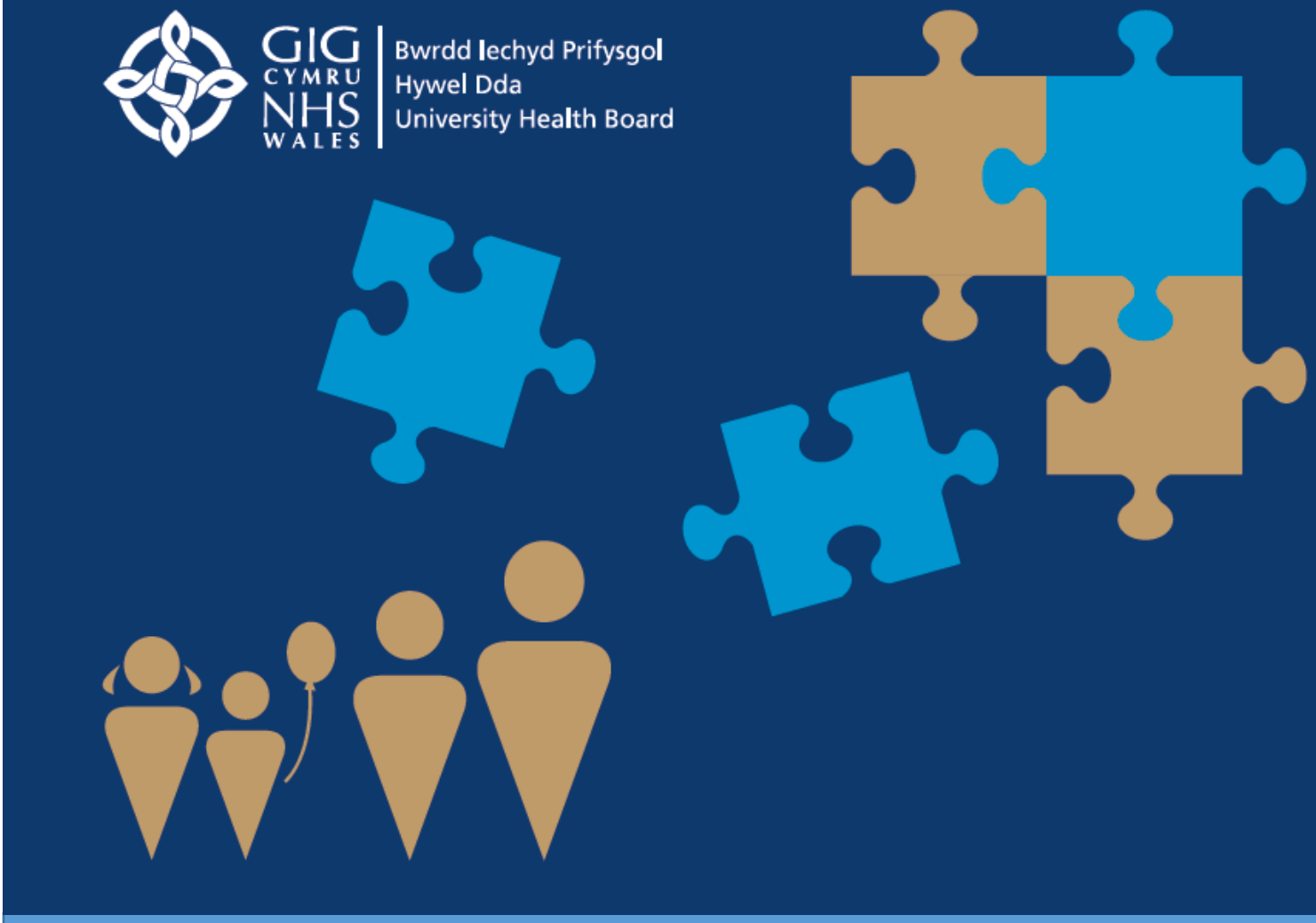
GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board



Transforming Mental Health Services

Consultation Closing Report

January 2018

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Cyngor Sir Gâr Carmarthenshire County Council

Cyngor Sir Penfro - Pembrokeshire County Council

WWAMH

Heddlu Police DYFED-POWYS

Cyngor Sir CEREDIGION County Council

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1.1 Introduction and Background to the Closing Report

1.2 Introduction

This Closing Report is a technical document that sets out the information necessary for Hywel Dda University Health Board (HDdUHB) and partner agencies to reach a decision on the proposed adult mental health service redesign. Its purpose is to enable the Board to:

- Consider the themes that have emerged through the Transforming Mental Health public consultation as they relate to each of the consultation areas;
- Understand the process adopted to analyse the responses;
- Understand the approach to equality impact assessment;
- Note the issues that have emerged that were not subject to consultation but were raised as part of the process;
- Consider a recommendation for each of the areas that were subject to consultation; and
- Provide assurance that the consultation process was delivered as outlined within the project plan presented to the Board in June 2017.

