model of care.

Our strategy commits us to essential improvements to ICB commissioned services over the next five years to ensure we achieve good mental health for the people living in our area. It is founded on what people have told us matters and is important to them.

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Welcome

Sue Harriman

Chief Executive Officer, Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

The publication of our BSW ICB five-year Mental Health Strategy is a pivotal moment for the future of mental health services in our area and I am delighted to present it to you.

This Strategy is a tangible example of collaboration in action, building on the multiple examples of excellent partnership working in BSW. Improving mental health services is close to my heart as my previous career in a community and mental health trust demonstrated how these vital and often life-saving services can be overlooked.

Over recent years we have achieved a high and more positive profile for the importance of mental health services, with initiatives such as the Parity of Esteem agenda, helping address inequalities within the health and care system – but we know there is much more to do.

The success of this Strategy and its aims will require everyone involved in the development and delivery of mental health services and support to play an active role in transformation. We know that our services require targeted investment and action and that they need to work in a more seamless and personalised way, ensuring that the people of BSW can get the care and support they need in the right way, at the right place and at the right time.

This strategy sits alongside the BSW Integrated Care Strategy, where the three overarching objectives are the foundation stone for the vision set out within this Strategy:

- Focus on prevention and early intervention
- Fairer health and wellbeing outcomes
- Excellent health and care services

We have worked closely with our partners to set out what we will do to improve the mental health of people in BSW, to better support those with mental ill health and to reduce mental health inequalities across our Integrated Care System.

This Strategy will be supported by a delivery plan with clear outcomes, which is co-developed and delivered by the system. We will put this in place shortly after this Strategy is published. We will also look to the publication of the national 10 Year Plan for Health in 2025 to help us further refine and support the delivery of the Strategy.

This is an exciting time for mental health services in BSW. I hope this Strategy will act as our ‘true north’ as we work together to help the people of BSW live longer, happier and healthier lives.

Sue Harriman, January 2025

Foreword

Anna Ferguson Montague

Chair of the strategy's patient and public involvement group

I got into mental health advocacy because of my dad, George. He used secondary mental health services pretty much all his life. So I helped my mum care for him.

Over the years of caring for my dad, I saw first-hand the impact that funding cuts had on mental health services.

He started out with lots of support. In the 90s he had access to occupational therapy groups, talking therapy groups, he had a home support team who came to the house once a week. This all helped him cope with some of the issues he was facing.

But as time went on, the thresholds for accessing services became higher and my dad didn't meet them. The services kind of fell away.

Of course, times have changed since the 90s. This abundance of services is unlikely to return any time soon. I've worked in mental health myself, so I understand the pressure and stresses people are working under. But I hope that this strategy will help the BSW Integrated Care System do more with what they've got.

It identifies the pinch points and areas in the system where change could make a real difference to the people who use services. We've gone through an inclusive process to develop it. It's informed by the experiences of service users and carers.

While developing the strategy, people shared some really difficult experiences with us. They had the space to be open and honest. It was great to have that environment to talk about these experiences in a supportive way.

Despite these difficult experiences, I really felt there was an atmosphere of hope during these conversations. People really wanted to think about what could be different, to use their own experiences to help improve care for others.

Since losing my dad, being involved in work like this has helped me deal with my own grief.

My hope is that this strategy will lead to better mental health care for people in our BSW geography in the future. That would be a fitting legacy for my dad.

Anna Ferguson Montague, May 2024

Executive summary

Overview of the 2025-2030 BaNES, Swindon and Wiltshire All Age Mental Health Strategy

Our person-centred strategy sets out the transformational commitments that will drive essential improvements to BaNES, Swindon and Wiltshire (BSW) ICB commissioned services and a roadmap for the next five years. The strategy offers a life-span view, from pregnancy and birth, through childhood and adulthood, to older adults. It is for every person living in BSW regardless of diagnosis, demographic or protected characteristics. The strategy is specifically focused on mental health services within the commissioning remit of the ICB; in recognition of the importance of prevention of mental health onset, as well as emotional wellbeing, and achieving the "left shift"references and commitments to supporting partnership working regarding these areas are made throughout the strategy. The strategy commits us to shaping our implementation plan with agility in order to respond and ensure compliance with future national directives and government objectives.

Enable good mental health for the people living across BSW through delivery of the following strategic commitments

Timely access to high quality services for everyone → People's voices and experiences held at the heart of how we commission and transform services → Commissioning of outstanding, evidence-based, high quality and sustainable services → Commissioning of holistic care, support, assessment and treatment/ intervention → BSW mental health and care system is a great place to work → People can access evidence-based, early intervention and treatment so that people achieve their goals and outcomes

Commission services and lead partnership forums to:

Implementation Phase	High-level actions:
Foundations for the future – 2025-2026	• Development of key service lines/areas: CYP trauma integrated pathway, Talking Therapies, Community MH service 2+ contacts, in-treatment/service waits • Implement key programmes of work: Inpatient Quality Improvement Programme (inclusive of Community rehabilitation) • Full pathway and service reviews, setting corresponding development plans and/or commissioning intentions: Memory/Dementia, CYP (inclusive of s75/ jointly commissioned services) • Service level return on investment and outcome evaluation informing right sizing and shaping our commissioned provision (undertaking will span the 5 years of the delivery plan)
Transforming our care models – 2027-2028	• Develop service specifications - integrated model of community-based mental health provision (adults and children) • 'Right-sizing' inpatient mental health capacity (adults) to deliver improved pathways • Implementation of next steps from phase pathway, service reviews and right sizing/shaping evaluation
Partnerships for the future – 2029-2030	• Establishment of an all-age mental health provider collaborative

What can people and system stakeholders expect next

- Continued commitment through action to operating within the BSW Integrated Care Partnership to ensure we support and enhance a unified system approach across ever level of need and sector of provision.
- Publication of the implementation plan in Q2 2025/26.
- Published bi-annual implementation plan updates, accompanied by an overview of impacts and outcomes.
- Continued coproduction opportunities to review the content, impact and outcomes of the implementation plan, refine in light of progressing population needs and national directives – ensuring they are tailored to our systems preferences and population requirements.

Executive summary

We are committed to ensuring BSW mental health services [commissioned by the ICB] are accessible and of good quality, and we have high aspirations to make this a sustainable reality for our population.

The strategy offers a life-span view, from pregnancy and birth to older adults. It is for every person living in BSW regardless of diagnosis, demographic or protected characteristics.

Our strategy sets out the transformational commitments and a roadmap for the next five years. The strategy will be complimented by an implementation plan, which will be a "live document" co-produced with stakeholders [including experts by experience], holding our mental health system to account for its' delivery; this will commence development in early 2025/2026.

This strategy has been developed through analysing population needs, as well as listening to people that live in BSW, people with lived experience of mental health, which includes personal experience, family members and carers, and system stakeholders. The strategy offers a life-span view, from pregnancy and birth, to older adults and is for every person living in BaNES, Swindon and Wiltshire regardless of diagnoses, demographic or protected characteristics.

We recognise that there are many factors that influence an individual's mental health and wellbeing, and that's why our partners across BSW are critical in the successful delivery of the strategy. Whether that's housing, employment, education or other areas, the BSW system will work in partnership to effectively support our population at the earliest opportunity and offer support in the most appropriate setting.

Our ambitions are also grounded within a learning culture; whether that's learning from incidents, to adopting recommendations as an outcome of safeguarding reviews and partnerships, we are committed to setting a positive culture to continuous learning and improvement.

Whilst there are a number of key enablers, we recognise that recruiting and maintaining a workforce that is valued, supported, and of high quality is central to the success of our strategy.

Strategy will link to wider BSW ICS strategic programmes and published strategies (appendix) and will be reportable through the BSW ICB Board.

We're excited to bring about changes to our mental health system to enable those that live within BSW to have good mental health.

By 2030 BSW ICB will commission services to

Population experiences

1 Enable people live a mentally health life from birth.

2 Reduce the morbidity gap between those with severe mental illness (SMI) and the general population.

3 Reduce the prevalence [against the trajectory] of mental health and Dementia. Enable people to live well with Dementia.

4 Prevention and intervention should start early, in education settings.

5 Eliminate out of area admissions for acute inpatient admissions [across all ages].

6 Reduce the length of stay for inpatient admissions.

7 Significantly reduce self-harm and suicide.

8 Assess, treat and support people in suitable environments [where possible] in their local community.

9 Eliminate mental health Emergency Department presentations where there is no physical health need.

10 Increase community mental health awareness and mental health literacy.

11 Improved outcomes across services; focus on holistic, person-centred outcomes (eg DIALOG+).

Services

12 Right size and shape our inpatient provision to create more localised care for our population.

13 Commission services proportionately too need [early in onset/presentation].

- where possible [evidenced and clinically safe] redirect investment from high acuity areas without need to community provision [close beds, expand the multi-agency integrated primary care offer]. /Reduce our spend on inpatient care (for adults) and specialist placements.

14 Have a sustainable trauma-informed health eco-system.

15 Have co-production at the heart of service design, delivery, evaluation and evolution.

16 Structure services to meet people's holistic [bio-psycho-social] needs [across all ages].

17 Commission fully integrated community services that create seamless pathways between early help and more specialist care in the community.

18 Have bespoke pathways for children with complex trauma in partnership with our local authorities and shift spend accordingly to support improved outcomes.

19 Shape services to positively respond to community demographics, reducing health inequalities. We will balance resources with risks and outcomes across the system, ensuring the sustainability of services.

20 Ensure equity of provision across our geography with no unwarranted variation in the services available.

21 Set up open-access, multi-disciplinary and multi-provider teams in the community, working seamlessly with GPs, the voluntary sector and local authorities to provide person-centred, co-ordinated care that meets the needs of people and their family, friends and carers.

22 Make the BSW mental health system a 'great place to work' so that we can staff our services effectively/efficiently.

Our vision and aims

Our vision and aims

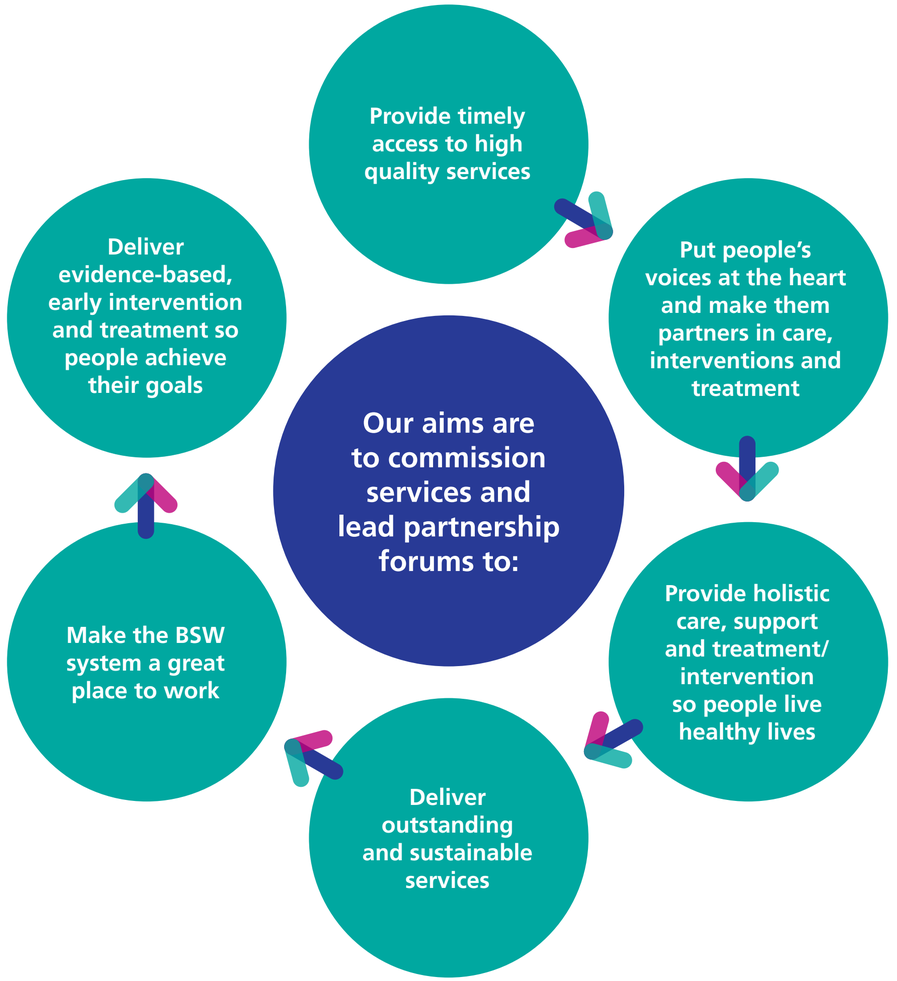
Vision

We will ensure accessible, high-quality care and evidence-based effective treatment(s), provided at the right time to meet an individual's need, local to them. This will be delivered through person-centred, co-ordinated care approach that meets the needs of people, their families, friends and carers.

Aims

Our mental health strategic aims are aligned to the ICS's model of care, and will direct the ICBs commissioning and approach to system leadership over the coming five years to:

- Enable timely access to high quality services for everyone across BSW
- Put people's voices and experiences at the heart of how we commission and transform services. Make people true partners in their care and treatment/intervention
- Commission holistic care, support, assessment and treatment/intervention so that people live with good mental health
- Commission outstanding, evidence-based, high quality and sustainable services
- Make the BSW mental health and care system a great place to work
- Enable people to access evidence-based, early intervention and treatment so that people achieve their goals and outcomes



Our strategy

Our strategy

The Bath and North East Somerset, Swindon and Wiltshire (BSW) ICB mental health strategy gives an overview of our priorities for the next five years, and the enablers and values that will help us achieve them. All of these will ensure we deliver our vision and aims for the population of BSW.

Our strategy aims to:

- Be ambitious and transformational
- Be applicable across the system
- Be service, condition, provider, population group and age 'agnostic'
- Reflect local and national priorities
- Bring together a wealth of data and information, including documentation analysis, interviews and workshops to gather the input and views of providers, service users and carers

In this strategy, we do not intend to explicitly explore or propose diagnostic or service care pathways. However, it does describe important points in pathways, such as starting and stepping down care.

It is deliberately designed to be applicable across all diagnoses. This reflects our ambition to provide needs-led care that supports people to maintain good mental health across all care and treatment settings. However, there are diagnostic specific commitments national directives require a targeted approach.

The strategy is specifically focused on mental health services within the commissioning remit of the ICB. Prevention of mental health onset, and emotional wellbeing are incredibly important, and references and commitments to supporting and partnership regarding these areas are made throughout the strategy. However, the management and therefore strategic approach will be depicted through our prevention programme, and commissioning led by our Local Authorities.

The strategy may mention other conditions such as learning disability, autism and physical health long term conditions. The strategic detail and plans related to these areas of service provision are not included in this strategy.

Who is the strategy for?

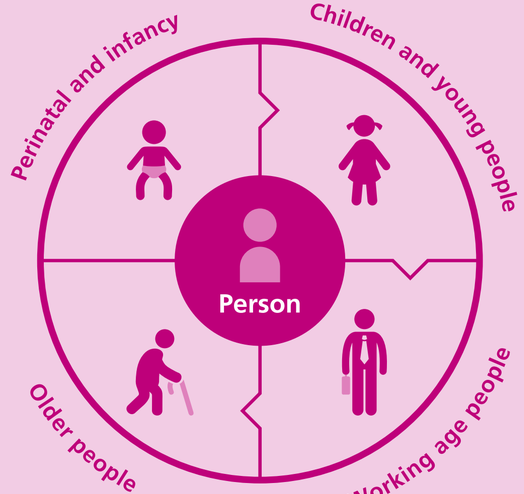
This strategy is primarily aimed at those in our system delivering care and support, as they are key leads in delivering the strategies commitments. However, we want the strategy to make sense and be readable to everyone, especially service users and carers.

A person-centred strategy

At the centre of our strategy are the people who use our services. You will see them represented at the centre of the strategic model. This person represents everyone who uses our services, regardless of demographic and protected characteristics. This includes age: children, young people, working age adults and older people are all represented in our model.

The term ‘person’ is used throughout our strategy. It applies to those who directly access our services, regardless of the nature of support, care or treatment they are receiving.

It is a person-centred strategy



The role of partners in delivering our strategy

Our partner organisations are critical to the delivery of our strategy. A partnership approach to transformation is essential to improve population mental health, to enable reach outside of the ICBs commissioning scope to factors which we know result in high risk of future mental health, for example experiencing childhood trauma, poor housing, and problem debt.

To achieve our strategic commitments, we will continue to work with:

- Our local authorities to support early help, prevention and broader social needs across our communities, supporting people to make best use of the services commissioned by local authority partners.
- Our Third Sector organisations – making better use of their skills and expertise as the first point of contact for all people across BSW and enabling them to actively ‘walk alongside’ individuals throughout their mental health pathway, and deliver a wide range of effective interventions.
- Our mental health Trusts– enabling evidence-based, clinical interventions and treatment to be delivered at the right time and in the right place for our population.
- Our wider partners such as the Acute Trusts, community healthcare services, primary care, ambulance service, police, criminal justice services and specialist inpatient service providers to ensure that we support people holistic and multifaceted requirements of our population.
- Other systems – we will continue to work with other ICBs to learn from them and collaborate where it will improve outcomes for our population.

Our context

Local and national drivers

There are many external factors informing our mental health strategy for BANES, Swindon and Wiltshire. These include legal, structural, policy and social directives as to how we deliver mental health services and support.

Integrated Care Systems and Alliances

The restructuring of regional NHS services into Integrated Care Systems (ICS) promotes a whole-system approach to mental health. The BSW ICS includes an array of organisations, which includes local health service providers, health (ICB) and local authority commissioners, Local Authority services, Third Sector organisations, council officers, and public and voluntary groups. BSW ICS includes three place-based Integrated Care Alliances (ICAs) for each of the three localities [Bath and Noth East Somerset, Swindon and Wiltshire].

The focus on local population health needs through ICAs, with the ability to scale down further to neighbourhood level, and our overarching mental health system ambitions are a powerful combination. Together they provide the platform for us to design and deliver integrated mental health services to meet local needs.

This structure is an opportunity to develop more person-centred, local, pro-active and preventative mental health services to meet the needs across our population.

Core 20+5

As part of the UK Government's commitment to reduce inequalities in health and care outcomes, all systems must work towards a Core 20+5 approach. This means focusing on improving outcomes for those who:

- Live in the most deprived 20% of the population (as defined by the index of multiple deprivation)
- Live in one or more of the population health groups across the system where health and care experience, access or outcomes are disproportionately lower than for other groups

The Core20Plus5 defines 5 clinical areas of health inequalities that systems should target. Mental health is a feature of both adult and children and young people's Core20Plus5, specifically:

- For adults: ensuring annual physical health checks for people with serious mental illness to nationally set targets as a minimum
- For children and young people: improve access rates to services for 0-25 year olds for certain ethnic groups, age, gender and deprivation

The UK Government's mental health priorities

The mental health of children and adults is one of 6 major conditions that the UK Government is focusing on from 2023 to 2028. The Department of Health and Social Care's mental health priorities for England include:

- Starting early to promote mental wellbeing and prevent problems
- Increasing access to mental health services
- Integrating physical and mental health care
- Providing early intervention to support people with mental ill health

The NHS Long Term Plan 2019-2024 committed to ring fence money for mental health and to invest in it at a faster rate than the overall NHS budget. Although the plan period ended in March 2024, there is more to be done to improve and develop services. We anticipate a new national 10-year mental health plan will be published in 2025, building on the NHS Long Term Plan commitments.