The report consolidates the work undertaken as part of formal engagement, options development and consultation (stage 1 of the consultation process). It aims to provide assurance of compliance with the Ministerial Guidance for Health Boards on engagement and consultation with particular focus on stage 2 of the consultation process, formal consultation. It also details the process undertaken to give conscious consideration to the consultation feedback received and outlines the revised proposal and recommendations, including a high-level draft implementation plan.

The consultation process has been subject to an independent rigorous assurance process by the Consultation Institute. The Consultation Institute has developed and deployed a tried and tested method for the quality assurance of public consultations. This quality assurance process has included the testing and review of the project plan, documentation, mid-point review, closing date and final closing report. As a result of this HDdUHB has received notification from the Consultation Institute that the project should receive endorsement of 'Best Practice' standard for the consultation, pending final approval.

1.3 Background

The Transforming Mental Health programme has been overseen by the Mental Health Programme Group (MHPG). This group is made up of representatives from HDdUHB, service users, carers, General Practitioners, Dyfed Powys Police, the Welsh Ambulance Service Trust, trade unions, the voluntary sector, West Wales Action for Mental Health (WWAMH), the County Council Local Authorities, and the Community Health Council (CHC). The group has been working together over the past two years to consider the challenges and opportunities in meeting the mental health needs of the local population.

Figure 1- The MHPG testing consultation analysis feedback

As leaders within mental health support and services, the group has a clear responsibility to work in a co-produced way to drive continuous improvement in the quality of mental health care within HDdUHB. They are clear that they want to develop and provide a range of high quality and sustainable services that respond to the future needs and aspirations of local people. The best way to achieve this is to 'connect' with local people, staff and partner organisations:

- **C**ommunity – involving communities in developing services so that they are shaped around local people and are not simply 'made to fit' existing organisational structures or traditional healthcare environments.
- **O**pen access – bringing services to people, not people to services; this means exploring new ways of working, making better use of modern technology and developing a workforce that is flexible, highly skilled and able to meet the needs of service users in any healthcare setting, including within hospital and in the community – 24 hours a day, 7 days a week.
- **N**eeds led – everything should be based on what each person using services needs in order to live a happy, independent life – to help everyone to not only get healthy, but to stay healthy.
- **N**othing about us without us – involving people and informing them every step of the way with a commitment to designing services in a way that supports this and takes into account the different needs of each person.
- **E**ngagement – moving away from the view that only healthcare professionals have the answers; a new approach that appreciates the equal contributions of people with a lived experience of mental health problems, including our partner organisations.
- **C**ollaboration – not doing things alone but working with service users, carers, the voluntary sector, local authorities and other agencies.
- **T**imely help and support – working in a much more joined up way across health and social care, and the voluntary and independent sectors. Breaking down traditional barriers to provide better services which reduce waiting times and unnecessary referrals to other services.

HDdUHB want people to be supported by the best mental health services that are on a par with the best in the UK, Europe and the rest of the world.

1.4 Mental Health Services in HDdUHB

1.4.1 The HDdUHB landscape

HDdUHB plans, organises, commissions and delivers local health services for the 384,000 people who live in Carmarthenshire, Ceredigion and Pembrokeshire. It organises and pays for the care and treatment local people receive in their hospitals, health centres, GPs, dentists, pharmacists,

optometrists and other healthcare settings. The Mental Health and Learning Disabilities (MHLD) Directorate provides mental health services across primary and secondary care through inpatient and community care. It also commissions a range of services from the voluntary sector to support core service delivery.

1.4.2 Current provision of adult mental health services

Historically, adult mental health services were designed to help people with a variety of needs, ranging from mild anxiety, depression and stress, through to more severe mental health conditions such as schizophrenia and psychosis. Most people are referred to services via their GP or they may refer themselves. Once referred, an individual can be seen either within the community or an inpatient setting, depending on their level of need. The services that are currently delivered are outlined below:

Community Mental Health Services (CMHS)

Community Mental Health Services (CMHS) work with people with a range of needs which are often categorised as severe and enduring. Services are provided from mental health facilities within the community or through outreach support in people's homes or other convenient local sites. CMHS are staffed by mental health and social care professionals including psychiatrists, psychologists, psychiatric nurses, occupational therapists, social workers and support workers. They typically work from 9am – 5pm, Monday to Friday.

There are eight CMHS teams based in:

- **Carmarthenshire**: Ammanford, Carmarthen, Llandovery and Llanelli
- **Ceredigion**: Aberystwyth and Llandysul
- **Pembrokeshire**: Haverfordwest and Pembroke Dock

Inpatient services

People are usually referred to inpatient services because they may be in need of intensive support or present a risk to themselves or to others, which makes it difficult for them to live at home and make use of community support during times of crisis. Inpatient services are provided from small hospital-like buildings where adults with acute mental illness and/or challenging behaviours receive specialist assessment and treatment.

There are three adult inpatient units to support people with short term mental health needs:

- **Bryngofal:** an 18 bed unit in Llanelli
- **Morlais:** a 9 bed unit in Carmarthen
- **St. Caradog:** a 15 bed unit in Haverfordwest

HDdUHB does not provide an inpatient unit in Ceredigion, therefore Morlais Ward in Carmarthen is used as the closest admission point for individuals living in Ceredigion.

Inpatient units are staffed by psychiatrists, mental health nurses, occupational therapists, psychologists and healthcare assistants. Psychiatric intensive care and low secure care is provided at two specialist inpatient units based in Carmarthen.

- **Psychiatric Intensive Care Unit (PICU):** an 8 bed unit providing short term intensive assessment and treatment for people with acute mental health problems who are too unwell to be managed safely elsewhere
- **Low Secure Unit (LSU):** a 14 bed unit for men with a severe mental illness who have been detained under the Mental Health Act

Inpatient mental health units are necessary to meet the requirements of the Mental Health Act (1983 as amended 2007). HDdUHB must provide facilities where individuals can be detained under the Act for a period of assessment and/or treatment, as well as providing voluntary care and treatment to those who need it.

Crisis Resolution Home Treatment (CRHTs)

Crisis Resolution Home Treatment teams (CRHTs) support adults with a mental health condition who are experiencing an acute episode of illness, often referred to as being 'in crisis'. They care for people outside the working hours of the CMHS. In addition to providing assessment and treatment, they provide intensive support in managing emotional distress, medication and relapse prevention.

CRHTs have an office base but carry out most of their work in the community in the most convenient and appropriate place for the person requiring support e.g. in people's homes or GP surgeries. CRHTs work 24 hours a day, 365 days a year, in Carmarthenshire and Pembrokeshire. They are in the process of extending their hours to provide 24 hour coverage in all areas.

There are currently four CRHT teams:

- **Carmarthenshire:** Carmarthen and Llanelli
- **Ceredigion:** Aberystwyth
- **Pembrokeshire:** Haverfordwest

A wide range of professionals work in CRHTs, including psychiatrists, mental health nurses, social workers, occupational therapists and healthcare assistants. Their contact with service users is short term and typically lasts up to six weeks.

Local Primary Mental Health Support Services (LPMHSS)

This service is for people with mild to moderate mental health problems. It is provided within the community and can only be accessed via a referral from a healthcare professional. It offers a variety of support, including mental health assessment and advice, support and signposting to other relevant services, stress management and other psychological interventions.

Other adult mental health services

The voluntary sector is commissioned to provide a range of mental health services, many of which focus on preventing crisis, supporting wellness, counselling, advocacy and signposting to various statutory services within health and social care. They add an important additional range of services that complement and work alongside the statutory services provided.

1.4.3 Other services

MHLD services within HDdUHB also consist of a number of other services that interface with the adult mental health service. These include Psychological Therapies Services, Older Adult Mental Health

Services, Learning Disabilities Services and Specialist Child and Adolescent Mental Health Services (S-CAMHS). These are described in further detail below.

Psychological therapies services

Psychological therapies services provided by the MHLD Directorate include:

- Adult Mental Health Psychology Service
- Forensic Mental Health
- Integrated Psychological Therapy Service including the Psychotherapy Department and Therapeutic Day Services
- Eating Disorder Service
- Older Adult Mental Health Psychology Service
- Learning Disability Psychology Service
- Perinatal Mental Health Services
- Veterans' Mental Health Service
- Neuropsychology Service

They provide a range of psychological assessment and treatment functions that support care delivery. Their core function in adult mental health services is to provide psychological assessment, cognitive assessment, psychological therapy and therapeutic intervention delivered through staff groups. The role also includes staff supervision and consultancy. The service provides input to eight CMHTs, four acute inpatient wards and three CRHT teams.

Older adult mental health services

Older adult mental health services are currently provided in a traditional model of inpatient and community services, each operating with its own referral criteria and referral processes.

Older Adult Mental Health Services currently consist of:

- Inpatient Services
- Community Mental Health Services
- Memory Assessment Service
- Psychiatric Liaison Service
- Commissioned Intermediate Care Beds

They provide a service to people who are older in age and have mental health and / or memory problems. They often work closely with adult mental health services where people transition between services or where they provide an assessment and treatment service to those who have been admitted to a general hospital and appear to have mental health needs.

Learning disabilities services

Learning Disabilities services provide secondary care services to the population of Carmarthenshire, Ceredigion and Pembrokeshire. Services are currently provided through two inpatient units, three residential units and four community teams. They often interface with adult mental health services where individuals have co-existing mental health needs along with a learning disability.

S-CAMHS

S-CAMHS services provide mental health services at both a primary and secondary level for children and young people under the age of 18. The service is delivered based on a “hub and spoke” model with service delivery coordinated from a central base in Carmarthen. This is due to the large geographical area covered by HDdUHB. They provide services within primary care, including early recognition of mental health needs, secondary care community services, access to inpatient beds where needed, a Crisis Assessment and Treatment Team and a Single Point of Contact that makes services easier to access. They will typically interface with adult mental health services where a young person is approaching adulthood, has ongoing mental health needs and will need to transition to adult mental health services.