Changes to the Mental Health Act

The Mental Health Act is being updated, with the changes coming into law soon.
The draft Mental Health Bill 2024 includes 4 guiding principles for children and adults:

- **Choice and autonomy** – ensuring service users' views and choices are respected
- **Least restriction** – ensuring the Mental Health Act powers are used in the least restrictive way
- **Therapeutic benefit** – ensuring patients are supported to get better, so they can be discharged from the Mental Health Act
- **The person as an individual** – ensuring patients are viewed and treated as individuals

Think Family - NHS Safeguarding (safeguarding-guide.nhs.uk)

We know that the mental health and wellbeing of parents/carers can have a profound impact on children and young people.

Availability of parents/carers to sufficiently meet the attachment needs and have quality interactions with their child, particularly in the earlier years, is critical for healthy brain development and the future mental health and wellbeing of the child. Parents capacity for such interactions can be reduced directly by the parent's own health and wellbeing challenges (e.g. mental health needs, disabilities, drug and alcohol problems) and/or indirectly by environmental factors (such as domestic abuse, financial stress, poor housing) which can cause overwhelming stress for parents.

All too often, adult services work in isolation, treating the individual but not looking at the wider impact on the family around them. The Think Family approach aims to address that, with services required to work together to not only support and treat the individual but to consider the needs of affected children and young people.

Systemic support (Children Act, 1989 Children Act 1989 (legislation.gov.uk)) is essential to achieve the best outcomes, ensuring early help with a partnership approach operating with agency around the child/young person and their family/carer, aiming to sustain the family network, or achieve reunification where possible.

Patient and carer race equality framework

NHS England's Patient and Carer Race Equality Framework was published in October 2023. Mental Health Trusts and providers are required to embed the framework as they progress to becoming actively anti-racist organisations. It aims to ensure children and adults from racially minoritised communities have better access to services through a focus on leadership and governance, data and feedback mechanisms.

Right Care, Right Person

Right Care, Right Person (RCRP) is a new model to address how the police and health services can work together to ensure that people are enabled to access the right service for their mental health needs. RCRP is currently being phased into operation and is being rolled out with a partnership approach. Local management of RCRP is working on an ongoing basis to improve and enable the best use of the capacity and capability across the system to support people in crisis through routes other than police intervention. Initial phases went live in April 2024, and the full programme in place by the end of 2025-26.

Mental health, learning disability and autism inpatient quality transformation programme

This programme focuses on new models of care for people with mental health, learning disability or autism who require or are at risk of admission. It defines the workforce, skills, competencies, values and approaches to transform care for these people, aiming to improve the quality and safety of care provided. ICBs co-produced responsive plans that will enable people to access inclusive, personalised, effective therapeutic care which achieves the best outcomes for the individual in the least restrictive environment. For BSW we have and continue to ensure a joint approach across the MH and LDAN programmes in the development and oversight of the local plan. The high-level commitments of the BSW plan include:

- Developing a strong quality improvement approach for our inpatient settings
- Embedding the Culture of Care Programme
- Addressing health inequality experienced when accessing services
- Implementation of "Your Team, Your Conversation, Your Plan" [in place of the care planning approach]
- Expanding inpatient workforce with Clinical Leads and therapeutically trained staff
- Delivery of trauma informed training across ward staff

Post-pandemic

The pandemic impacted many people's mental health, but especially some groups. The World Health Organisation (WHO) has published several studies on the global impact of the pandemic on mental health. Key conclusions include:

- There was a significant increase in mental health problems in the general population in the pandemic's first year
- Being younger, female or having pre-existing health conditions were often reported risk factors
- Higher risk of suicidal behaviours occurred among young people
- Among people living with mental disorders, illness severity and mortality increased with younger age
- Psychological interventions studied were effective at preventing or reducing pandemic-related mental health problems, though data is limited

Since the pandemic, depression and anxiety rates have increased across the UK population. Self-harm and anxiety have increased among children and young people. The long-term impact on mental health, and consequent demand for services is currently being researched.

NHS workforce were celebrated during the pandemic, and workforce wellbeing gained a national profile. Operational policy, practice and support related to workforce wellbeing has been retained as a key learning point following the pandemic.

Wider determinants of mental health

Mental ill-health is influenced by a range of factors, especially experiencing trauma. Around 1 in 3 adults have experienced some form of trauma life event, which can lead to both common and serious mental illness. Compounding factors such as living in poverty, homelessness, unstable or temporary housing, social isolation and debt can all affect mental health and wellbeing at any age.

People with mental health needs can also have drug and alcohol misuse problems.

The on-going cost of living crisis will increase the number of people needing support for mental health issues impacted by financial distress. The cost of living also disproportionately affects children and young people, with higher numbers of children and young people living either in poverty or on the edge of poverty. BSW rates have continued to grow in recent years as shown in the table on the next page.

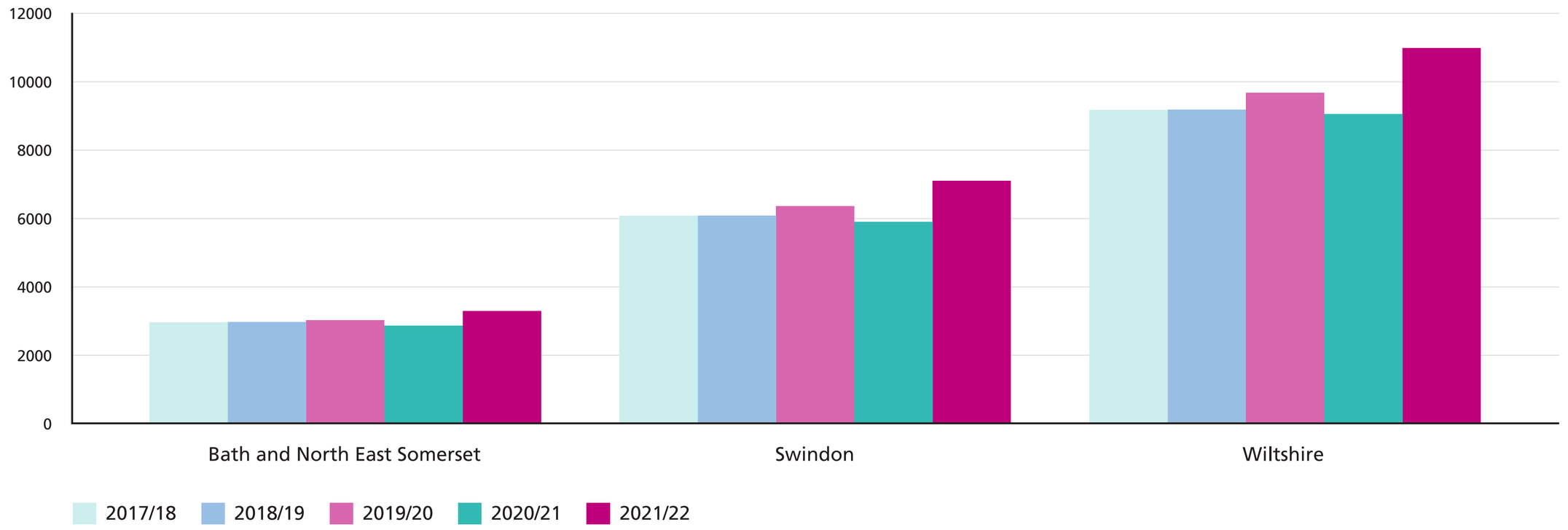
In order to enable people to have good mental health we must shape and connect support for the wider determinants of mental health and wellbeing. Taking a trauma-informed approach, must be at the heart of what we do at every stage of the life course, as this enables sensitivity and compassion to these factors, which may go unknown entirely or until they are shared. As many services supporting the wider determinants of MH are outside of the ICBs direct commissioning scope, this emphasises the importance of a partnership approach to transformation and service delivery.

Around

1 in 3

adults have experienced some form of traumatic life event

The number of children and young people living in absolute poverty as measured by government (Stat-Xplore - Table View (dwp.gov.uk)):

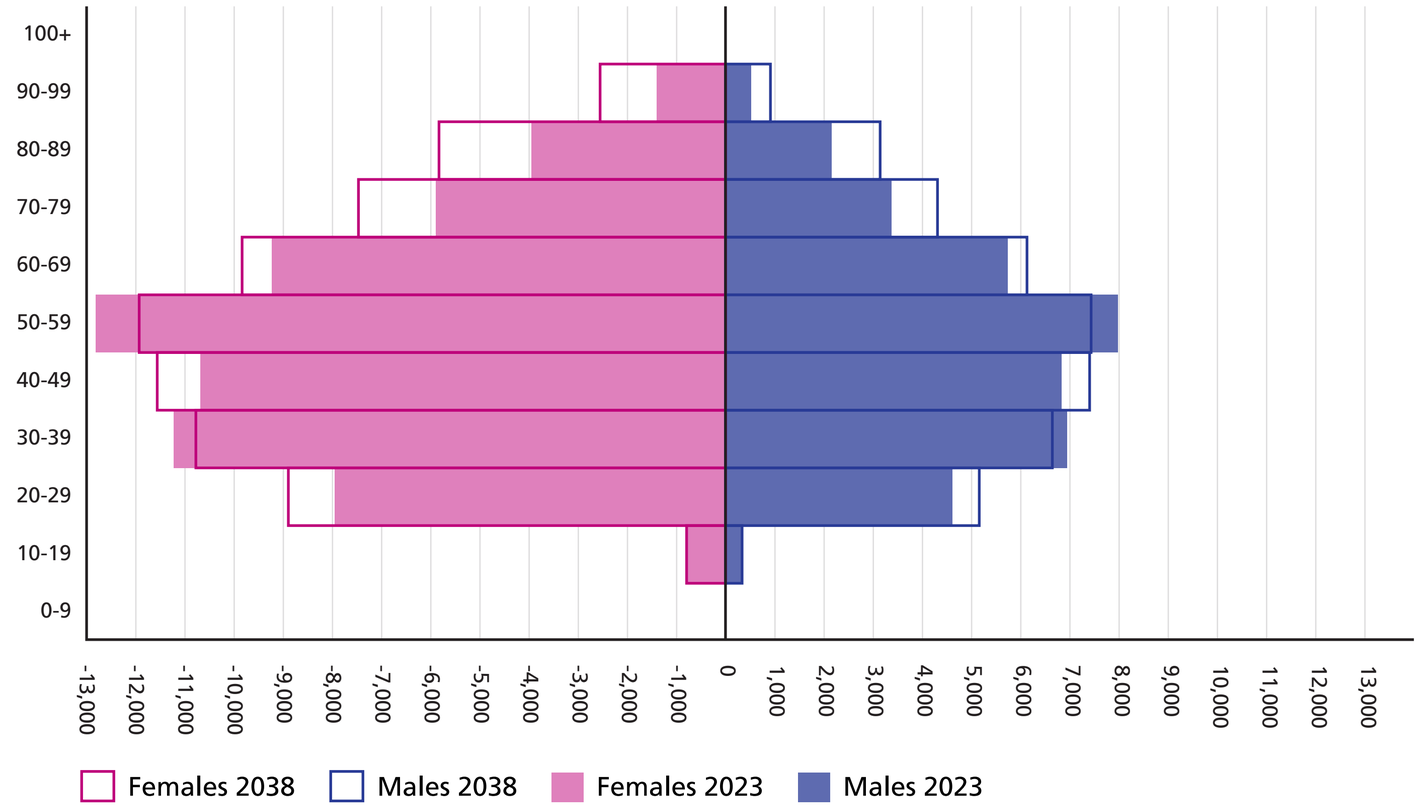


Local population needs

Among our population of 980,000 people, more than 100,000 have been diagnosed with dementia, depression or serious mental illness. Around 3,500 have more than one of those conditions.

We recognise there will be many more people who haven't had an official diagnosis or don't fit diagnostic categories, but who may also need mental health support. Our population is expected to grow by 6% over the next 15 years.

People in BSW with dementia, depression or serious mental illness by age and gender:



Deprivation, protected characteristics and diversity

The BSW population is diverse. We know that mental illness rates are higher in more deprived areas. Our area is one of the least deprived in the country according to the index of multiple deprivation (2019). However, this masks pockets of high deprivation and inequality including 14 neighbourhoods within the most deprived 10% nationally (2 in B&NES, 1 in Wiltshire and 11 in Swindon).

We have a range of educational attainment,

and 1 child in 10 lives in poverty, and 1 in 200 is in care

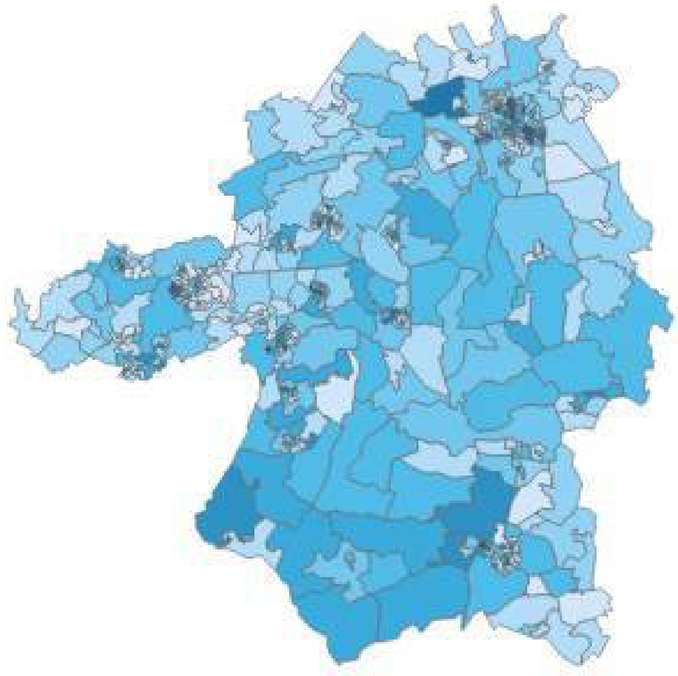
Across BSW, 103,014 people are from ethnic minority communities,

with 1,669 of those using mental health services

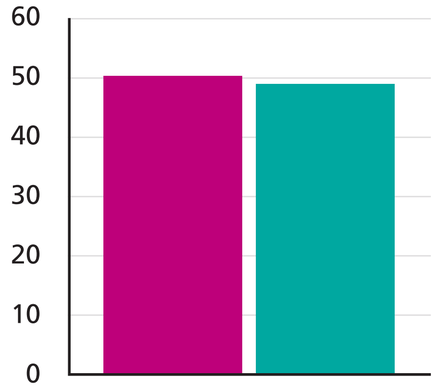
Swindon has more residents from a Black or other ethnic minority group:

In the last 2 years, the number of asylum seekers and refugees has increased across BSW, supporting individuals resettling from the Ukraine, British national oversee passport holders (from Hong Kong) and Afghanistan. We anticipate further growth in our communities, particularly in Wiltshire, through the Afghan resettlement scheme. The boating and traveller communities represent more mobile populations across BSW.

Deprivation map of BSW. The darker the colour, the more deprived the area

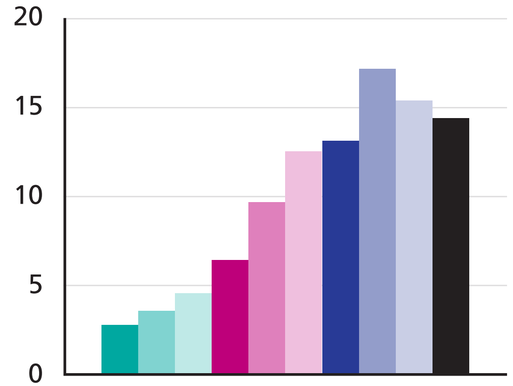


BSW population mosaic showing key demographics



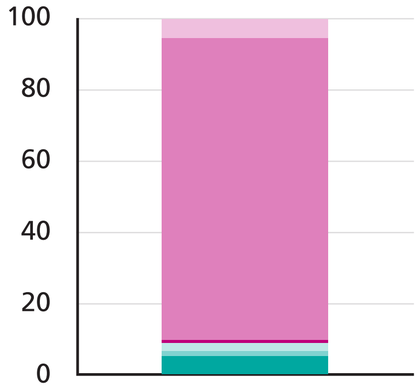
Gender

- 50.7% Female
- 49.3% Male



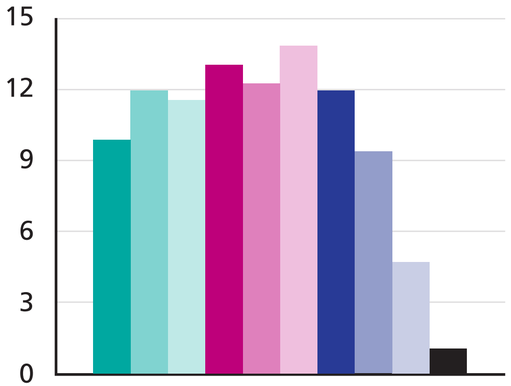
Deprivation

- 2.7% IMD 1
- 3.5% IMD 2
- 4.5% IMD 3
- 6.4% IMD 4
- 9.7% IMD 5
- 12.6% IMD 6
- 13.2% IMD 7
- 17.3% IMD 8
- 15.5% IMD 9
- 14.5% IMD 10



Ethnicity

- 4.7% Asian or Asian British
- 1.5% Black or Black British
- 2.2% Mixed
- 0.9% Other Ethnic Groups
- 85.2% White British
- 5.5% White Other



Age Group

- 9.9% 0 - 9
- 12% 10 - 19
- 11.6% 20 - 29
- 13.1% 30 - 39
- 12.3% 40 - 49
- 13.9% 50 -59
- 12% 60 - 69
- 9.4% 70 - 79
- 4.7% 80 - 89
- 1% 90 - 99