2. The Case for Change

2.1 The National Context

The national strategic direction for mental health is to move services to a more community focused model of service delivery wherever it is appropriate and safe to do so. Welsh Government policy has clearly and consistently indicated the changes needed in the way community based care in Wales is delivered. The range of community mental health services has extended significantly in recent years and the core values and drivers remain focused on delivering services within and alongside local community infrastructures however there remains significant opportunity to deliver more services within the community.

The Welsh Government ten-year strategy to improve mental health and well-being, Together for Mental Health (2012), encompasses a range of actions, from those designed to improve the mental well-being of all residents in Wales, to those required to support people with a severe and enduring mental illness. The strategy reinforces the need to promote better mental wellbeing among the whole population and address the needs of those with mental health problems, ensuring that those who are most vulnerable or in need are appropriately prioritised. There is a focus on how to improve the lives of service users and their families using a recovery and enablement approach. It recognises the huge impact and cost to society from poor mental health and mental illness borne by individuals, families, society and the wider Welsh economy.

The Mental Health (Wales) Measure 2010 has provided a platform for services to be delivered differently across primary and secondary care. This has enabled a more flexible and targeted use of resources ensuring that people receive more appropriate support at the right time by the most appropriate service.

The Social Services and Well-being (Wales) Act 2014 provides an opportunity to engage with key stakeholders and partners to approach the planning and delivery of care in a more collaborative manner. The Act stipulates a focus on delivering services that are co-produced with partners, including service users and carers, to deliver services that are more responsive to their needs.

The Well-being of Future Generations (Wales) Act 2015 provides an opportunity to engage with communities and plan services early rather than responding to needs as they arise, ensuring they are fit for the future.

2.2 HDdUHB's Changing Mental Health Needs

Changes in government policy towards an increasing focus on providing mental health care in the community led to a change in services in the Hywel Dda UHB area in the late 1990s and early 2000s. A model of care was developed where each county developed a local inpatient facility supported by teams of community based mental health staff.

Community teams were strengthened with developments in care such as Crisis Resolution Home Treatment teams and Early Intervention teams. This shift happened at a different rate in each county. The service developed in slightly different ways, reflecting perhaps both the demands placed upon them in each county and to some extent the interests and skills of the staff in each county.

The Hywel Dda Mental Health and Wellbeing Strategy 2012-2017 provided a launch vehicle to engage with partners with greater co-production to improve and support good mental health and wellbeing, focusing on sustainable recovery and preventing mental health problems and illness through:

- Promoting mental wellbeing
- A new partnership with the public
- A well designed, fully integrated network of care
- Promoting one system for mental health.

2.3 Challenges and Issues Facing Mental Health Services

Over the past decade services have faced increasing challenges presented by difficulties in recruitment and retention of staff and new treatment options for evidence based care, as well the very welcome shift in focus to a recovery based approach to mental health issues. Demand for mental health services has been increasing each year and this is predicted to continue as illustrated in figures 2&3 below.

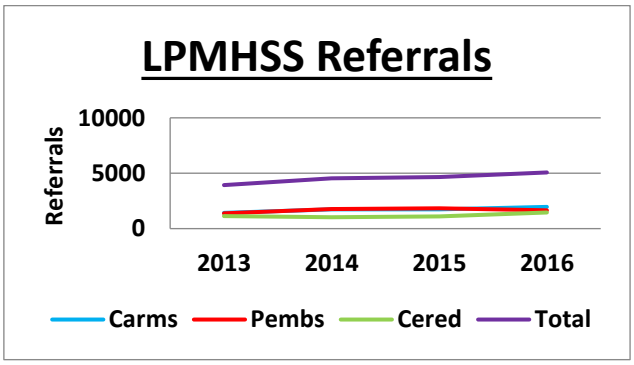

Figure 2- Graph demonstrating the increasing referrals to primary care mental health services

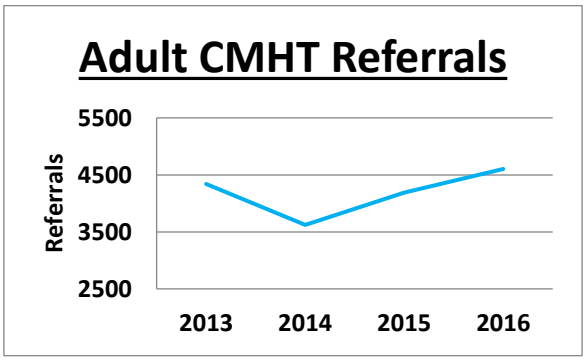

Figure 3 - Referrals to secondary care mental health services

The majority of this increased demand is placed on primary care services. They have received an additional 1145 referrals in 2016 compared to 2013. Future services need to have a greater focus on the promotion of mental wellbeing and preventing the development of mental illness.

Community mental health services currently struggle to meet the growing demand due to their level of resourcing and limited hours of operation. This means that the response people receive is not always timely. Community services need to be developed and grown to meet this demand.