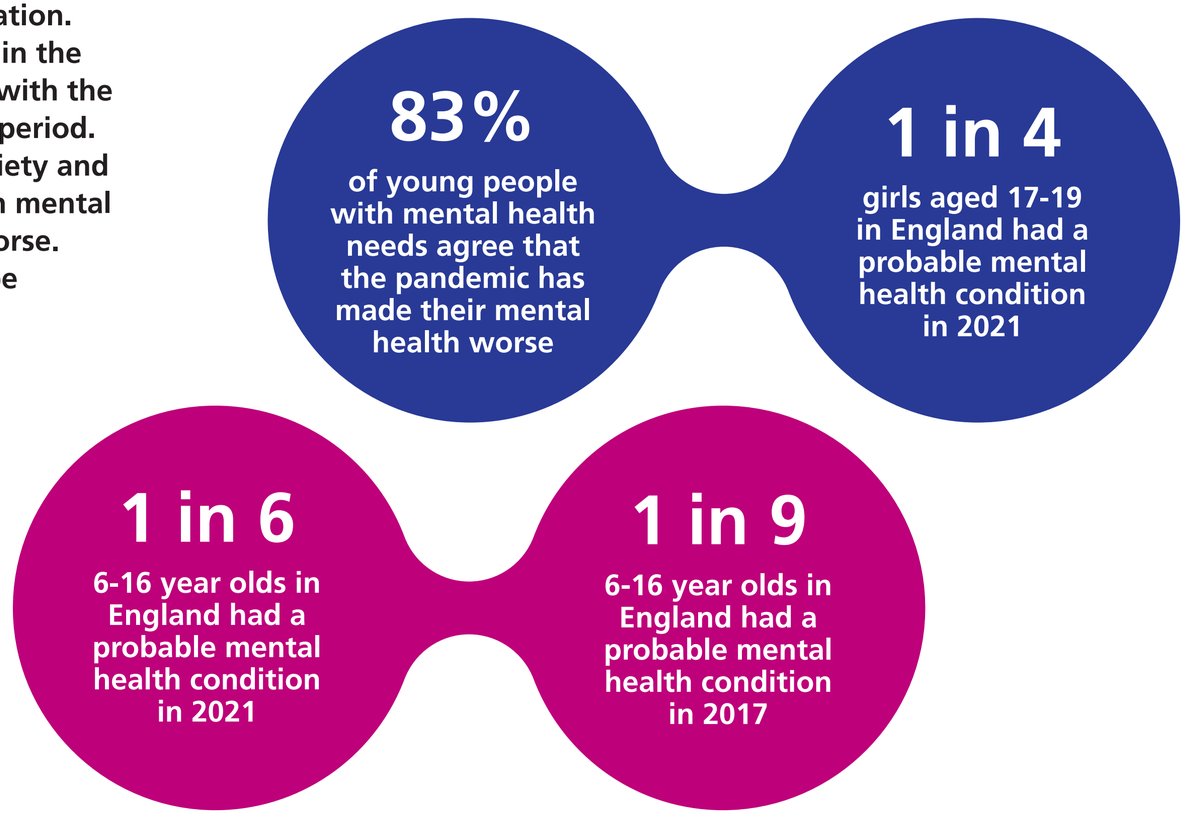
Mental health over the life course

Children and young people

Children and young people (CYP) account for almost 30% of our population. We have a large population aged 12-18, and those reaching adulthood in the next 5 years are those who experienced significant impacts associated with the covid-19 pandemic to their educational and adolescent developmental period. We know there has been an increase in mental ill health, including anxiety and self-harm, amongst CYP since the pandemic: 83% of young people with mental health needs agree that the pandemic has made their mental health worse. CYP with mental health conditions are more likely than their peers to be in the most deprived group.

Children who are Looked After [including care leavers] are more likely to experience mental illness, both in childhood and as adults. Experience of care is often associated with significant psychological trauma during early life; BSW CLA total [2024] 1007.

Mental health conditions have become more common among CYP. Among those aged 6-16 in England, 1 in 6 had a probable mental health condition in 2021, an increase from 1 in 9 in 2017. Figures are especially concerning for girls aged 17-19: 1 in 4 had a probable mental health condition in 2021.



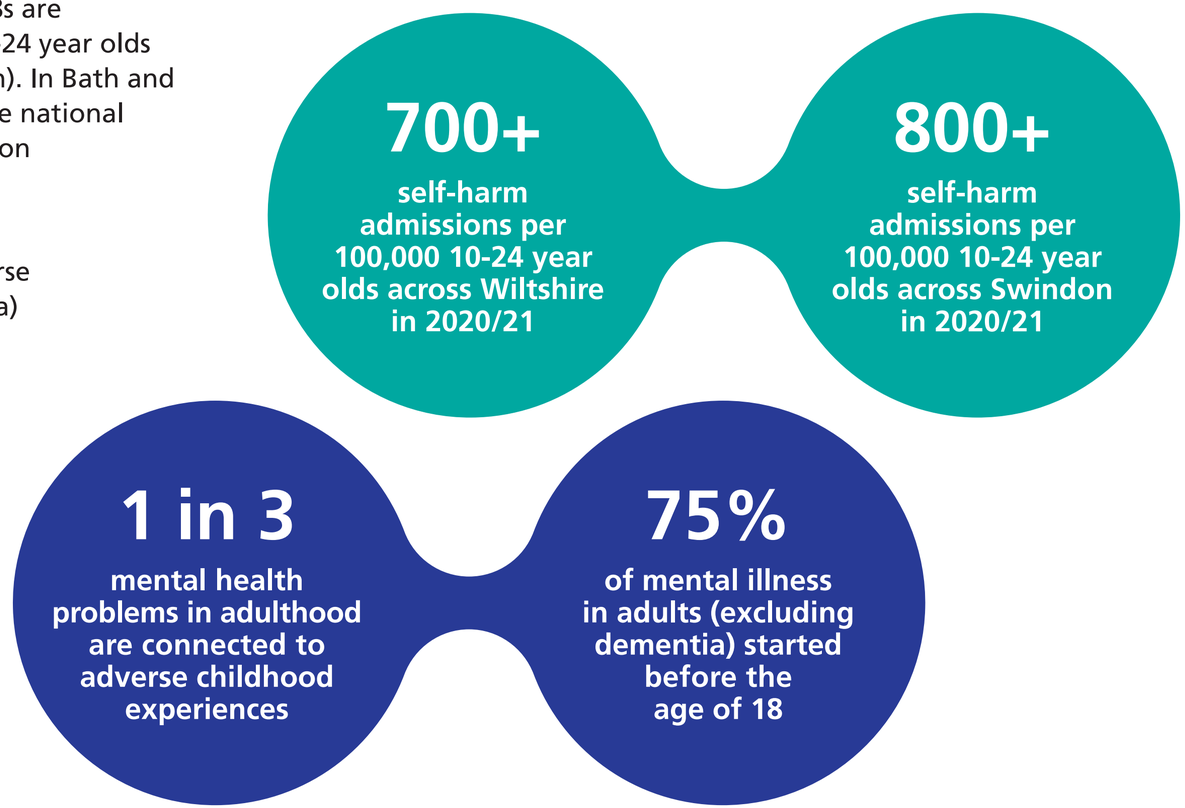
Mental health over the life course (continued)

Children and young people (continued)

Across BSW, acute hospital admissions for mental health conditions in under 18s are consistently higher than the national average. Self-harm admissions among 10-24 year olds in Wiltshire were also at a 5 year high in 2020/21 (700+; per 100,000 population). In Bath and North East Somerset (B&NES) admissions have been consistently higher than the national average since 2011/12;500+, per 100,000 population . However, rates for Swindon are the highest in our footprint; 800+, per 100,000 population.

Reaching children and young people with the right mental health support is crucial. A third of mental health problems in adulthood are connected to adverse childhood experiences, and 75% of mental illness in adults (excluding dementia) commenced before the age of 18. When CYP wait for services, 76% of parents reported them deteriorate while waiting. Only a third with a diagnosable condition get to access NHS care and treatment.

Crucially, the consequences of failing to address mental health in younger people means their needs will extend into adulthood. We need to do much more for children and young people across our area.



Mental health over the life course (continued)

Students

In B&NES, college and university students make up 30% of the population, with three large higher education providers (the University of Bath, Bath Spa University and Norland College). For those already receiving mental health care, moving to university or starting college can lead to significant disruption. This includes transitioning to new teams, building rapport, awaiting referral and acceptance into services.

University can be an exciting yet intimidating time. For many young people, it's the first time they've been away from home on their own for a prolonged period. It's easy to feel isolated when you're away from your usual support network. Managing finances and life on top of studying can be a lot to cope with.

Due to pressures associated with further education and independent living, student lifestyles can involve alcohol, drugs and lack of sleep, all of which can have a negative effect on mental health.

Starting university, exams and other assessments can also be a source of stress. Pastoral care is available in universities, as well as university mental health services. These are designed to complement rather than be alternatives to NHS support, with a focus on enabling students to continue their studies.

Students make up

30%

of the population in Bath and North East Somerset

Adults of working age

The stresses of working, parenting, caring for ageing parents and daily life stressors can take their toll in this age group. As a result, working age adults are at higher risk of common mental disorders such as depression and anxiety.

Prevalence of depression in BSW is the lowest in the South West Region, and is 1% below the national average at 11%.

Around 25,000 adults in B&NES have a common mental disorder (15,500 females and 9,600 males). Depression rates are lower in B&NES than England, but post-covid nearly 2,000 people were diagnosed with depression for the first time.

In Swindon 15.3% of adults aged 16-74 are living with common mental disorders, with 11.9% of adults living with depression in 2021-22.

The pandemic and its restrictions caused a 6% rise in anxiety levels in Wiltshire's adult population, compared to the previous year. Around 11% of people over 18 had a diagnosis of depression.

Around

25,000

adults in B&NES have a common mental disorder

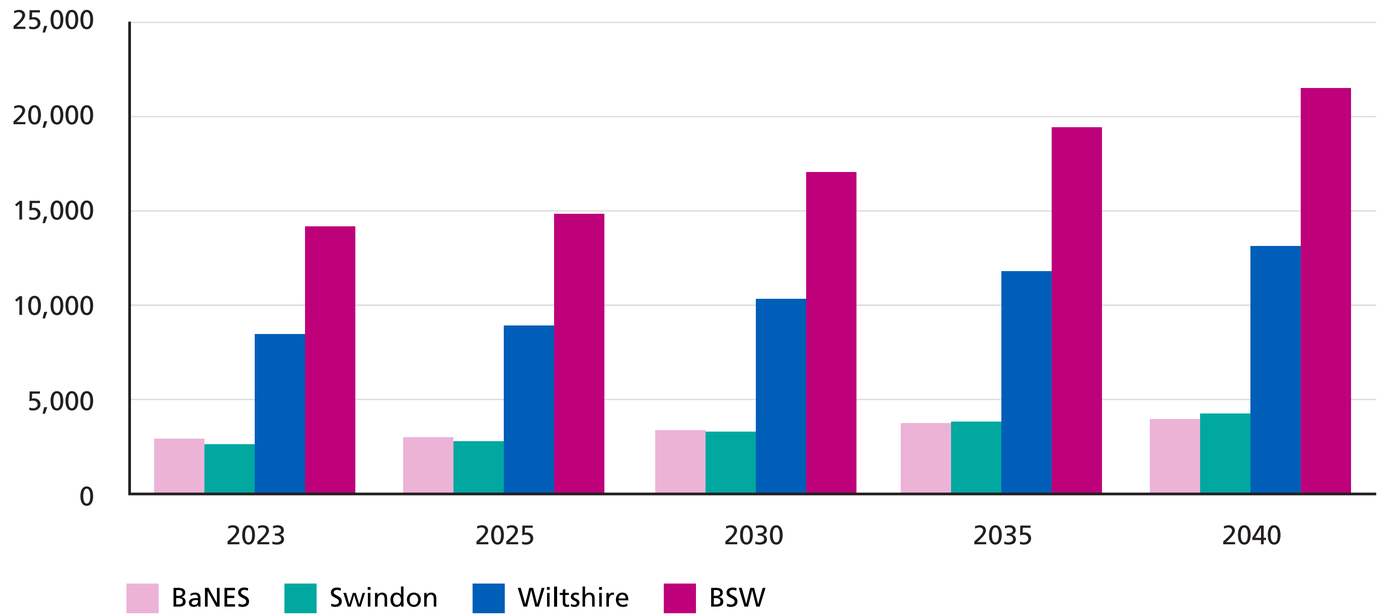
Mental health over the life course (continued)

Later life

Loneliness and isolation are particular challenges faced by older people. These can have a detrimental effect on mental health. Grief and loss are also more common for this group. Milestones like retirement can have a negative effect on mental health for some people. Biological risk factors correlate with mental health need in later life [other than dementia], examples include physical comorbidities which occur at a higher rate with aging, cerebrovascular disease and an accumulation impact of lifestyle choices such as drug and alcohol consumption.

Organic mental health issues linked to age are another challenge. Over the next 15 years, the BSW population over 60 will grow by 35%.

People aged 65 and over predicted to have dementia 2023-40:



Mental and physical health

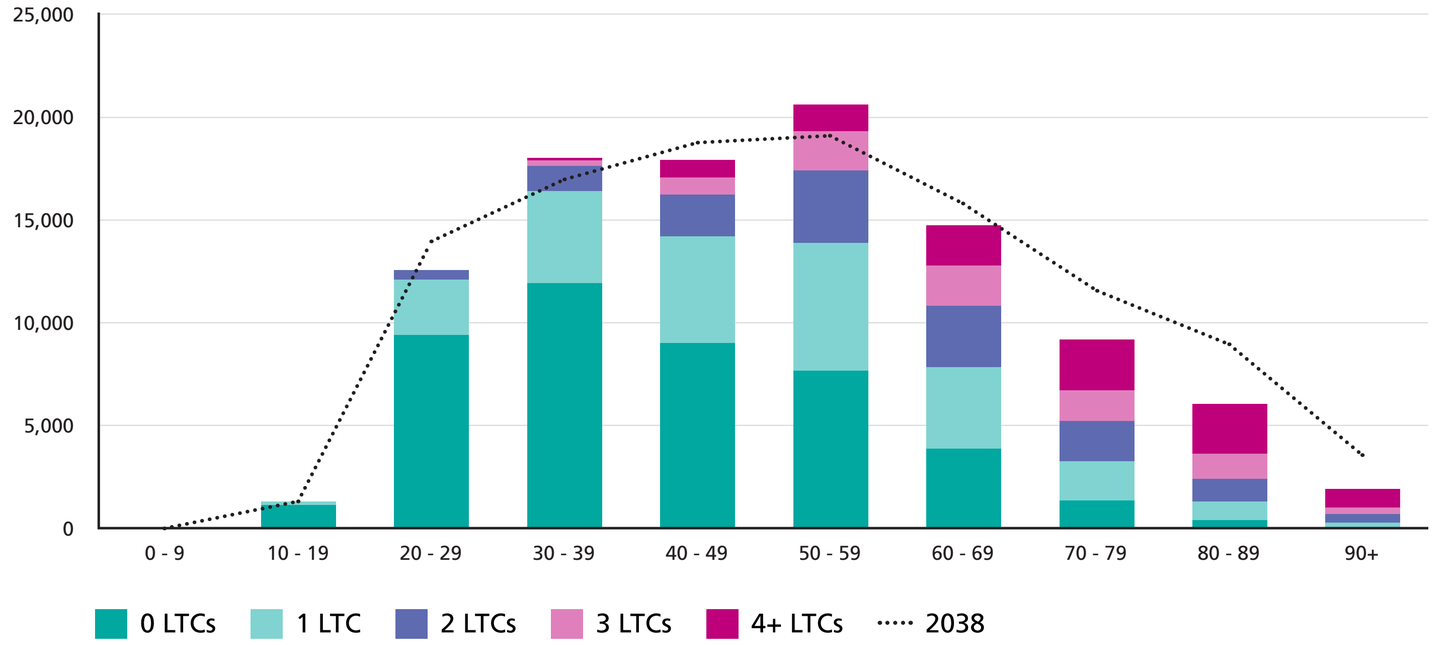
Children and adults with mental health problems have poorer physical health than the rest of the population. Of the 100,000 people with a mental health diagnosis, over half have a physical long-term condition. One in six people have three or more.

Rates of physical long-term conditions are 1.5 to 2 times higher for people with a mental health condition in BSW. This is also true of many of the risk factors for poor physical health, like smoking and obesity, meaning that in turn physical health conditions occur at a higher rate in those with mental health conditions. There is also a converse causation, with mental health resulting from the presence of physical health.

People with mental health needs find it harder to access screening and treatment to support behaviour change. Without the right support, they can miss critical points where physical illness can be identified and addressed.

To address this, the NHS Long Term Plan set out a requirement to increase the number of people with confirmed serious mental illness on GP registers receiving an annual health check. To improve outcomes we need to ensure we are conducting the checks but also working across our system to act on the results.

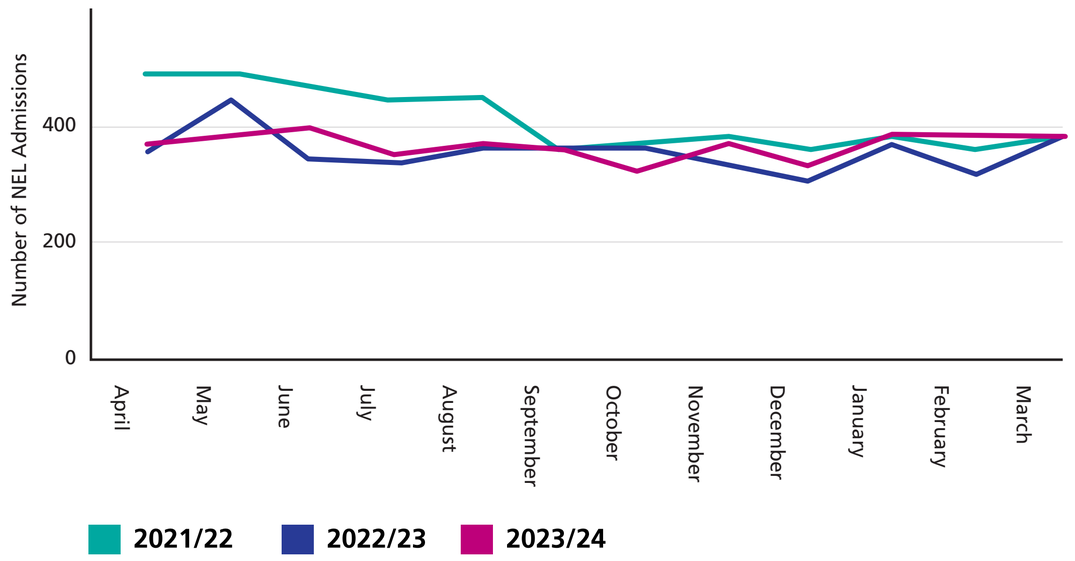
People on depression, serious mental illness or dementia GP registers by age and number of physical long-term conditions



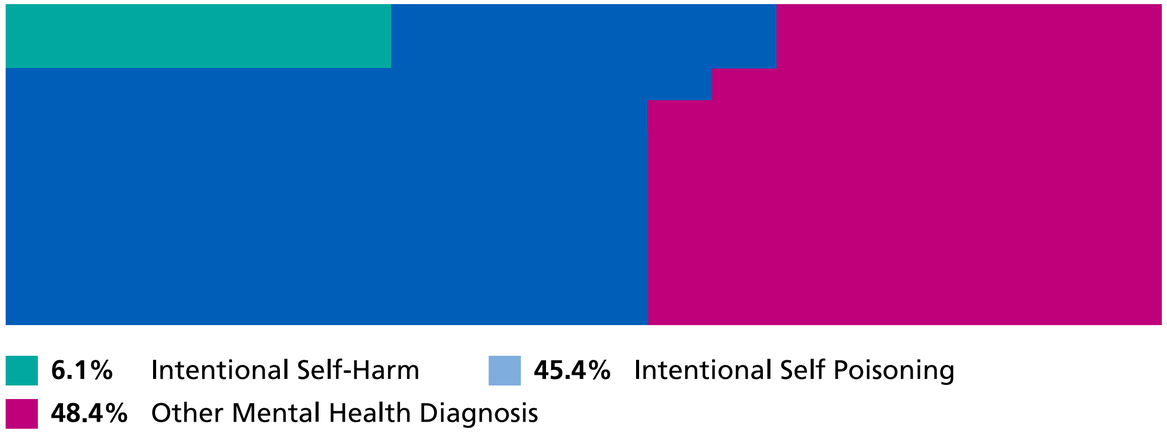
Mental health and emergency care

There are around 5,000 emergency department attendances in BSW each year specifically associated with mental health. Admission rates are stable throughout the year, although there is a slight increase observed during Winter and Spring months. The nature of mental health need for those admitted demonstrates a high rate of mental health crisis in the form of self-harm and self-poisoning accounting for 50% of presentations.