The mental health needs of the population have changed significantly in the last few decades. Many people who used to go into hospital for their mental health treatment now remain at home with support from community services. A major European review of the evidence base for modernising meant health services (*Long Term Mental Health Care for People with Severe Mental Disorders*, 2011) listed the following studies as amongst the best examples of the need to change the way services are organised:

- Accessibility to mental health care of people with longer-term mental disorders is much better with community-based services than with the traditional psychiatric hospitals. (Thornicroft & Tansella, 2003)
- Community-based services are associated with greater user satisfaction and increased met needs. They also promote better continuity of care and greater flexibility of services, making it possible to identify and treat more often early relapses, and to increase adherence to treatment (Thornicroft & Tansella, 2003; Killaspy, 2007).
- The community-based services better protect human rights of people with mental disorders and prevent stigmatisation of those people (Thornicroft & Tansella, 2003)
- Studies comparing community-based services with other models of care consistently show significant better outcomes on adherence to treatment, clinical symptoms, quality of life, housing stability, and vocational rehabilitation (Braun P. et al.,1981; Conway M. et al.,1994; Bond et al, 2001)
- Studies also show that, for patients who require prolonged stays in the hospital, hostel wards provide a cost-effective alternative that is preferred by the patients themselves (Goldberg 1991). Other studies show that, when deinstitutionalisation is correctly developed, the majority of patients who moved from hospital to the community have less negative symptoms, better social life and more satisfaction (Leff, 1993;1996)

2.3.1 Quality of Care

The range of community mental health services has extended significantly in recent years however there is a need to continue to grow these alongside other services in our communities, to help build resilience and allow people to access the services that best meet their needs. Future services need to have a greater focus on the promotion of mental wellbeing, preventing the development of mental illness, reducing the stigma and discrimination associated with mental ill-health, offering appropriate and easy access to care and treatment, early intervention and timely treatment when needed.

Mental health is equally as important as physical health, but this has not always been reflected in the way that services are provided. People are not always helped at an early enough stage, potentially resulting in them becoming more unwell before receiving treatment and potentially requiring an admission to hospital where earlier support in the community may have helped them improve more quickly.

Services do not feel joined up for people with mental ill-health, with communication between different parts of the service not always being as good as it should be and many people having to endure repeat assessments before they receive the right care. Service users should expect better access to higher quality mental health care in their communities, helping them to stay well and out of hospital where possible.

HDdUHB takes part in a national benchmarking survey to provide a comparison with other mental health providers across the UK. The results of this survey show that HDdUHB currently provides an average number of beds for its population. However there has been a sustained pressure on the availability of inpatient beds due in part to the limitations of the current community service provision, as shown in figure 4 overleaf. The environments within the wards, whilst more modern and comfortable than previous environments, are not always the most conducive to assisting with wellbeing and recovery. This has been highlighted by a number of Healthcare Inspectorate Wales visits

to the inpatient services. Earlier access to more timely treatment, that can help people avoid the need for admission, is therefore important.

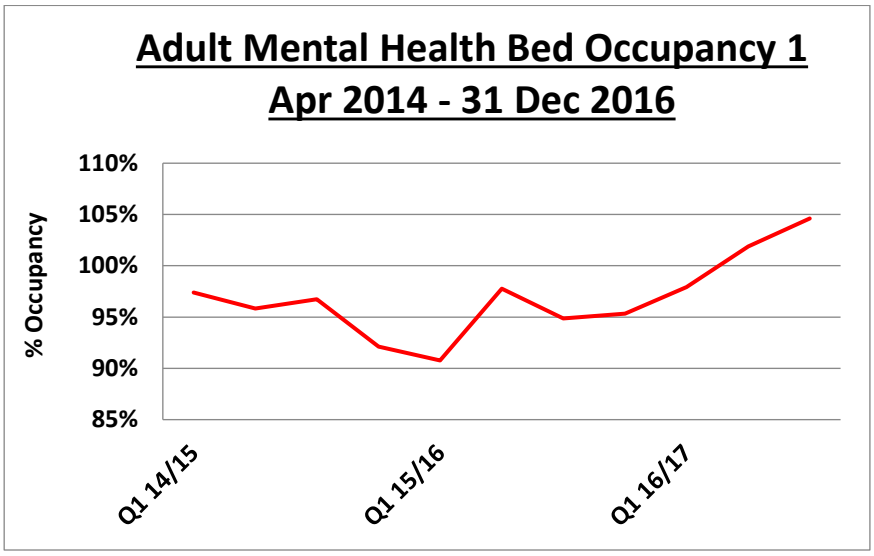

Figure 4- Adult mental health bed occupancy over three years

Service users should expect timely and effective access to crisis care in an emergency, with a plan in place ahead of any crisis developing. Most community teams currently operate between the hours of 9am to 5pm, Monday to Friday which means that the number of services available outside normal working hours is limited.

However, whilst community services have developed, the way that inpatient services are currently provided has largely remained unchanged. Waiting times to see a consultant or to receive psychological therapies in the community remain higher than they should. It is not viable to continue to deliver inpatient services in the same way when there is a need to develop more comprehensive and responsive community mental health services.

2.3.2 An Unsustainable Workforce

Despite the development of new models of care in community mental health services, there will always be a need for inpatient services for people who are acutely mentally unwell and cannot be cared for at home or within their communities.