BSW acute hospital mental health non-elective admissions



BSW Acute Hospital Mental Health Non-Elective Admissions By Need Category



6.1% Intentional Self-Harm
45.4% Intentional Self Poisoning
48.4% Other Mental Health Diagnosis

Each acute hospital across BSW has an onsite mental health liaison team, however we know acute hospitals are not the optimal environment to support an individual with mental health needs. The experience of being in an acute hospital setting itself for some has an impact on their wellbeing. Acute staff have shared the challenges of caring and treating individuals with needs outside of their core remit.

Improving our services

The NHS Long Term Plan (LTP) for mental health (2019-March 2024) set a national road map for transforming services, including:

- **Increasing access rates**
- **Expanding evidence-based models of care**
- **Providing services in new areas**

We therefore increased investment in key existing services and developed new services. Providers have diligently gathered data to demonstrate the impact of this investment against national success measures.

Our LTP performance data demonstrates great improvements in a relatively short period of time. However, we recognise there is more to do.

We are committed to improving access across all services and focusing on our reporting to demonstrate and drive improvements to waiting times and outcomes. We cross reference this data with people's reported experiences of services, to ensure our mental health offer achieves the best outcomes for our population.

Perinatal and maternal mental health services

Since 2019 we have invested in two new multi-disciplinary services for perinatal mental health. One supports women during pregnancy and the first year after birth with a range of evidence-based interventions. The other is the maternal mental health service for women are experiencing birth-related trauma and/or anxiety.

These well-established services are exceeding the national target for access, reaching many women who need this specialist support. Service outcome measures demonstrate a reduction in PTSD severity for those treated by the service (psychological therapy).

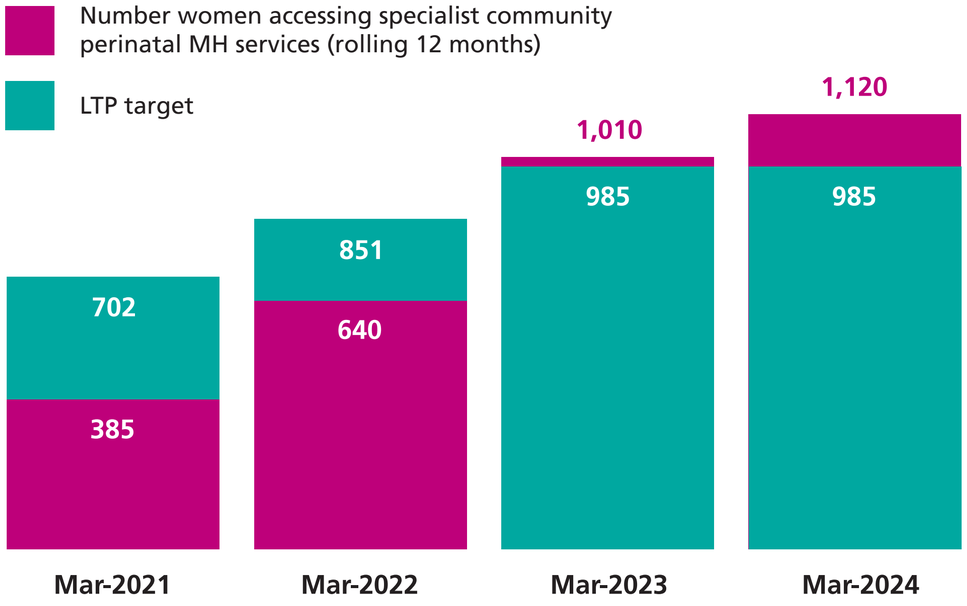
These services are essential in improving maternal mental health. They also help improve the wellbeing of infants and partners. Suicide causes 39% of deaths among women during the first year post-pregnancy, emphasising how essential this service is.

We need to go further and invest in extending the therapeutic pathway for the perinatal service, at present women are only supported for a 12month period following the end of pregnancy. The LTP set out a requirement for perinatal mental health services to work with women with complex emotional needs for up to two years, improving outcomes and enabling better attachment. We also need to further review and develop the assessment and support offer to partners, a further essential LTP deliverable.

Perinatal and maternal mental health services (continued)

As the BSW Maternal Mental Health service has become more established the demand for the service has grown, consequently waiting times have increased beyond the intended maximum of 6 weeks to 10+ weeks.

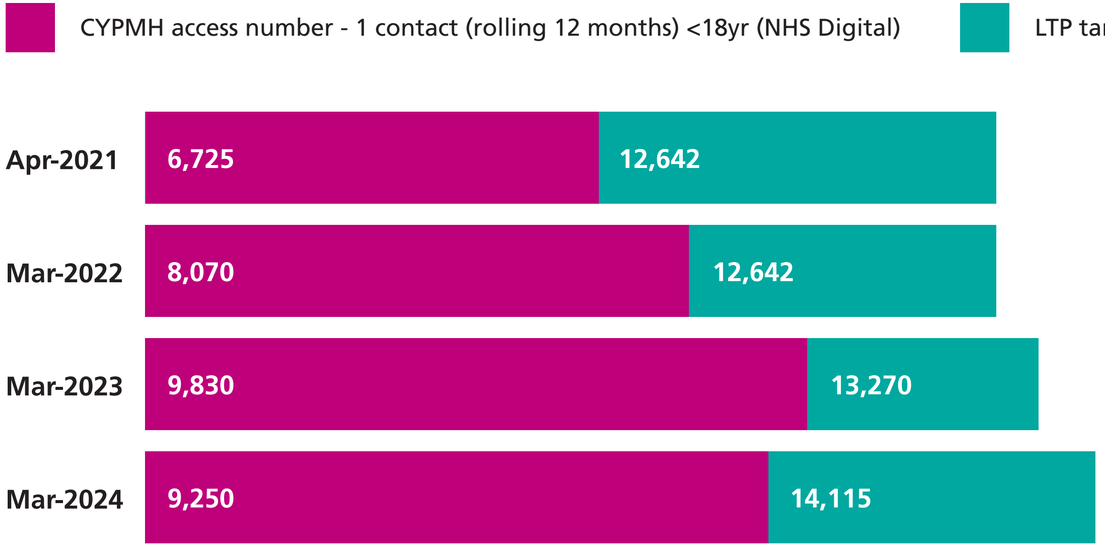
Further investment is required to expand the service to sustainably meet the incoming demand as well as the final elements of the LTP.



Children and young people access

BSW mental health community provision for children and young people is based on the i-Thrive model of care (Wolpert et al, 2019). This ensures a seamless approach, with a strong emphasis on prevention.

Working in partnership with Local Authorities and wider Third Sector organisations, BSW has made progress in supporting a more holistic approach to early intervention and prevention of mental ill-health in young people. A key feature of this is delivering and supporting more interventions in schools - either through training and education for staff or as part of direct work with children and young people.



BSW CAMHSi Thrive Model

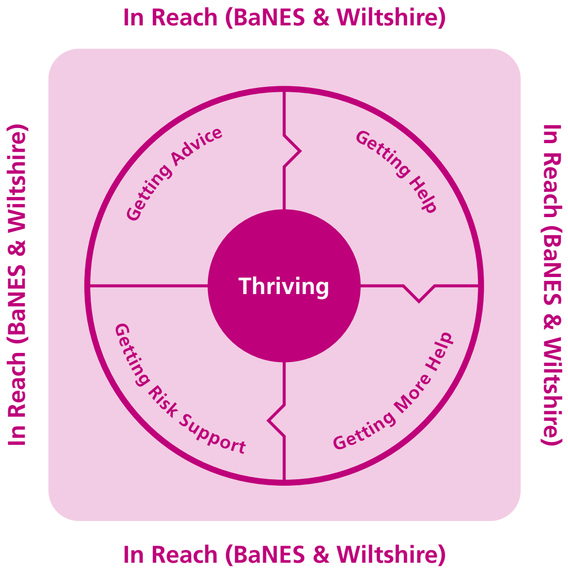
Getting Advice

Single Point of Access (SPA) - Wiltshire
Single Point of Contact (SPOC) - BaNES
Request for Service - Swindon

Getting Risk & Crisis Support

Crisis and Home Treatment Service (CAHTS) Duty
CAMHS Helpline
Complex Case Consultation and Care, Education and Treatment Reviews (CETR)
Hospital Liaison
Out of Hours On Call
CAMHS inpatient

Mental Health Support Teams (MHSTs) (in schools)



Crisis and Home Treatment Service (CAHTS) Forensic CAMHS (FCAMHS)

Getting Help (GH)

Coping Skills
Anxiety/Parenting - Child Wellbeing Practitioner (CWP)
Video Interaction Guideance (VIG)
Mentalization-Based Treatment for Families (MBTF)
Cognitive Behavioural Therapy (CBT) Informed Behavioural Activation (low mood) - Child Wellbeing Practitioner (CWP)

Getting More Help (GMH)

Psychology - Cognitive Behavioural Therapy (CBT) / Interpersonal psychotherapy (IPT)
Psychology (Trauma, etc...)
Family Therapy [Attachment Based Family Therapy (ABFT) / Systemic]
Psychotherapy [Shortterm psychoanalytic psychotherapy (STPP) / longer term]
Mentalization Based Treatment for Adolescents (MBTA) - all disciplines
Dialectical Behaviour Therapy (DBT)
Positive Behaviour Support (PBS)

<u>Specialised services within GMH</u>
Learning Disabilities Service, Neurodevelopmental Disorders (NDC), Outreach Services for Children and Adolescents (OSCA), The CAMHS Community Eating Disorders Team (TEDS)
Multi agency complex case pathway

In BSW, 40% of schools and colleges are covered by specialist mental health support teams. During 2024-5, £4.4m will have been invested. From January 2025 our provision will expand further, helping us meet national ambitions and increase coverage of these teams across our school communities.

We have deliberately targeted those areas with greatest health inequalities, ensuring we provide earlier access for those children at greatest risk.

Staying in education is recognised as a protective factor for children and young people's mental health and wellbeing. Our teams are continuing to support this outcome across BSW. As we reach a greater number of children and young people through these teams, we are working with our local authority partners to consider how we can develop these services. For example, more specialist interventions for trauma and supporting children and young people who have both mental health and neurodiverse needs. We have also increased investment in access to Child and Adolescent Mental Health Services (CAMHs).

We have supported all services contributing to children and young people access to improve the quality of data in their reporting, making sure that every contact is "shown" in published reports.

During 2024-5,

£4.4m

will have been invested

In BSW

40% of schools

and colleges are covered by specialist mental health support teams

Severe mental illness physical health checks

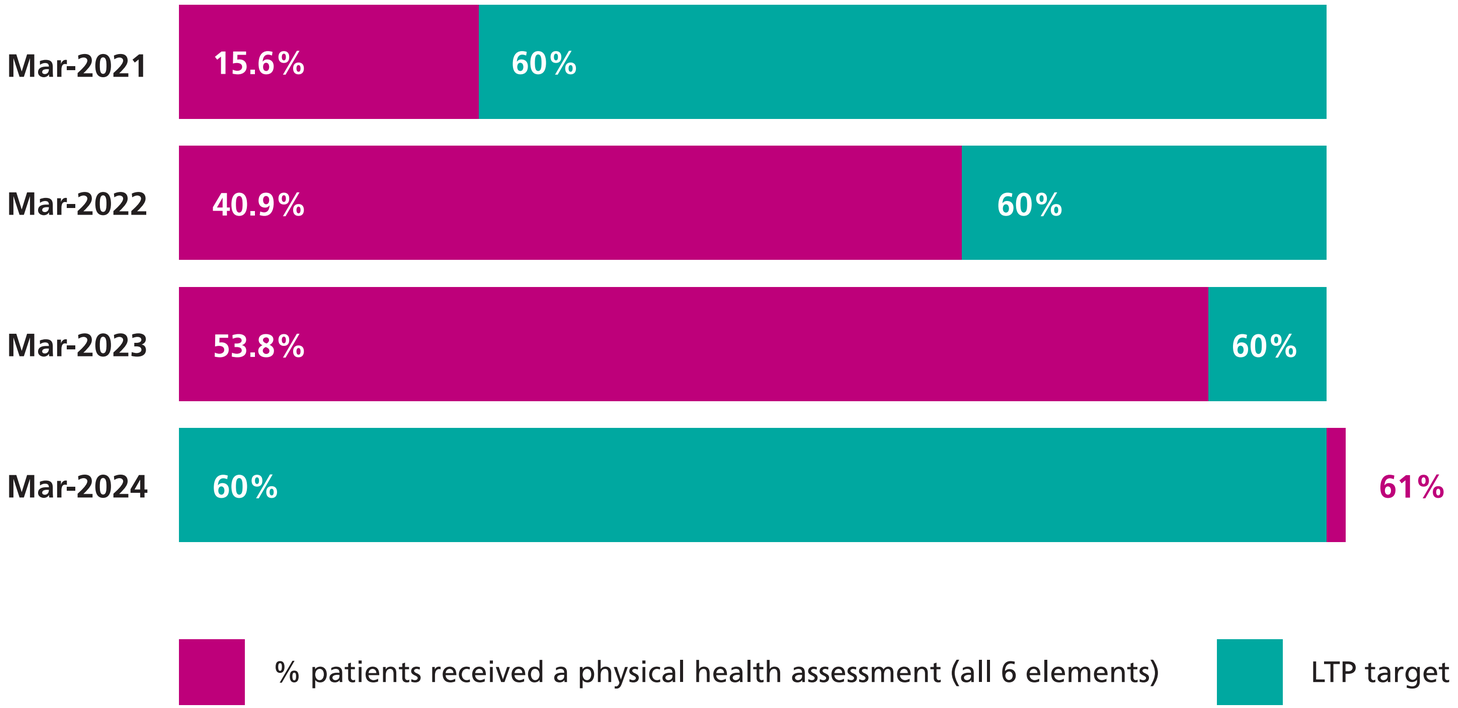
We have mobilised two new severe mental illness (SMI) services with our adult mental health trust and Third Sector organisations, a combined investment of £1.1m.

One aims to undertake annual physical health checks for all people on the case load of secondary care services. It supports them with making health behaviour changes and having further assessments or treatments needed to improve their physical health.

This service has significantly increased the number of annual health checks. We've gone from 6% of people on the case load having their full review to 85% (1390 people).

The Third Sector SMI outreach service aims to support people to better understand the importance of having an annual health check and is piloting an approach to support people with out-of-range results to engage with any further health reviews, treatment or positive health-behaviour changes interventions which have been indicated.

Further work is needed to reach more people, and to strengthen collaboration across primary and secondary care, with all agencies committed to enabling more people to access health checks and support them in accessing post check interventions and support.

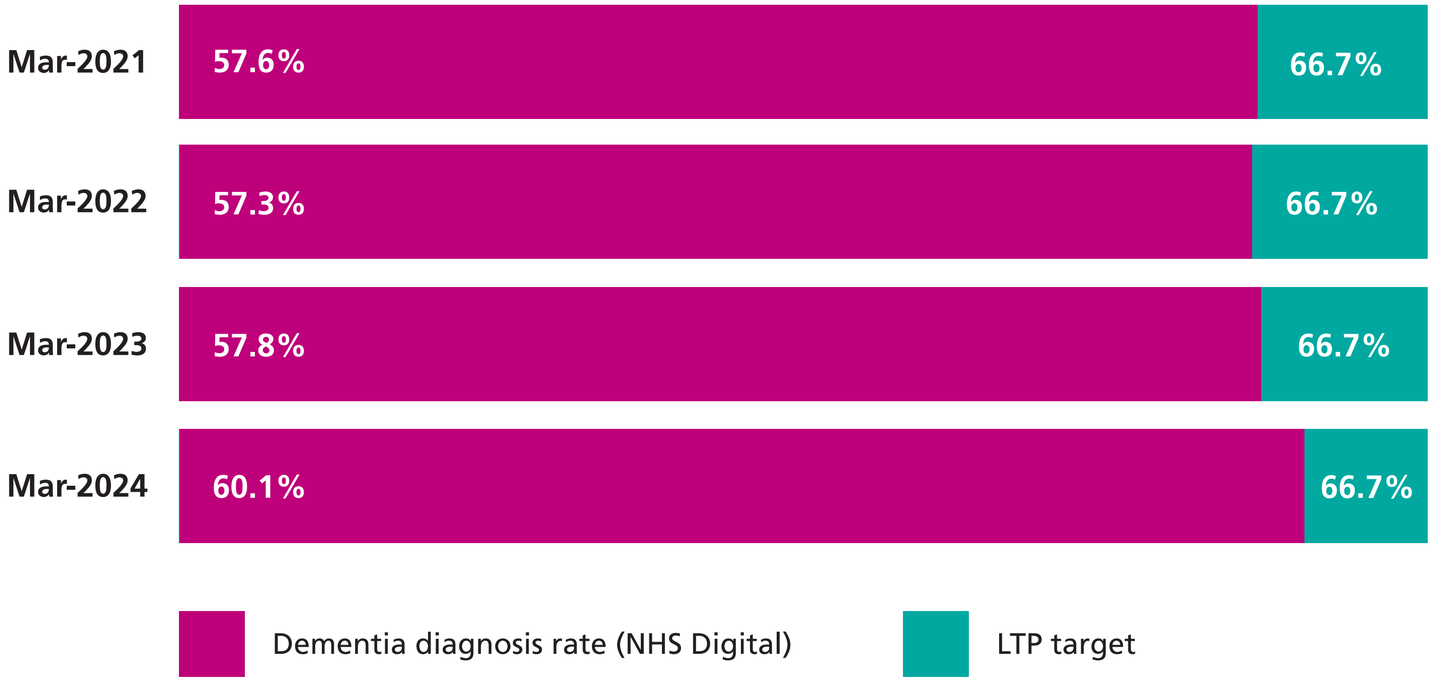


Dementia diagnosis

Dementia diagnosis is a complex and challenging area. Overall, BSW falls short of the dementia diagnosis rate, but a third of our area is reaching the expected number of people. The population is continually increasing, so we need to reach more individuals each month.