Mental health inpatient services are currently provided across two counties and three hospital sites. The available staff resource has to be used in a flexible way in order to meet the demands of these busy acute admission wards. This is very challenging given the geographical spread of the units.

A significant amount of the available budget is spent on bank nursing, agency nursing and locum medical staff. This has become the norm in some areas, caused in the main by long-standing recruitment difficulties to the outlying units. Some of the units are relatively isolated with staff managing patients with the highest level of mental health needs. They must do so without a large concentration of services around them to help support during busy times, or when managing people who have very complex and challenging needs. These are often not attractive environments for staff to want to work in and therefore recruitment continues to be a significant challenge in these areas. The reality is that with the development of new and exciting community services in some areas and alternative career pathways on offer, staff often choose to work in the community.

Another significant challenge in delivering traditional inpatient services has arisen from the availability of junior and senior doctors. There have been major changes to the way doctors work and are trained. The European Working Time Directive has put very reasonable limits on the hours doctors are able to work however the result of this is that junior doctors are less fatigued but more of them are required to provide inpatient care. There are fewer doctors available than there are training places in the HDdUHB region. This means that many training places are currently unfilled and this is not predicted to improve in the near future. The Royal College of Psychiatrists (RCP) launched a 'Choose Psychiatry' campaign in autumn 2017 to encourage medical students. The RCP stated that dwindling numbers of consultant psychiatrists in the NHS has led to a "postcode lottery for psychiatric care." New research by the RCP reveals large inequalities across the NHS in access to consultant psychiatrists. While Scotland has 10 consultant psychiatrists per 100,000 people, this falls to 8 in England and Northern Ireland, and to 6 per 100,000 in Wales.

Changes to the way doctors are trained after they qualify from medical school have also had an impact on the way services are provided. As training has become more complex and intense, doctors in training need to see larger volumes of patients to ensure they have the necessary skills to specialise. Doctors in training want to come to busy inpatient services where they see large numbers of patients and work in larger teams of medical staff. This is difficult in areas where there is an isolated mental health inpatient unit, with a reliance on locum and agency staff. While using locums may ensure a service stays open, this way of working does not provide the best quality of care and means money is spent which could be better invested elsewhere in developing community mental health services.

2.3.3 Financial Challenges

A significant factor driving the financial challenge for adult mental health services is the cost of variable pay (costs of agency, locum and overtime pay). Like many other Health Boards in Wales, mental health services in HDdUHB are challenged financially due to difficulties in recruitment. Mental health services have seen significant rise in the costs incurred on variable pay during the past two years. Table 1 below demonstrates the rising cost of variable pay in mental health services, from £1,298,115 in 2014/15 to £3,342,235 in 2016/17.

Table 1 - Variable Pay Costs for Adult MH Services

Variable Pay Category	2014/15	2015/16 Total	2016/17 Total
Agency	572,682.91	1,486,388.70	1,970,248.90
Bank	323,697.00	359,472.70	593,564.19
Locum	271,157.09	610,908.55	410,712.93
Overtime	130,578.25	170,560.44	367,708.82
TOTAL	1,298,115.25	2,627,330.39	3,342,234.84

2.4 Summary

Service users deserve better access to high quality mental health services in their communities, helping people to stay well and out of hospital where possible. Services should support people to recover from

mental health difficulties and to live full and meaningful lives and should inspire hope, confidence and understanding.

Demand upon services has been increasing each year. There needs to be a greater proportion of investment into community services that can provide an improved focus on mental wellbeing, greater accessibility to those seeking assistance, better support for families and carers, a more flexible response at different times of the day, earlier intervention and easier and quicker access at times of crisis.

There are clear advantages to further developing a community model of mental health care. If services do not develop and change then:

- Adult mental health services will struggle to meet growing demand
- There will be longer waiting times for assessment and treatment
- The cost of variable pay will continue to increase
- There will not be money to invest in the community services people want
- There will not be the skilled staff we want to deliver care where it is needed
- It will be more difficult to get good care outside normal working hours
- It will be more difficult to help people in crisis to avoid admission to hospital
- People will not receive the service that they are asking for and deserve

It is important to address the challenges outlined above and avoid the need to take short term emergency measures in the future, moving forward together in a calm and planned way that is better for patients and staff.

3. The Proposal for a Co-Designed New Model of Care

3.1 The Strategic Vision for Mental Health Services

The commitment to design and build a fully integrated network of care that responds promptly and holistically to mental health and contemporary social needs is at the heart of both the Welsh Government and HDdUHB mental health strategies. HDdUHB is committed to a greater focus on the promotion of mental wellbeing, preventing the development of mental ill health, reducing the stigma and discrimination associated with mental ill health, offering appropriate and easy access to care and treatment, early intervention and timely treatment when needed. It proposes improvements to the provision of healthcare in rural areas and is consistent with the Mid Wales Healthcare Collaborative MHLD Subgroup priorities including the provision of mental health crisis management, facilitating care under Section 136 of the Mental Health Act and improving the use of telemedicine.