Encouraging more people to come for assessment as early as possible on recognising symptoms needs a multi-faceted approach. As does the configuration of services and workforce to undertake these diagnostic assessments. We know that diagnosis is just the first part of the journey, and we are committed to improving our post diagnostic offer to help people live well for longer.

We have increased the number of older adult specialist practitioners in secondary care. They offer post-diagnosis support and interventions for those with complex behavioural and psychological needs resulting from dementia. We have invested in professionals to work in care homes, ensuring all people with dementia symptoms are recognised and supported. We are in the process of developing plans to strengthen our cognitive (memory) assessment and support offer. Given the scale of need, number of agencies involved and extent of work in progress to improve our Dementia offer BSW will produce a Dementia Delivery Plan (2025-2030).



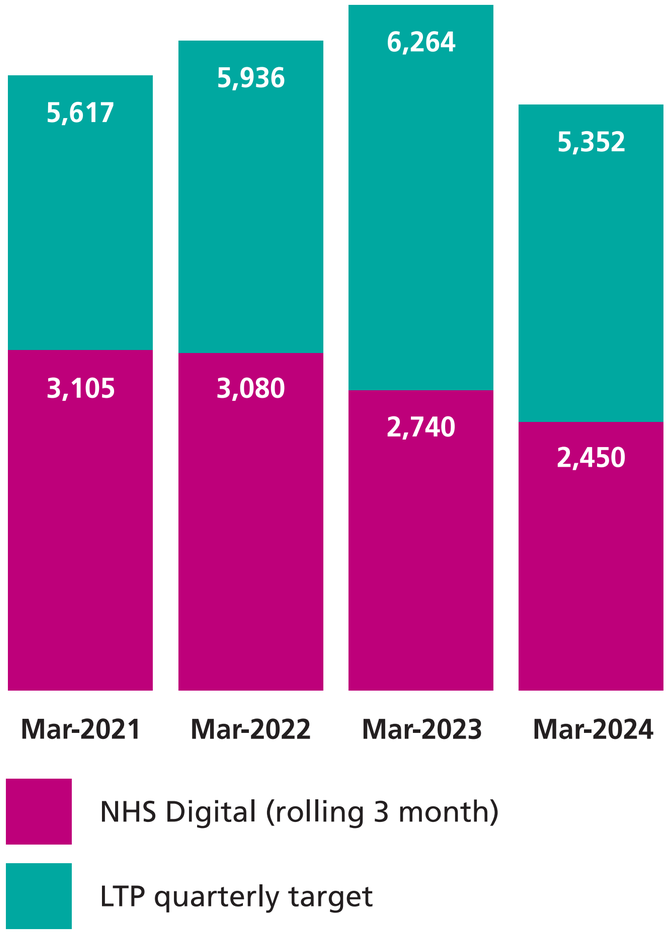
NHS Talking Therapies

Our Talking Therapies service, available to those aged 16+, has been through a deep transformation over the last few years and has seen additional investment growth of 108.2% in five years. This involves ensuring pathways are evidence-based and reconfiguring the workforce and service model.

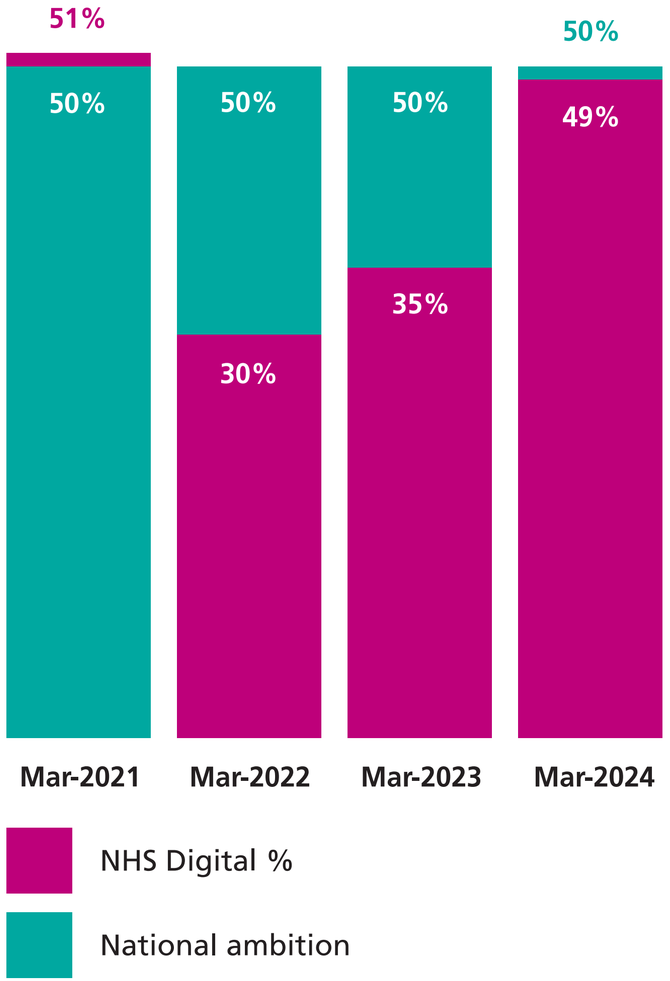
We are not yet meeting the key national targets of access and recovery, but such a substantial transformation takes time to achieve and sustain its targets. We are very nearly meeting the national recovery rate and anticipate achieving this within 2024.

We have undertaken an in-depth full service review our service, which has informed a further substantial workforce expansion [with additional investment] this is currently mobilising. The workforce expansion will ensure more people access the service and are able to receive a treatment which meets their needs within shorter timeframe than present waits. Once fully mobilised this will see the spend per mental health weighted head of population rise significantly from £13.64 to £16.49 per person.

Access Rate



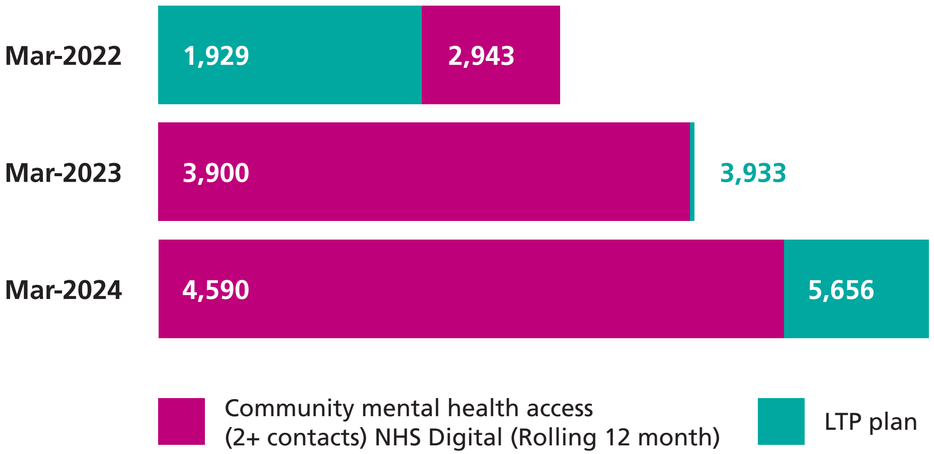
Recovery Rate



Community mental health services

We have already made strides in aligning with national priorities in expanding and transforming our integrated primary and community offer for adults and older adults with severe mental illness, which includes development of specialist support and treatment pathways for those with eating disorders and complex emotional needs.

An example is our alliance between Third Sector providers on a new primary care integrated access mental health model. This aims to improve prevention and access, provide choice and control, and create connections between services. We have further to go to achieve the full ambition set, particularly related to community rehabilitation, but we are seeing a good rate of access across all providers and specialist pathways creating our community offer.



Urgent and crisis mental health responses

Recognising the importance of responding appropriately for those with urgent and crisis mental health needs BSW has greatly expanded is offer.

BSW further invested to enable extended the coverage of mental health nurses working in the Ambulance control rooms to operate around the clock. This means that those calling through to Ambulance services with a mental health associated need can have their call supported either directly, or with advice to the call handler issued by a mental health professional. This will soon be further supplemented by the addition of a mental health ambulance to the BSW footprint from April 2025.

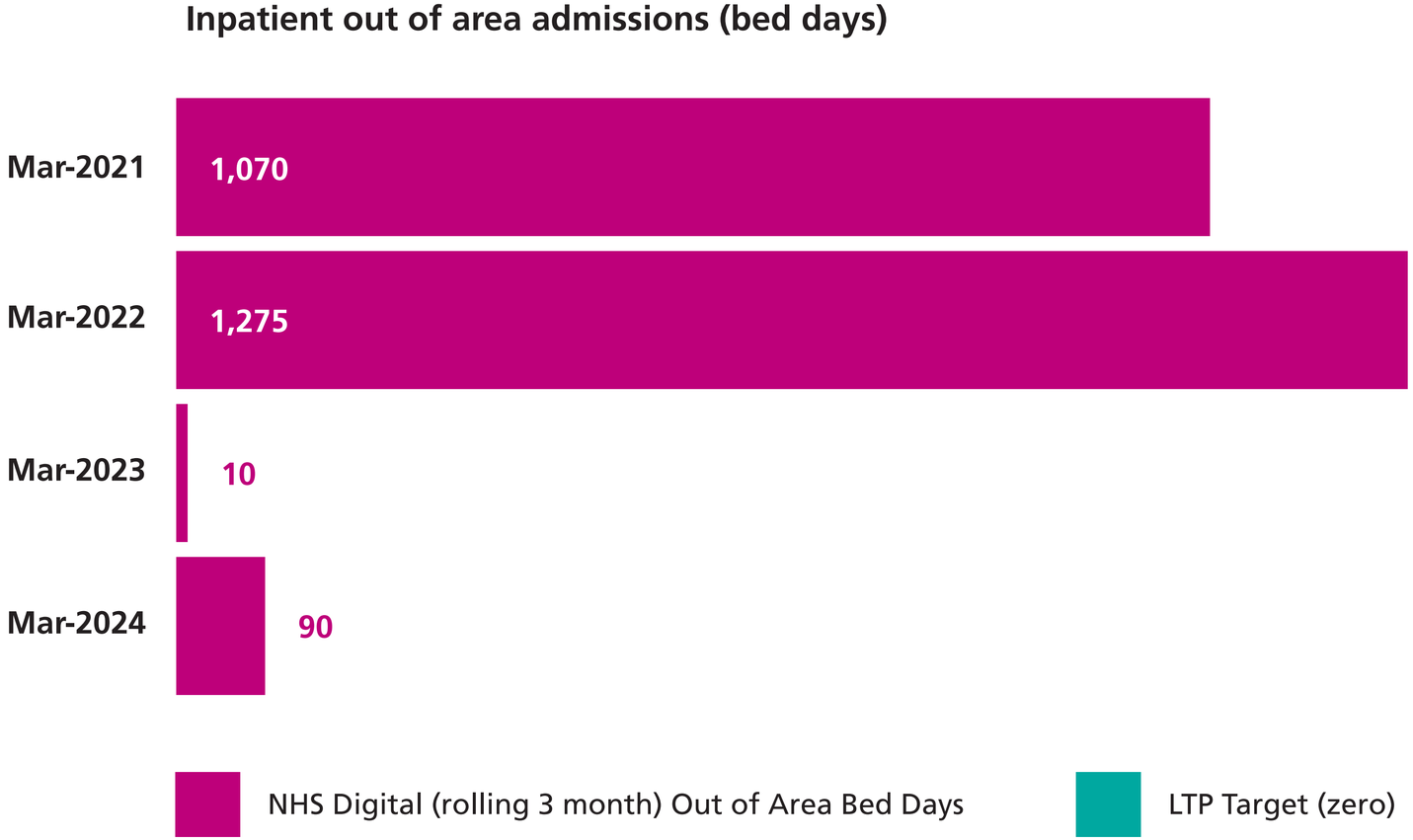
BSW has been developing its 111 mental health service model (111-2) over the course of several years and mobilised around the clock service in April 2024. This service enables assessment of need and facilitates an individual on to the most appropriate pathway for further support as required.

We recognise the importance of having a diverse crisis offer to ensure that people can be supported in a range of ways in the community setting. Across BSW we now have three places of calm, which provide safe spaces for individuals to be supported during periods of distress/crisis. These can be accessed directly in person or via telephone support. For those requiring more intensive support we have four crisis accommodation houses with a total of 17 beds. A stay in crisis accommodation can operate to avoid admission to an acute mental health hospital or for those being discharged, where a further period of support is beneficial before returning to a place of residence. People can also be supported in their own homes by our intensive and assertive outreach (Third Sector) service, which focuses on reablement interventions.

Inpatient care and out of area placements

BSW is working towards the NHS E national target for zero out of area admissions by March 2025. Good progress has been made towards this, the position is variable, but with the improvement initiatives in place, and further ones launching we are confident that BSW will meet the target.

An incoming programme which will support delivery of this target, along with a great number of other improvements is the National Quality Improvement Programme for Mental Health and Learning Disabilities gives us the opportunity to improve the quality and practice of our inpatient and community services. BSW has developed its co-produced plan in partnership with Bristol, North Somerset and South Gloucestershire ICB (BNSSG) [reflective of our joint adult mental health trust footprint]. The programme is focused on personalising care and treatment to the individual, seeking to avoid admissions where possible, and where required that these are to wards offering trauma-informed holistic care, resulting in optimisation of improvements.



The key elements of this programme are set out in the graphic on the right, our plan sets out our journey through 2024-2027.

We have focused on reducing the number of people admitted to a mental health hospital outside our area over the last five years and have seen dramatic improvements. Teams have improved hospital admission management, striving to admit people as close to home as possible. We are very nearly at a point where no one gets admitted out of area. We are confident we will meet the national target of zero out of area placements by March 2025.

Some people will need long term rehabilitation in an inpatient setting. Not all of these people are currently treated in our BSW footprint. Whilst we have made good progress in stopping people being admitted to out of area beds at the point of crisis, we must also reduce the number of people in longer term mental health care out of area. Being treated in an inpatient setting closer to home means they can maintain connection to their loved ones and community and have a shorter length of stay, or for some admission will be avoided entirely.

4 key principles

- **Personalised care and shared decision making**
- **Trauma-informed care**
- **Joined up partnership working**
- **Care that advances health equality**

3 key stages

Purposeful admissions

People are only admitted to inpatient care when they require assessments, interventions or treatment that can only be provided in hospital, and if admitted, it is to the most suitable available bed for the person's needs and there is a clearly stated purpose for the admission.

Therapeutic inpatient care

Care is planned and regularly reviewed with the person and their chosen carer/s, so that they receive the therapeutic activities, interventions and treatments they need each day to support their recovery and meet their purpose of admission.

Proactive discharge planning and effective post-discharge support

Discharge is planned with the person and their chosen carer/s from the start of their inpatient stay, so that they can leave hospital as soon as they no longer require assessments, interventions or treatments that can only be provided in an inpatient setting, with all planned post-discharge support provided promptly on leaving hospital.

2 key enablers

- **A fully multidisciplinary, skilled and supported workforce**
- **Continuous improvement of the inpatient pathway**
  Using data, co-production and quality improvement methodology.

Quality of services

The NHS Patient Safety Strategy (2019) notes that "Patient safety is about maximising the things that go right and minimising the things that go wrong for people experiencing healthcare."

We are embedding the Patient Safety Incident Response Framework principles so that we take into account the often-complex system factors at play during a patient safety event. We will learn from these events and make sure improvements are made to better support our service users and carers.

Safety is an ever-changing issue. We will work with all our partners to identify opportunities to improve the care we provide for people. We will also seek to understand and address any associated risks.

Culture plays a significant part in creating an environment where staff learn and people feel safe. A "just culture" is vital, where staff feel confident and are treated fairly and without blame when things go wrong. We have already done work on this, co-developing a staff handbook for staff with six NHS organisations, including partners in the BSW mental health system, and Making Families Count.

This handbook aims to support staff in engaging positively and compassionately with families through the process following a patient safety event. It gives staff the tools to do this with confidence in a caring way.

Safeguarding partnerships

Statutory reviews require systems to address recommendations from Safeguarding Adult, Child Safeguarding Practice and Domestic Abuse Related Death Reviews. Nationally and locally there has been an increased recognition of the vulnerability of people of all ages placed in specialist hospital accommodation.

We are committed to ensure that our system is actively involved in responding to these reviews and provide assurance through the Safeguarding Partnerships that the learning is translated quickly into routine practice.

Joanna, Jon and Ben (September 2021) (Joanna, Jon and Ben - published September 2021 | Norfolk Safeguarding Adults Board)

Independent review – Greater Manchester Mental Health NHS Foundation Trust (Jan 2024) (NHS England — North West » Independent review – Greater Manchester Mental Health NHS Foundation Trust)

Safeguarding Children with disabilities and complex health needs in residential settings (October 2022) (Safeguarding children with disabilities in residential settings - GOV.UK (www.gov.uk)

Safeguarding adults review: learning from the circumstances of the deaths of Abi and Kim (June 2023) (Safeguarding adult reviews (SAR) | Adult Safeguarding Board (nssab.co.uk))

Financial investment

Context and national picture

The stigma surrounding mental health has always been the sectors biggest challenge, and a contributing factor to historic underinvestment in service provision. Mental health has therefore suffered a structural disadvantage, when compared to its physical health counterpart, which has spurred the national "parity of esteem" agenda.

Over the past couple of decades, great strides have been made to increase investment in mental health services. Following years of public advocacy and growing political awareness, mental health services have received a significant injection to funding. This is in part due to the commitments set out in The five year forward view for Mental Health and then built upon by The NHS long term plan – both of which highlighted the need to improve the quality and accessibility of mental health provision.

Services have also benefitted from NHS England's commitment to the Mental Health Investment Standard. The Mental Health Investment Standard (MHIS) is the requirement for all ICB's to increase mental health spending in real terms, by at least the same proportion as their overall increase in programme allocation. Introduced in 2013/14, the MHIS is a set of commitments designed to promote parity of esteem between mental and physical health.

To support progression towards the service transformation requirements depicted within the NHS Long-term plan ICBs receive a further form of annual funding allocation referred to service development funds (SDF), which commenced in 2019/20.

Mental health has suffered a

structural disadvantage

when compared to physical health

Where do we spend our funding?

Each year, ICB's are required to submit a MHIS plan to NHS England. This plan demonstrates where and how much systems are planning to invest in local mental health services. The figure below sets out the BSW SDF plan for 24/25 (total spend £14,533,000), presented by key service category.

MHIS spend - % of total:

2%	A&E ward liaison
5%	Prescribing
7%	Talking Therapies
9%	Crisis
13%	Children & young people
16%	Adult inpatient services
19%	Specialist & section 117 placements
26%	Community mental health
1%	Perinatal
2%	Early intervention in psychosis

Mental Health SDF Allocations 24/25:

18.98%	Children and Young People Mental Health including Eating Disorders
30.06%	Mental Health Support Teams in Schools (MHST)
8.97%	Mental Health Adult Crisis
36.33%	Mental Health Adult Community
1.76%	Individual Placement Support (IPS) additional funding
3.9%	Mental Health, learning disability and autism inpatient quality transformation

What does this mean for us as a system?

Whilst we have benefitted from additional investment in mental health services in recent years. We are awaiting national plans for investment in mental health services in the coming years, however we anticipate the need for a stringent approach to ensure investment not only is directed by population health needs, and shaped through co-production, but also that impact is demonstrated to affirm continuity of investment.

To create a financially sustainable system, we will need to focus on making the money we have go further and with greater impact for our population. We'll need to think differently about prioritising investment for prevention and early help services in our communities. The individual components of the strategic model explore this in more detail.

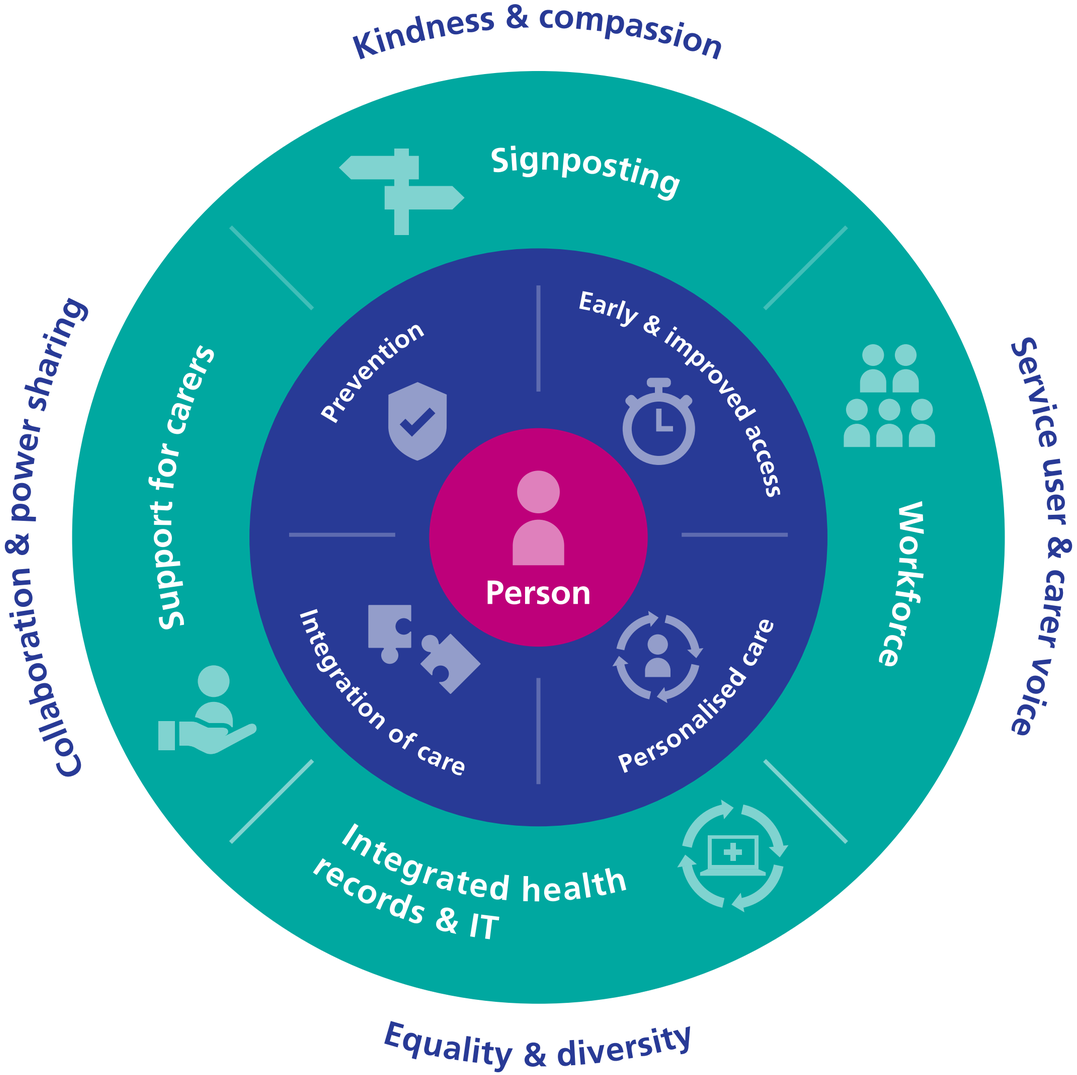
The strategic model

Through co-production we have created this diagram to show how the different elements of our strategy interact. A detailed explanation of each element within the model is provided in the following chapters.

Central quadrants = Priorities

Inner ring = Enablers

Outer ring = Values



Priorities → Prevention

What we know

When we reference prevention, we have two strands of approach – seeking to intervene and avoid further decline in mental health, or reoccurrence of a period of mental ill health which is the area with greater focus in the strategy. However, prevention intervention and approaches can reduce the rate of mental health need and therefore diverting the need for accessing mental health services, the strategy for this is led by the BSW Prevention Programme, and we are committed to working in close partnership.

Not all interventions need to be delivered by secondary care services. Often Third Sector organisations have the specialist knowledge and skills to deliver evidence-based interventions. These focus on encouraging and increasing protective factors and healthy behaviours to help prevent the onset of a diagnosable mental disorder. They also reduce risk factors that can lead to the development of a mental disorder.

They can involve creating living conditions and environments that support mental health and allow people to adopt and maintain healthy lifestyles or an environment that respects and protects basic civil, socio-economic and cultural rights. All of these things are critical to improving our prevention of mental ill-health across our population.

Prevention is at the heart of our BSW Model of Care and is central to the existing NHS Long Term Plan and the anticipated requirements of the new NHS 10-year plan (yet to be published). Prevention has the potential to improve our population's long-term wellbeing, while also reducing the number of people needing secondary mental health care. Effective prevention **which focuses on increasing protective factors will positively help to build stronger, more resilient communities**, it will also improve the quality of life of our population, and in doing so release capacity to care and provide in-depth treatment for people experiencing severe mental ill health.

There are three types of prevention in mental health:

Universal prevention
Across the population to help people avoid problems arising

Selective prevention
Targeted interventions for those likely to be at greater risk of mental ill health

Indicated prevention
Preventing deterioration among those who have experienced mental ill health

Prevention at the earliest opportunity is best. We know the first 1,001 days (which includes pregnancy) are essential to developing physical and mental wellbeing. Adverse childhood experiences increase the risk of mental ill health for children and young people. This is likely to extend into adulthood with increasing complexity if unaddressed. If we are committed as a system to truly improving the mental wellbeing of our population this must be a priority.

The Third Sector, local authorities and schools excel at prevention work and should be recognised as key partners in delivering this priority.

Universal prevention

Primary prevention **ensuring that people have the resources and capacity to thrive**. This includes building mental health literacy in the community **so that it becomes better equipped to deal with the ups and downs of life.** Community groups and holistic support that looks at wider aspects of people's lives are examples of primary prevention interventions.

Selective prevention

Mental health is influenced by many wider determinants, including physical health, financial circumstances and environmental factors.

There are certain groups who are more at risk of mental health issues. For example, those experiencing inequalities relating to ethnicity, sexual orientation, financial status or neurodiversity. Groups such as children and young people who are not in school, students and carers may also be at increased risk of mental health deterioration.

Life stages and experiences also play a role. Offering support to people at key moments, such as pregnancy and childbirth, cancer diagnosis or job loss, could help them navigate these challenges.

Prevention needs to start from a very early age. Mental health issues can start early in life or in early teens, including those triggered by adverse childhood experiences. We also know that mental health issues can be passed down the generations in a family. Interventions supporting perinatal mental health, families and social support in the community could address this.

Indicated prevention

If you have an existing condition, it can be difficult to get mental health treatment because of criteria and thresholds for access.

We need to offer services that help people avoid deteriorating, reaching crisis and relapsing.

Mental health is influenced by many wider determinants, including

physical health, financial circumstances & environmental factors

What people told us

Universal prevention

Interviewees wanted to increase knowledge and awareness of how to look after mental health and wellbeing, particularly in workplaces and education settings.

Services in the community where people can gather, connect and support each other were key to thriving. People reflected that many excellent local groups haven't reopened since the pandemic and are sorely missed.

Loneliness was widely acknowledged as negatively impacting people's mental and physical health.

Selective prevention

All service providers, particularly local authority colleagues and acute hospital trusts, were concerned intervention isn't being provided early enough for the most vulnerable infants, children and young people. This is reflected in the increasing self-harm rates and presentations of suicidal intention, alongside increasing absence rates in schools.

Some service providers were frustrated that children and young people who have had adverse childhood experiences are often unable to access trauma-informed care. They can face long waits to access services. This is impacting them at key stages of development and on their education.

Mental health support teams only cover up to 40% of schools, and school nursing (drop ins) is only in secondary school settings. Local authority teams and acute trusts also described a training need for all professionals on trauma informed practice, and how to support a young person presenting with self-harm or suicidal intentions.

Recognising the wider determinants of mental health, such as housing and financial hardship, were seen as key to prevention among Third Sector and local authority colleagues. Increasing opportunities for community connection could be a protective factor for many people.

Indicated prevention

People with existing mental health issues felt that the system only responded once they had reached a crisis point or had become a risk: *"It's almost as if, if you don't present a risk to others or yourself, you don't get anything."* – public workshop attendee.

People also described how support could often "drop off a cliff" once treatment had been finished. Discharge from in-patient services could be much smoother and planned with more notice to put in place appropriate accommodation or less intensive support.

What needs to happen next?

The ICB will work in partnership with system leads to take forward the recommendations of the Prevention Concordat for Better Mental Health. and in turn will see the commission of evidence-based prevention interventions increase.

In Universal prevention, we will

- Commission improvements and an increase to evidence-based prevention and early support for perinatal mental health, children aged 0-5 and families
- Strengthen the coverage and specialist approach available through our mental health support teams
- Lead the development of our community mental health support offers through an asset-based approach to promoting mental health and wellbeing, working with communities and non-health organisations as direct partners
- Continue partnership work with Public Health and wider partners to further our approach to suicide prevention; including partnership work to support the delivery of the BSW Suicide Prevention Strategy
- Further invest in mental health services for children and adolescents to improve access and treatment, with a focus on trauma, with managed transitions into adult services
- Improve our system-wide training offer to upskill more colleagues from all sectors to recognise and respond to mental distress or emerging mental health needs

In selective prevention, we will

- Invest in the Third Sector to target the wider determinants of mental health, for example employment [and higher education] support
- Commission services to ensure an increase the uptake of annual physical health checks for people with severe mental illness. This includes support for post check behaviour change and general health and wellbeing. Develop a consistent severe mental illness enhanced service for primary care and dedicated health checks and outreach teams

In indicated prevention, we will

- Identify cohorts across BSW who most at risk are or unable to access our mental health service offer. To do this we'll undertake a deep dive into population health data and develop with our providers a programme of community outreach
- Co-design with people how to tailor and improve accessibility to the services and operational models we commission
- Ensure prevention enablers and services are coordinated and joined up to meet people's needs and work with system partners to integrate preventative services with other community-based offers. Wherever healthcare is accessed, mental health and wellbeing are considered, and people are supported where they present. This is the principle of 'making every contact count'
- Commission for developments to our community-based mental health offer to help people maintain good mental wellbeing post-discharge from mental health services. This includes careful tapering of support when working towards discharge, proactive periodic review post discharge and rapid access via the integrated community primary care mental health service

What will be different for our population in 5 years?

- Increased range and scope of services during the perinatal and early years, including family support, to avoid longer-term mental health needs and improve overall quality of life
- Increased comprehensive community awareness and responsiveness to mental health
- Reduced rates of self-harm and suicide
- An increased number of children and adolescents can access mental health services and receive trauma focused support and treatment
- Increased understanding, recognition and response to mental health across all health services
- Commissioning of a robust support offer targeted to the wider determinants of mental health, reducing the severity of mental health need for the BSW population
- Lower mortality rate of people with a severe mental illness
- Proactive and inclusive service offer in place for those with higher risk factors associated with mental ill health and those who experience greater obstacles [i.e. health inequalities] to engaging with our mental health offer
- Improved recovery rates for those supported by BSW mental health services

In 5 years time our population will have a

lower mortality rate of people with a severe mental illness

Priorities → Early and improved access

What we know

Early and improved access is a national priority, strongly advocated for by those delivering services in BSW and by out population. It enables those who need support to access it more quickly and earlier in their mental health journey.

People experiencing mental health issues must navigate complex routes to different services. This means many people fall through the gaps, especially those from marginalised communities. If it takes a long time to access services, people's conditions are more likely to deteriorate before they can access the input they need. We know that people can experience waits at different points along their care pathway, meaning that even if people are 'in services' they may not have timely access to the right care and treatment at the right time.

"If you have had a mental health condition a long time, you know the warning signs of your mental health getting worse, so you ask for early help. But they tell you your symptoms are not bad enough [to access the service]."

Public workshop attendee

What people told us

We know if people wait a long time for access, their needs may have changed, and the service may no longer be suitable. This means some people then go through a new access process and potentially onto a new waiting list. People described general frustrations associated with waiting for service access or treatment. Some described experiencing escalation into a mental health crisis whilst waiting. This could be prevented "by offering services when people were [first] reaching out" (public workshop attendee).

People across our communities have told us that there's no easy way to get back into services for those experiencing a relapse or who have noticed their mental health deteriorating.

Thresholds to access services can also be a problem, especially for children, young people and students. Young people who are self-harming, for example, were considered too high risk for some Third Sector services.

People we spoke to also said there seemed to be no middle ground between the GP and going to the Emergency Department. There was a perception that only those at crisis point gain access to services, potentially leading people to take more extreme action such as self-harming.

"Improved access is the number one priority...you don't have to be in crisis for more help."

Public workshop attendee

What needs to happen next?

We will

- Commission services with waiting time standards for access and "in stage waits" (within a [treatment] pathway) which are compliant with national waiting times, or in the absence of these waiting times are co-produced
- Where there are longer waiting lists (either for access or within a pathway), we will work closely with providers to implement improvements through targeted initiatives or redesign
- To improve people's preparedness for treatment, the ICB will commission providers to apply a principle of 'active waiting' across all services, so people are ready for treatment and do not experience further deterioration in their mental health
- Apply population health needs forecasting to ensure commissioning of future proofed service capacity
- Respond to population health data to ensure evidence-based services and interventions are available to people at the point of need. These will be tailored through design and review with people
- Embed co-production in our commissioning cycle to enable us to remove service access barriers
- Reduce the complexity in accessing mental health support through leading integration and/or optimising joint working practices across "access" services, including integrated primary care mental health service, MH Ambulance response and 111-mental health offer, alongside a system 'no wrong front door' approach, removing the onus from the person and referring professional to navigate our services
- Commission greater diversity in our local mental health offer, especially strengthening our digital offer
  - We will also evaluate the ratio of remote and face-to-face engagement opportunities across services, setting parameters to optimise outcomes, workforce resource and people's preferences

In 5 years time our services will be compliant or exceed access and [locally set] waiting time standards

What will be different for our population in 5 years?

- Our services will be compliant or exceed access and [locally set] waiting time standards
- People will experience our mental health services as easy to access at the point of need
- People will not experience a decline in their mental health owing to long waits for access or treatment
- Where people do wait [for an appropriately defined period] there will be a support offer, in the form of information and interventions designed to support and improve mental wellbeing whilst they wait. People will find direct benefit from 'active waiting' and will describe a greater sense of preparedness when they commence treatment
- Access to services will be improved for those who are at risk of health inequalities
- People will be able to access mental health support through a variety of media

Priorities → Personalised care

What we know

Care should be 'person-based': tailored where practicable to the child or adults needs and preferences, rather than expecting them to fit into categories or a diagnosis. The aim of personalisation is to improve individual experiences regarding the quality of support received, the perception control regarding care and treatment, which contributes to progression to recovery.

Personalised care needs to be a principle and approach spanning from the point people describe a need, right the way through to more specialist mental health provision. The degree of personalisation required will of course vary and can be about finding a suitable approach to appointment arrangement through to specific treatment options.

Continuity of care is important to people. Seeing the same professional means improvements or deterioration can be observed. Without this consistency, building a therapeutic alliance is much harder. We know that a lack of continuity can affects how confident people perceive their care and support offer.

Some people don't get on well with certain types of support or treatment, so where possible there should be different options within NICE guidelines or evidence-based treatments informed by clinical judgement.

Diagnostic overshadowing - where a clinician thinks a person's symptoms occur because of an existing condition, i.e. a learning disability or neurodiversity - can lead to other potential causes or contributing factors being missed. It can also lead to people being given the wrong support or information.

Care should be tailored to a person's personal history and presenting needs, not pre-determined based on diagnosis, and people should only have to tell their story once. This is only possible if patient records are integrated across organisations.

What people told us

Interviewees and workshop attendees shared that they want a shift from diagnosis to need. Accessing condition-based services and pathways often has a severity threshold attached to it. Such services can be too focused, excluding support for/accommodation of comorbid conditions, such as substance misuse or neurodiversity.

"My bipolar disorder and PTSD are lifelong conditions that need ongoing support. Without some form of ongoing support people like me will just bounce in and out of secondary services."

Service user

"My big concern is people who are too ill to be looked after by primary services but not considered ill enough to be treated by secondary services."

Carer

What needs to happen next?

We will

- Commission services to improve care [including discharge] planning, which includes involving service users and carers more fully
- Commission services to improve continuity of care, ensuring people see the same professionals as much as possible. This will be achieved through formalisation of the requirement where practicable, and sufficiency of workforce
- The ICB will lead develop of a system agreement protocol for the management of transferring people across services/providers; a proactive transfer process will take place, to include professional-led introduction and information sharing
- Commission services to enable people to be empowered to make decisions about their mental health journey
- Ensure services [workforce] are skilled and resourced to tailor (including environment, service information and joint working) support for comorbid diagnoses, for example autism, neurodiversity, dementia and substance misuse
- Co-production of services with people, including carers
- Strengthen transition to adult services for care experienced young people recognising that the impact of trauma doesn't stop when they cease to be looked after

People and their families/carers will be

more involved in the planning of their care

What will be different for our population in 5 years?