The vision for HDdUHB mental health services has been co-produced in order to transform mental health services to provide:

- **24 hour services** – anyone who needs help will be able to access a mental health centre for immediate support at any time of the day or night
- **No waiting lists** – when referred, people will receive first contact with services within 24 hours and their subsequent care will be planned in a way that ensures the support they receive is consistent
- **Community focus** – a move away from admitting people to hospital when it isn't the best option; providing community services where people can stay when they need some time away from home, or require extra support or protection
- **Recovery and resilience** – not focusing services purely on treating or managing symptoms but assisting people with mental health problems to live independent, fulfilling lives.

3.2 The Co-Designed Model

The proposed model put forward for consultation was developed through discussion, engagement and co-design with staff, stakeholders, service users and carers. The various aspects of the model were explained in a consultation document developed by the multi-stakeholder MHPG, with further detail available within supporting technical documentation. Figure 5 presents the proposed model as detailed within the consultation document:

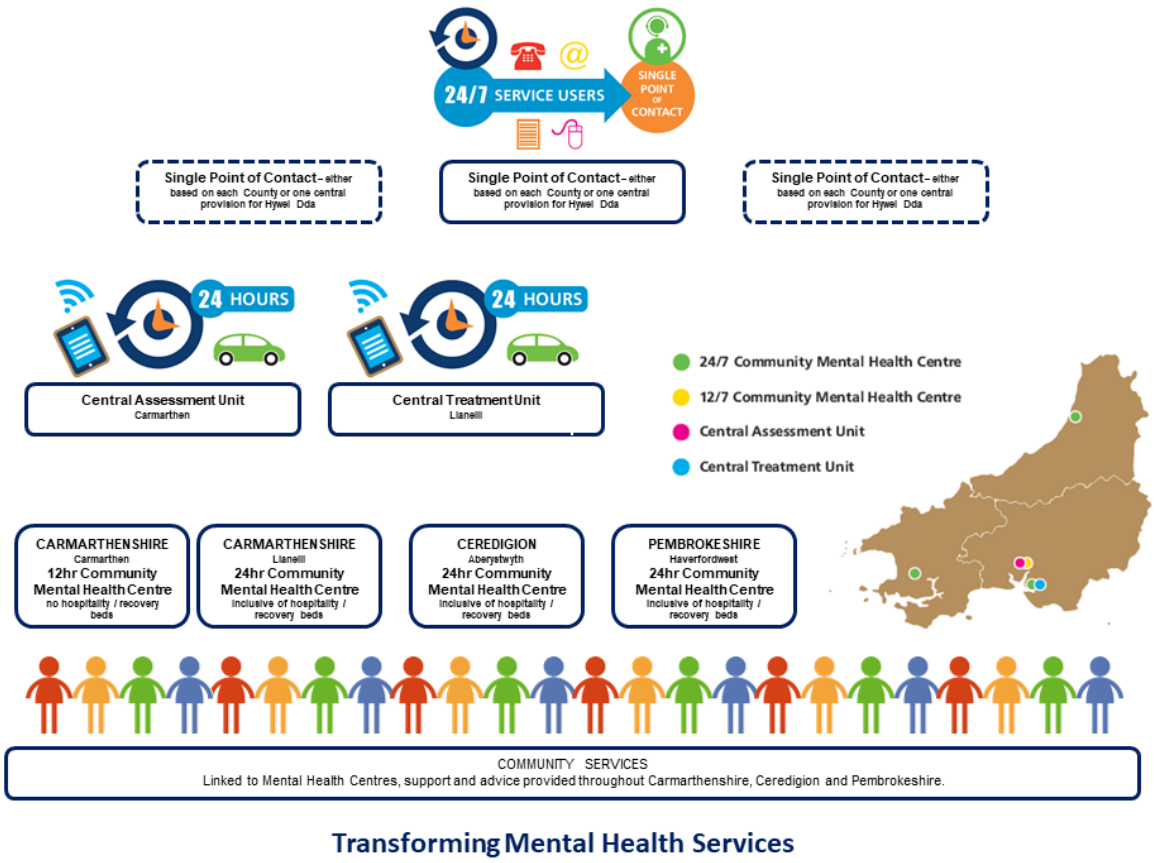

Figure 5 - Graphical representation of the proposed co-designed model

Community Mental Health Centres

Community Mental Health Centres (CMHCs) are buildings with a homelier feel than traditional mental health inpatient units. They provide a wide range of support for people in difficulty and their families, including:

- emergency assistance in crisis situations
- outpatient services
- therapies, treatment and support
- crisis and recovery beds and daytime hospitality

'Hospitality' is an approach to providing support in a setting which is warm, friendly, generous and kind. People using the centres will receive daily reviews and will not be designated as 'inpatients', but as individuals needing short-term mental health assistance.