- People will report accessing good quality services tailored to meet their needs and preferences, enabling them to achieve the best possible outcomes
- People will report good continuity of care, enabling them to achieve the best possible outcomes
- People will only have to tell "their story" once
- People and their families/carers will be more involved in the planning of their care
- People will experience a well navigated journey across services, which is directed for them [as opposed to by them/ the referring practitioner]
- Continuity of care for children looked after when they move in and out of area and for care experienced young people when they leave care

Priorities → Integration of care

What we know

Integrated care systems have been designed to enable services to work seamlessly together.

While it's still early days on this path, the model has many advantages. They are an opportunity to integrate mental and physical health, health and social care, statutory and non-statutory services across the whole pathway. Integrated and transparent commissioning of services and open book finances are an enabler to achieving this.

However, there are challenges:

- There is no mechanism for holding risk across the multiple organisations which can be supporting a person
- BSW doesn't yet have shared patient records across all provider organisations

Many people with mental health issues also experience physical health issues. Physical health issues can also lead to a worsening of mental health. Greater integration between physical and mental health services enables more holistic, effective care, which is more likely to achieve improved outcomes as well as provide an improved experience regarding quality of care.

This similarly applies when people experience co-occurring substance misuse and mental health. Partnership arrangements to care as opposed to treating needs in isolation lead to optimisation of outcomes.

We know insufficient housing, problem debt and other social issues [the wider determinants] impact people's mental health, therefore collaboration across health, social care, Third Sector, housing and other local authority services is essential.

Lack of integrated care can have a significant impact on children and young people transitioning from children's mental health services into adult service provision. Poorly managed transitions can result in people 'falling between the gaps' as a result of process, threshold differences and consequently worsening of mental health.

For those adults whose mental health conditions (such as dementia) impact on their decision-making ability, SAR Norman (Wiltshire Safeguarding Vulnerable People Partnership (SVPP) - Home page (wiltshiresvpp.org.uk) recommends improvements to how their information is shared and pooled to enable the right support to be commissioned as they need to move between services.

What people told us

The experience of discharge or stepping down services was described as a problem for many people. One likened discharge to "falling off a cliff edge". People described being discharged to feel unsafe and ineffective due to barriers such as delays in accessing accommodation and absent post-discharge support.

People we talked to wanted to know how services are evaluated. People described that communication when being offered services could improve confidence and engagement.

People described that communication when being offered services could improve

confidence & engagement

What needs to happen next?

We will

- Work with partnership forums to Audit patient journeys, focusing on transitions between services where people report experiencing delays, a poor process or impact, or other challenges. Facilitate the implementation of improvement plans based on this analysis
- Improve the information available to people on the services they're being offered and their delivery standards
- Develop, with key stakeholders, principles, mechanisms and processes for dealing with risk (in the context of mental ill health) across organisations
- Improve joint working practices between physical and mental health; Strengthen our integrated long-term conditions pathways with Talking Therapies and the severe mental illness physical health checks services
- Develop collaborative working agreements to improve joint working practice between mental health and substance misuse services
- Extend our approach to transparent commissioning with our local authority partners through bi-annual finance oversight meetings
- Expand commissioning of integrated children's and adults service provision for 16-24 year olds so that transitions are supported by relationship building with professionals ahead of transfer into adult services, with a focus on understanding and continuing to address trauma that may have happened in childhood

In 5 years time people will

experience seamless transitioning between services

What will be different for our population in 5 years?

- People will experience seamless transitioning between services – either as a young adult, adult of working age or older adult
- Increased awareness among people of service scope and delivery standards against key performance indicators, through the BSW mental health directory of services
- BSW will have a system approach to mental health risk management, improving collaboration on care and treatment
- With enhanced integrated care for long-term health conditions, health assessment and follow-up, and health behaviour change services we will reduce the mortality rate across BSW, improving the holistic health and wellbeing of people
- Enable alignment, integration and complementary commissioning approaches of mental health services to be strengthened across BSW
- Improved outcomes for people experiencing co-occurring mental health and substance misuse

Enablers → Signposting

What we know

Mental health systems are complex.

Readily available accurate and up to date information about the system enables professionals to signpost effectively. Availability of information for people also improves their ability to self-direct access to services or make more informed decisions about services recommended to them.

Considering equality and diversity, we know that people from different backgrounds and cultures may conceptualise mental health differently from UK mental health services. Information should be given in a way that's appropriate for the person. This includes alternative languages and [culturally] accessible formats.

Signposting by professionals was viewed as an active process, one which could be supplemented by robust handovers, professional directly introducing people to services and get to know the system better. Signposting isn't a one-off event but needs to happen at every point in a person's journey, so that they have access to the range of support which could contribute to their recovery.

What people told us

Navigating the system is a challenge. This is especially true when people are struggling with their own or a loved one's mental health.

During workshops and conversations with service users, carers and providers, it was clear that many people are confused by or don't know about what's available in the system. Some had differing expectations of what a service's remit and offer should be.

Some people described receiving conflicting advice by different professionals, both about their treatment and their condition. They described being referred to services where they didn't meet the threshold for access. Some said they were bounced between services because providers didn't have up to date eligibility criteria. Sometimes people were even referred to services that no longer existed.

What needs to happen next?

We will

- Lead development of locality-based system-wide service overview snapshot training – to be updated and repeated annually, to become part of organisational induction packages and mandatory annual training
- Lead development of an online professional's service directory that's kept up to date by the services themselves, to include eligibility criteria, location and other meta data
- A publicly accessible version of the directory will be made available through the ICB website, with cross-linking from all services' websites. This version will include self-referral services, holistic and carer-focused support
- Lead development of work shadowing programme to increase knowledge of the system and understanding of different sectors, fostering closer working relationships
- Hold annual BSW cross-sector and provider mental health conference and world cafe
- Work with provider partnership forums to develop signposting transition protocols. These will facilitate an introduction and passage of appropriate information to reduce the responsibility on people to self-navigate our services

In 5 years time our services will be

easier to find and navigate

What will be different for our population in 5 years?

- Our services will be easier to find and navigate for people, their families and professionals
- Professional across the BSW system have readily available information about our mental health service offer and will be better informed about how to support people to the services best placed to meet an individual's needs
- Signposting will be a welcomed part of the BSW offer as opposed to being perceived as a "hand-off"

Enablers → Workforce

What we know

BSW are committed to make our area an excellent place to work in mental health. We know our key challenges include;

- A national shortage of mental health care professionals which is replicated in BSW
- Staff turnover and in turn vacancy rates
- Requirement for agency staff to fill vacancy pressures in the clinical workforce. The temporary nature of their relationship with service users means they can't always provide consistency of treatment and interventions which impacts upon people accessing our services

Improving clinical staff retention, wellbeing and engagement is key to offering personalised and integrated care. Providers across BSW undertake an array of initiatives and reviews of workforce wellbeing, and have implemented many successful initiatives to retain staff, such as annual workforce wellbeing reviews, wellbeing support offers and holding "listening" forums.

Staff with lived experience have enormous value within the system. They are key in realising many of our priority areas, including in prevention and early and improved access. Previous public engagement events in BSW highlighted people's high regard for peer-led support.

Over the last three years we've made progress against some of our workforce challenges with innovative workforce growth and development approaches. Our aspiration is to ensure people have ready access to professionals with the right skills to meet their needs. Across BSW providers have been progressing an array of actions to expand and develop our workforce, which includes:

Staff with lived experience have

enormous value within the system

- Clinical associate psychology trainees
- Talking Therapies workforce expansion through low and high intensity trainees
- Apprenticeships
- Overseas recruitment
- Training for professionals to enhance their work with service users: Connect 5 Training, Oliver McGowan Mandatory Training
- Cross provider training programmes
- Recruitment of mental health professionals in primary and urgent and emergency care

What people told us

Lived experience was seen as a particular advantage in mental health, whether in clinical or other roles. Indeed, it can be the driving force for why people want to work in the field.

"We know that a large number of the staff that will work within mental health will have either experienced it personally or their families will have experienced it. So there's a lot more lived experience in mental health than you find in other walks of nursing. And so people are very driven to go and work in mental health."

Service provider

What needs to happen next?

We will

- Through the NHS E multi-professional education and training plan (METP) strengthen access to quality mental health training programmes, and create cross-system training, including trauma-informed care
- Lead the development of a system approach and package to support staff emotional and mental wellbeing, building on the national NHS staff package of apps
- Support providers aspirations to strengthen and increase career opportunities and development pathways for those with lived experience, including access to clinical qualifications
- Support and facilitate "explore, grow, develop" opportunities for staff at all levels across all sectors, including opportunities such as shadowing programmes to increase knowledge of the system and understanding of different sectors, and rotational posts
- Create a bi-annual workforce improvement forum, where providers will share and commit to measurable actions to improve recruitment and retention, and optimise staff skills and wellbeing

What will be different for our population in 5 years?

- Increased workforce satisfaction and organisational pride
- Increased staff satisfaction on the perceived positive impact on the people they support or treat
- Improved staff emotional and mental wellbeing
- Improved staff recruitment and retention with workforce growth across all sectors, including peer and lived experience roles
- People and their carers will report greater satisfaction in accessibility of staff with the right skills to meet their needs
- Reduction in spend on agency across the system, achieving nationally set standards

Enablers → Integrated health records and IT

What we know

We know that people, their families/carers only want to have to tell their story once. Reliving trauma and repeating personal history is exhausting and can be counterproductive. It also takes up time that could be better spent having active treatment.

Integrated records help professionals, and the system more generally understand a person's journey. Additional benefits can include prevention of people falling between services, and more informed support in complex circumstances such as a mental health crisis.

To deliver integrated care, teams across the system need to access shared digital case notes - also known as electronic patient records (EPR) - securely and appropriately. Without this, it's impossible to have a good understanding of a person. This then makes it difficult to deliver personalised care. At present BSW mental health have limited access across EPRs i.e. Third Sector providers access to mental health trust record systems. We do not have integration across systems operating for BSW mental health providers.

What people told us

Service users, carers and staff from all sectors expressed frustration that there wasn't an easy way to share information about people's mental health care between teams and organisations.

Smaller organisations and teams felt unsure how to deal with GDPR requirements and sharing data. Large organisations had concerns about how their systems would be able to interface with those in other organisations.

Integrated records were recognised as key to providing integrated care across the system. Without this, the aspiration for people to "only tell your story once" will be a significant challenge.

People want to have access to their own records. They are important for understanding and keeping focused on their personal goals and outcomes.

What needs to happen next?

We will

- Develop a method for commissioned organisations to view and integrate patient records where digitally possible
- Explore with people and providers opportunities to develop digital integration, enabling efficiency in accessing services and treatment
- Support the commissioning of EPR systems which enable people to have greater sight and control of their records, giving them ownership of their plans, goals and outcomes
- Ensure that we have mechanisms in place to identify children looked after at an early stage and if they move out of our footprint, there are robust and effective systems in place to share their information and continue their care

What will be different for our population in 5 years?

- People of all ages will only have to tell their story once
- Integrated EPR will be in place, in turn this will enable;
  - Services to have oversight of a person's journey through the EPR system
  - Improved crisis management, through the ability to hold shared access to crisis and risk management plans
  - Reduced complexity and risk associated with prescribing, particularly between primary and secondary care
  - Continuity of care for children looked after when they move in and out of area

Enablers → Support for carers

What we know

Carers, parents, families and people's other supporters are incredibly important to the functioning of the mental health system. The value of these carers cannot be overstated. Maintaining carer wellbeing and resilience is crucial as they spend far greater time with the individual in need/receipt of mental health services than any professional. However, appropriately informing carers regarding the needs and what to expect from their loved one's journey as well as how they can support them is important to support wellbeing.

What people told us

Carers were very well represented at the public workshops for the strategy. They told us they need more support.

When their loved one can't access services or is on a long waiting list, carers are left trying to fill the gap. This inevitably impacts the carer's mental health. Many carers we met were unaware of the resources available to support them.

Some carers talked about the benefit of accessing online training, such as the HOPE course. Peer networks were another invaluable source of support, which in the case of HOPE were integrated into the training. However, carers wanted more consistent access to peer support.

How information about people was shared with carers was a particular concern. Sometimes carers were missing out on vital information about their loved one. They highlighted that as situations change to the status of whether to share or not share information should be regularly reviewed.

What needs to happen next?

We will

- Develop a system-wide core support package for carers, parents and families while their loved ones are waiting to access services, ensuring that the needs of young carers are also considered and supported
- Develop targeted support and information for young carers, co-designed with them and partners
- Work with provider organisations to create a training and peer support offer for all carers
- Review and ensure the commission of services to respond to gaps in support available to carers, both young and adult
- Ensure carers are involved in the co-production, progress and review of the BSW mental health strategies delivery implementation plan
- Through the mental health directory of services ensure that feature information regarding wider carer forums, and support offers that exist in their communities

What will be different for our population in 5 years?

- Improved wellbeing of carers
- Improved, timely and appropriate support offer to carers
- Reduction in crisis escalations and admission associated with unsustainably carer support in the community setting

In 5 years time our population will have

fewer crisis escalations

Our values

We want our values to be embedded in the culture of our system. They are only achievable through culture change and organisational development. We want to create a sensitive system which recognises and addresses closed cultures.

Kindness and compassion

What we know

Kindness and compassion are essential to offering effective mental health support. We recognise that living these values can be challenging under pressure.

We want these values to become an intrinsic part of every interaction – people and carers, staff and professionals alike.

Mental health issues are stigmatised in society. Our services must avoid stigmatising behaviour and language so that people feel they are in a safe space. This includes understanding the intersecting stigma that people in more than one group experience, for example people in both minority ethnic and LGBTQI+ groups.

Anticipating where service users might be distressed or anxious in the system, such as moving between services or being discharged from a service, will also lead to a more kind and compassionate experience. This means understanding the whole pathway for an individual service user, identifying those points of anxiety and distress.

When care hasn't gone as planned, an environment of shared reflection and ongoing learning to understand what could be done differently is the ideal approach.

What people told us

- Members of the public told us that agency staff were less likely to show kindness and compassion. This is perhaps a symptom of the effects of working as temporary staff within a service, especially the challenge this brings to developing therapeutic relationships and continuity of care
- Service users could see that mental health teams had unmanageable caseloads. People also reported that times of crisis were particularly hard for service users, their carers, family and friends
- One service user told us the crisis line felt like a call centre. It was "depersonalised" as they didn't look at their notes
- Local safeguarding adult reviews (REF: DHR Emily & Adult L: https://www.wiltshiresvpp.org.uk/p/learning-hub/learning-from-case-reviews) have identified that the individual needs of people should be better understood, so that they are not discharged from services without reasonable adjustments applied and the risks of doing so informing the decision

What needs to happen?

We will

- Lead the development of a system-wide training package and supervision approach to support kind and compassionate care
- Lead the development of an organisational development programme to enable culture change to deliver the commitments in our strategy
- Lead the development of standard "did not attend" policy across the system to enable improved uptake of appointments
- Providing more opportunities for service users and carers to give feedback on their experiences
- What will be different for our population in five years? Improved satisfaction for people and carers accessing mental health services across BSW
- Increased staff perception of peer and organisational kindness and compassion

Our values → Service user and carer voice

What we know

All elements of our system should be designed in the spirit of true co-production. This means working closely in partnership with people and carers, as well as key providers and staff. Time and space need to be given to enable genuine co-design of services.

Within services, we want to ensure people and carers are listened to. Their needs and wishes must be properly heard to inform and direct care and transformation.

To reinforce our equality and diversity value we need to hear voices from a range of perspectives and backgrounds.

What people told us

Most people and carers wanted their voices and opinions to be included when considering changes or developments to services. They also valued other opportunities to give their input, such as on interview panels when hiring staff.

However, some people we spoke to were fed up of being asked to give their views: *"Why is [the] onus on service users to come up with solutions?" "Stop over-consulting and come back with action."*

A lot of co-production has already been done across the system. This is a great starting point when developing services, before going out for further views.

What needs to happen next?

We will

- Draw on co-production frameworks to design a system-wide model for the co-design of mental health services, and in support of wider BSW work to support co-production across our system
- Ensure existing co-production work is used effectively across the system, with a robust feedback cycle demonstrating action and impact of input obtained from people
- Commission providers to build co-production at a individual/direct care level to make improvements
- Ensure that lived experience representatives are part of our transformation at each and every stage of implementation, making them a core part of design, delivery and development of our mental health and care system

What will be different for our population in 5 years?

- By embracing co-production of service design, delivery and development, services will be tailored to for those who need them and achieve better outcomes

Our values → Equality and diversity

What we know

Understanding our local population and ensuring services are culturally appropriate and inclusive are essential.

Health inequalities are variations in health and wellbeing across our area and between different groups in society. Some are preventable, while others aren't. These inequalities affect how well people live their lives and ultimately how long people live. This includes the likelihood of having physical as well as mental long-term or multiple conditions.

People from marginalised groups and communities are more likely to experience mental health issues. They may also be less likely to seek professional help due to fear of being discriminated against or mistrust of services.

The population of Asylum seekers and refugees residing in BSW is increasing, unfortunately many have experienced significant trauma through conflict and persecution. They may not know how the health and care system is structured and so may not seek support. There may also be cultural barriers to accessing services.

Evidence from the national NHS Race and Health Observatory suggests that even when people do seek help, they face additional barriers to receiving the care they need. For example, they are less likely to receive a referral for Talking Therapies.

People from other marginalised communities, such as people who are receiving treatment for drug use, also often find themselves unable to access services. Their needs are considered too complex, and they are seen as high risk. They can fall between services with a debate over whether their mental health or substance misuse requires support and treatment first. This in turn can create delays in action being taken by services.

People who identify from our LGBTQI+ communities want care and support that is tailored to them. This is particularly true for people who have undergone gender reassignment.

Issues of trust and fear of discrimination could be addressed through meaningful co-design of services. This includes not just the service offer, but the spaces and places where it's offered.

People from marginalised groups and communities are more likely to experience mental health issues

Long-term outreach and engagement to build meaningful relationships with local communities would also overcome these barriers.

Equality and diversity play a key role in the personalisation agenda. Personalised services should reflect the needs of the individual at every stage of the pathway. This includes protected characteristics such as age, gender and ethnicity. Through personalised services, dedication across all our services and collaborative working informed by co-production we can achieve equality and ensure our services respond positively to diversity.

What people told us

Providers told us that historical lack of funding in mental health services had led to 'exclusivity' and that ensuring access for people from a range of minoritised backgrounds was vital. While cultural awareness training and other interventions were welcomed, representation in the workforce was seen as an issue. As one service user said: *"People from minoritised groups often do better when cared for by someone with a similar background."*

In our workshops, adults with lived experience spoke about not disclosing autism or ADHD. They felt a neurodiversity diagnosis was a barrier to accessing mental health care. Symptoms would be explained away in the context of their neurodiversity. This well-observed phenomenon is known as diagnostic overshadowing.

What needs to happen next?

We will

- Evaluate population health needs and map across services to understand gaps and opportunities for improvement
  - Commission culturally appropriate adaptations/sensitivities across services where gaps exist, applying co-design principles
- Through partnership forums strengthen links between mental health and wider services, such as drug and alcohol services
- Support and inform workforce diversity programmes
- Commission services to record and be responsive to equality and diversity data; This data will be required by providers to be drawn from to inform continual service development and identify areas where targeted improvements are required
- Ensure a system approach to embed and adhere to the Patient and Carer Race Equality Framework (2023) and the NHS Advancing Mental Health Equalities Strategy (2020)
- What will be different for our population in five years? Tailored actions to overcome factors associated with health inequalities, improving access, experience of services and outcomes
- Robust data on diversity among the people using our services, demonstrating good outcomes equal to the rest of the population

Our values → Collaboration and power sharing

What we know

To achieve transformation in health and care provision across our system, we need to move away from models of care built around organisations and historic structures.

The move from traditional commissioning structures and boundaries to the new world of Integrated Care Systems is a huge opportunity to do things differently.

This new way of commissioning and providing mental health care demands a more equitable approach to power and influence across the system. Embedding co-production across our system will provide the opportunity for people to influence, guide and shape the services that matter to them.

Power sharing applies to the interactions between people and professionals, where equal and respectful relationships support engagement and outcomes. This connects to the personalisation agenda, empowering people to direct and hold agency in their journey through mental health services.

These principles apply to the relationships between providers too. There must be a joint focus on shared solutions that make the best use of our collective skills to have the greatest impact for people.

This kind of collaboration and integration must be founded on high-trust relationships, between staff and people and across organisational boundaries. This includes an agreed approach to holding and sharing risk, both operational and financial, across the pathway.

There must be a joint focus on shared solutions

that make the best use of our collective skills

What people told us

Many providers saw the imbalance in power across the system as a key barrier to strategic development. Depending on the provider and sector, this was described as power or responsibility. Responsibility was often used in connection with the severity of people's mental health.

Funding was one factor in power imbalances. Non-statutory services often had short-term funding from a range of sources, leading to a constant churn of funding applications and a lack of long-term job security for their workforce.

Other issues providers felt powerless to address related to integrating systems, particularly if key systems such as EPRs were held by statutory providers.

What needs to happen next?

We will

- Develop trust between partners across the system through open and honest dialogue, and regular constructive spaces to discuss key issues and develop shared solutions
- Focus on outcomes across as well as within services so that flexible budgets (or resource/workforce migration can be considered where appropriate

What will be different for our population in 5 years?

- Enable faster transformation and support efficiency
- People report having greater agency in the system

Implementation and finance

Implementing our strategy

Moving from strategy to delivery

Through this strategy we have committed to truly transforming the BSW mental health offer. We will ensure we reach a greater proportion of our population, at the earliest opportunity, with timely access to evidence-based provision. We will achieve better outcomes for them with a higher quality experience of our services. To attain these strong commitments, we know delivering an integrated mental health service structure is essential.

We will review the current contractual arrangements to ascertain the best future contractual model to achieve effective and sustainable services, considering redesign, reorganisation and introduction of new provision as needed. By 2030 we will have realised and established an all-age mental health provider collaborative model across our footprint.

Implementing our strategy

Our intention through this will be to create a lead provider arrangement, which could be a single organisation or a consortium. They will ensure end to end oversight of delivery and improvement of quality and outcomes for people across our system, working in partnership with the ICB as the statutory commissioner of services.

Achieving the substantial commitments in our strategy will require a strong collaborative infrastructure, with committed capacity, resource and leadership from all system partners. Most crucially it will need a commitment to enable change. This will be achieved through forming the BSW Mental Health Strategy Collaborative Implementation Plan Oversight Group (SCIPOG), which will include representatives from partners across our system.

Ensuring and measuring success

We know that holding a well-formed plan, supported by key mental health stakeholders (including people) is a critical factor to success.

The BSW Mental Health Strategy Collaborative Implementation Plan Oversight Group (SCIPOG) will develop a responsive delivery plan to the commitments embedded within this strategy by August 2025. Throughout this period and thereafter this will be overseen by the BSW Mental Health Delivery Group. Bi-annual progress reports will be submitted to the BSW ICB Board and will be openly published. The year end bi-annual report will take both a retrospective view; evaluating progress against the plan and will set out the annual plan for the subsequent year. This will ensure ongoing refinement of the delivery plan in the context of any new national directives, developments to local population health needs and co-produced requirements.

The delivery plan itself will be structured by the priority areas of the conceptual model and will be set out with key milestones and outcomes for every action. We will take a three phased approach to this, recognising that we need to establish successful and sustainable delivery in key areas initially, with the intention to evolve from a platform of strong performance to a new model of delivery. These are set out next:

Phase 1 – Foundations for the future – 2025-2026

We know that we have improvements to make in key areas. In order to move forward with a new model of delivery, it is critical that we achieve nationally mandated standards to enable us to create the right foundations. Key features of this will include:

- Ongoing development of BSW Talking Therapies, ensuring that we have an operationally and financially sustainable service model that provides early and easy access to support for people with Common Mental Illness. We will ensure we move to meet the national standard for the number of people receiving a course of treatment, and that of those who are treated at a minimum reach a 50% recovery rate. This will be achieved through the implementation of the Talking Therapies Full-Service Review recommendations and commissioning of a new and innovative model that makes best use of digital technology
- In partnership with our Local Authorities, establishing a more integrated CAMHS offer for children at highest risk of admission across our system, with a particular focus on Children Looked After and those who have experienced significant trauma. Through this we will achieve a reduction in length of stay for those children and young people admitted to our acute hospitals and reduce admissions where clinically appropriate
- Commission the implementing of our inpatient quality improvement transformation plan, aligned with the National Quality Improvement Programme ambitions
- Ensure that people with severe mental illnesses can access to the right support for their needs through our mental health community services, delivering the nationally mandated trajectory for 2+ contacts
- Lead improvements to dementia diagnosis rates to achieve the national mandate and provide a more consistent service offer across BSW
- Develop and implement a business case to pump prime mental health prevention interventions with a robust evaluation plan to understand the impact on mental health service demand (to note; there is a separate dedicated funding allocation managed through the BSW Prevention Group which will support this)
- Reduce our reliance on out of area hospital admissions and commence development of local community rehabilitation service provision as an alternative

Phase 2 – Transforming our care models – 2027-2028

Whilst the first phase of our strategy will necessarily focus on delivering against existing national ambitions, we recognise that this will focus on improving what we already have in place. The second phase of our strategy implementation will need to focus on further transformation to sustain improvement but also go beyond our existing ambitions to support the development of a new model of care. This will include:

- Developing our specifications for an integrated model of community-based mental health provision pan-system for both adults and children
- ‘Right-sizing’ our inpatient mental health capacity to deliver improved pathways
- Agreeing a new, integrated model of older adult provision that ensures the capacity and capability of all partners is used for the benefit of people to support early access (to diagnosis and treatment), support for carers and families and ensuring that there is an integrated offer across physical and mental health services pan-system

Phase 3 – Partnerships for the future – 2029-2030

Through the first two phases of implementation, we will work with partner organisations to develop and embed high trust relationships across the system, operating to a principle of equitable partnership in everything we do. Our values, set out our in our strategy, will be central to our system wide development, and will be evident to our communities at every stage of our work.

Having established strong foundations from which we will have begun the next phase of our transformation work, during 2029/30 we will implement our refreshed commissioning plan for mental health services, pan-system. A lead provider collaborative arrangement (which could be one organisation or a consortium approach) will be formally established.

How will we fund our commitments

We will commence delivery of our strategy in a time of national economic pressure. Therefore, a number of our commitments will only be enabled through a committed system approach to carefully reviewing and refining what and how we invest in our mental health services to ensure we optimise outcomes.

Ultimately this means us holding a tolerance for reduction or decommissioning of provision where we find a mismatch between our population health needs and/or poor outcomes experienced by people. We know already there are key areas where we can positively augment investment, for example directed through the transformation of community rehabilitation pathway and the NHS Inpatient Quality Improvement Programme we will significantly reduce the volume of activity in specialist placements (individual placements with mental health private providers, situated outside of the BSW area). This funding will be utilised to deliver robust care within local communities and will enable us to strengthen the left shift with funding allocated at a higher rate to Third Sector organisations and ensuring good mental health provision for CYP.

Acknowledgements

We want to thank everyone who has been involved at each step of developing our BSW ICB Mental Health Strategy. We greatly appreciate the time people have committed to ensuring we understand our services and the opportunities and requirements for improvements.

We view this strategy as the beginning of our journey for the next five years. We look forward to our continued partnership with people who access our services and the carers, families and friends supporting them, and professional organisations delivering our services.

Together we will work to ensure we meet the commitments presented in the strategy.

Find out more

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Appendices

Appendices

Our methodology

This strategy is a co-production between BSW ICB and NIHR ARC West. The BSW ICS partners were included in all aspects of the process, from deciding on aims and led on the determination of conclusions drawn.

This project had four phases of production:

- Scoping and summarising evidence on BSW-wide mental health status, needs and services
- Gathering the perspectives of commissioners, service leads, providers and users
- Triangulation of the two strands above to identify and agree the strategic mental health model for BSW
- Socialisation of the strategy with system stakeholders, and integration of their feedback.

The first three strands were iterative with each informing the others. At least three rounds of each were conducted. We also had a patient and public involvement group to help us design meetings and workshops, recruit service users and feedback on our work.

Scoping and summarising evidence

By the end of the process described above, we'd extracted data from more than 60 documents.

Data was extracted in standardised format in Excel, capturing: source, document details, key findings / data, locality, population group, theme (eg common mental disorders, prevention in childhood, severe mental illness).

We collated gaps for each theme and listed them as needs. We shared this with BSW partners to identify additional documents. We also found new ones via snowballing and included them if relevant. Comments were collated for each theme and document. Themes and needs were discussed in the light of comments, and any changes agreed.

We did a second round of information extraction, with new data added to the spreadsheet and any gaps communicated to BSW partners. In the final round in December 2023, we included unpublished data from the BSW data intelligence team, to update and finalise the needs assessment.

We also mapped out existing services. We used a standardised Excel form, and extracted: theme, provider, sector, locality, length of service, services provided, description of services, population groups.

We mapped service provision for each locality and BSW-wide, and national level services for some themes and conditions.

We collated the needs and service provision into Excel, detailing: current mental health needs (including figures such as % or numbers of episodes), existing services, missing services, reasons for these gaps, and priorities for future work for 17 mental health themes. This was a live document with access for all partners.

Gathering the perspectives of service users, carers, public and stakeholders

We conducted a total of 44 meetings, workshops and interviews, involving more than 200 people's views. This workstream incorporated:

- Reviewing existing service user experience data and co-production work, including Healthwatch reports, Third Sector co-production, service evaluations, data from system involvement and engagement leads
- In-person and online interviews with stakeholders from across the system. 40 were conducted between 26 October 2023 and 27 February 2024
- Presentations at mental health forums and events attended by a mix of stakeholders, service users, carers and public

- Two workshops with service users and carers in Bath and Swindon (39 attendees)
- A workshop with stakeholders (around 30 attendees)

Stakeholders were identified through contacts and introductions from the ICB team, followed by snowballing from conversations with stakeholders. We interviewed a range of providers and stakeholders from across all parts of the system.

Service users and carers were identified through Third Sector providers and system involvement coordinators.

Interviews, focus groups and workshops were recorded and transcribed where possible and consent was given. We took notes at each session and summarised them under the emerging priority areas. As the strategy development phase ended, we summarised them again under the agreed priority areas, values and enablers.

We revisited notes and interview recordings throughout the writing process, and we identified quotes from the transcripts to include to support the narrative.

Triangulation

Triangulation began early in the process, with initial ideas and priorities developed based on;

1. The existing conceptual models for mental health care in BSW
2. Themes from the existing co-production & engagement data
3. Priority areas that the ICB partners identified

Throughout we iteratively compared information from the evidence and perspectives workstreams.

We developed 8 potential priority areas for exploration, creating a diagram used in discussions (figure 1) alongside a data summary.

Over several iterations, this diagram became the basis of discussions in our meetings, interviews and workshops with service users, carers and stakeholders. We refined the model and priorities based on their feedback, to the eventual form you see presented in this strategy.

Strategy review and finalisation

The draft strategy was presented to an array of system forums and stakeholder groups (over 30) by ICB leads. Forums reviewed the strategy in terms of the rigour to which its aims and objectives had been upheld, the accuracy of content, for example analysis of data and research and inferences drawn, and considered the interface and interdependencies with wider ICS programmes of work. The draft strategy has been subsequently shared with over 100 stakeholders for full review. Feedback from all sources has been woven through the strategy, with leads notified as to how their perspectives and requests have been responded to. We hope this approach ensures that system stakeholders feel their input has been respectfully validated.

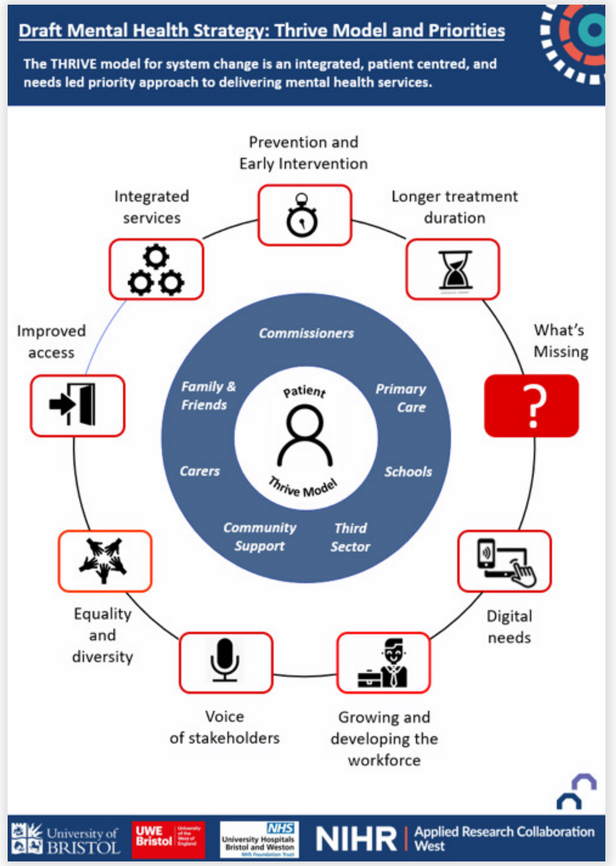

Figure 1: Diagram of 8 candidate priorities and space to discuss what was missing (version 1 of the strategy conceptual model)

Select bibliography

Local information

- Joint health and wellbeing strategy – Bath & North East Somerset Council
- Mental Health Needs Assessment 2022 – Bath & North East Somerset Council
- Bath and North East Somerset Strategic Evidence Base – Bath & North East Somerset Council
- Swindon Joint Strategic Needs Assessment – Swindon Borough Council
- Wiltshire Joint Strategic Needs Assessment – Wiltshire County Council
- Plus unpublished grey literature

Other regional mental health strategies

- Bristol, North Somerset and South Gloucestershire draft mental health strategy – Bristol, North Somerset & South Gloucestershire Integrated Care Board
- Greater Manchester mental health wellbeing strategy – Greater Manchester Integrated Care Partnership Board
- Hampshire mental wellbeing strategy – Mental Wellbeing Hampshire
- South West London mental health strategy - South West London Integrated Care Board
- Somerset local transformation plan for children and young people's mental health and emotional wellbeing - Somerset Integrated Care Board

BSW learning disabilities, autism and neurodiversity vision:

Strengthening community provision

Listening and hearing views of all

Supporting independence

Person centric

Prevention focused

Transformational

Collaboration

Codesign

Needs focused

Pathways not services

Understanding needs of people who are LD, ASD and Neurodiverse

Valuing each other's skills

Physical and emotional wellbeing

Proactive and Responsive

Achieving Potential

BSW interdependent strategies

- ICS Integrated Care Strategy
- BSW Inequalities Strategy
- ICA SEND Strategies
- Bath Mind 2023-2026 Strategy
- Wiltshire Dementia Strategy
- Swindon Dementia Strategy
- The BSW Primary and Community Care Delivery Plan
- Together we are AWP – 5 year strategy
- Oxford Health Trust Strategy
- BSW Suicide Prevention Strategy

Glossary

Acute trusts – NHS organisations that offer short-term treatment and care, usually in a hospital

Asset-based approach – Using the advantages and strengths of local communities to benefit local people's mental health

Autonomy – A person's independence and freedom, which enables them to have control over their lives

BSW – Bath, North East Somerset, Swindon and Wiltshire

BSW Model of Care – The commitments BSW have already made to how care is delivered

Co-production – Service users, carers and providers working together on a collective outcome, sharing power in decision making

Health inequalities – Unfair and avoidable differences in health across the population and between different groups

Holistic care – Care that considers wider aspects of people's lives, such as their physical, emotional and social wellbeing

Integrated Care Board / ICB – The NHS organisation responsible for bringing local health providers together to provide care in a planned, strategic way across a region

Integrated Care System / ICS – Integrated Care Systems were set up in 2022. They join up care across a region, bringing local partners, including the NHS, councils, voluntary sector and others to work together. They aim to create better services based on local need

Index of Multiple Deprivation – Measures how deprived different areas are, relative to each other

Inpatient care – Care provided in a hospital where you stay at least one night

Lived experience – Having personal experience of something, for example mental health deterioration, using services or caring for someone with mental health needs

LGBTQI – An umbrella term for lesbian, gay, bisexual, trans and queer people

Local authority – Also known as councils, the local government organisations responsible for delivering local services, such as social care

Long Term Plan / LTP – The NHS Long Term Plan 2019-24 is the strategy for improving NHS services

Marginalised communities – Groups of people who experience discrimination and exclusion from political, economic and social power structures

Mental Health Act – The key legislation governing how people with mental health issues are treated

Non-statutory services – Services that aren't funded by the government or underpinned by law, often provided in the community by charities

Peer support – Support for people experiencing mental health issues or caring for those with mental health issues, provided by people who have had the same experience

Personalised care – Service users have choice about their care and it is tailored to their specific needs

Primary care – Healthcare provided in the community, often people's first port of call

Provider selection regime – The provider selection regime is a set of rules for procuring health care services in England by 'relevant authorities', which includes Integrated Care Boards

Glossary

S117 – Free help and support offered to some people who have been hospitalised under the Mental Health Act

Secondary care – Care that isn't provided on the first point of contact with healthcare services, usually in hospital through inpatient or outpatient services

Serious mental illness / SMI – A mental illness which substantially limits or interferes with a person's ability to function

Statutory services – Services funded by public money and underpinned by law

Talking Therapies – Therapies involving talking to a trained mental health professional

Third sector – Third Sector provider organisations, sometimes referred to as Voluntary, community and charity organisations

Trauma informed – Recognising the role that trauma plays in many mental health issues, and offering services that take this into account

Treatment – the term treatment is used interchangeably with, and to refer to interventions, support and treatment (in the context of NICE compliant and evidence-based treatment)

Wider determinants – The social, economic and environmental factors which impact on a person's health

NHS

Bath and North East Somerset, Swindon and Wiltshire

Integrated Care Board