It is proposed that there will be one 24/7 Community Mental Health Centre in each county with four crisis and recovery beds on site, with an additional CMHC in Carmarthen which will be open for 12 hours every day. It is proposed that the Pembrokeshire CMHC will be based at the existing mental health site in Haverfordwest, with CMHCs in Aberystwyth, Carmarthen and Llanelli with the exact locations to be agreed as part of implementing the changes. Core staff will include: psychiatrists, psychologists, community psychiatric nurses, occupational therapists, pharmacists, social workers and support workers, including people with a lived experience of mental health problems to provide peer mentoring and befriending support. All staff, whether health, social care, or voluntary sector, will receive appropriate training and supervision for the roles they undertake.

The proposed CMHCs will support people much closer to home, providing access to a range of social opportunities throughout their rehabilitation; this could include housing, education, training and leisure activities as well as supporting their relationships with other external services and networks. They will always be open and will bring together staff and volunteers from the NHS, the voluntary sector, local authorities and beyond.

People will be able to come to the proposed centres whether they have a planned appointment or if they simply need to speak to someone for advice or support. The proposed crisis and recovery beds will be run flexibly, meaning people could stay for a few hours, overnight, or for longer if needed. There will be a place of safety for people detained by the police under Section 136 of the Mental Health Act and will also offer support to families, carers and friends of service users.

The Central Assessment and Treatment Units

The proposed CMHCs will provide greater accessibility and earlier intervention support to people. However, there will always be a need for hospital services where more intensive treatment is required. The feedback from options discussions demonstrated that people want a central, skilled pool of specialist staff available within inpatient services where service users with the most urgent and complex care needs are treated. There is a commitment to providing all of our staff with the appropriate supervision and training for their roles whether they are health, social care or voluntary sector staff. This is in line with the workforce plan and governance arrangements.

The proposed Central Assessment Unit will be based at Glangwili General Hospital in Carmarthen and will be open 24/7. It will have 14 assessment beds and two dedicated beds for people detained under Section 136 of the Mental Health Act, to ensure capacity for people from across the three counties. The unit will be led by a consultant psychiatrist working with nurses, psychiatrists, occupational therapists and pharmacists. The team will be supported by peer mentors and family support workers, as well as Social Care Professionals, and there will be facilities for families to visit.

The unit will benefit from being located within the hospital where a wide range of experts will be on hand to provide the clinical expertise needed to quickly assess people with severe mental health problems. Specialist staff will enable short term admission and ensure that planning for people's needs after they leave the unit begins at the earliest possible stage. People will not stay in the Central Assessment Unit for over five days as if they need more hospital care they will be transferred to the Central Treatment Unit.

The proposed Central Treatment Unit will be based at Prince Philip Hospital in Llanelli. It will be open 24/7 and will have 15 beds. It will be run by specialist nursing, medical and support staff including occupational therapists, psychologists and a range of mental health workers from the voluntary sector. The team will be assisted by peer mentors and family support workers, as well as social care professionals, with connections to community services to help plan care for service users after a hospital stay.

The unit will be treatment-focussed and will include a dedicated mental health library for service users, carers and staff. Voluntary organisations will provide support both on the unit and within the community after the service user returns home. Self-management and recovery-based education courses will be available to help people not only get well, but stay well. It will be a safe and supportive place for people to receive medical and non-medical treatment.

The Single Point of Contact

A Single Point of Contact means there is a designated point of contact for people if they want to seek advice or want to make a referral into adult mental health services. It can also be used by anyone, not purely service users, including people who want to make a general enquiry as well as healthcare professionals who would like information on making a referral.

The proposed Single Point of Contact will be free, open 24/7 and people will be able to get in touch in a variety of ways. The suggested model is that this might include using the telephone, email, online, letter or by text (SMS). The service will be delivered by skilled professional staff who will provide sensitive and specialist mental health screening before guiding people to the right place for their individual needs. We want to make it easier for people to access our services.

People have told us they can feel "lost in the system" or "passed from pillar to post", but this should not happen with the new model. Service users will not have to search for help as they will be able to get everything that they need initially from the Single Point of Contact, helping them to feel safer and more supported. The expertise and resources for screening will be concentrated in one place and there will be a single assessment pathway.

Financial Impact

The proposed co-designed model was designed to be cost neutral to run (revenue funding), with only existing revenue being available for use. These were carefully costed with the assistance of the HDdUHB finance team and are demonstrated below in table 2. None of the consensus model options will cost more than existing revenue.

Table 2 -- Cost of the proposed co-designed model

	Opening Budget Position	New Model with Central Point of Access	New Model with 3 Points of Access
Adult Mental Health Services including Medical			
Inpatient Services	5,512,122	3,235,321	3,235,321
Community Services	8,481,304	10,740,850	10,661,690
Commissioning	878,925	878,925	878,925
Psychological Services	2,183,370	2,183,370	2,183,370
TOTAL	**17,055,722**	**17,038,466**	**16,959,306**
Variance		-17,255	-96,415
	17,055,722	17,038,466	16,959,306

4. Approach to Engagement, Options Development and Consultation

4.1 Background

The Transforming Mental Health Services programme has embraced co-production, or involving people every step of the way, as an essential way to truly transform mental health services for the future. The Mental Health Programme Group (MHPG) has engaged with a wide range of staff and stakeholders to understand people's experience of the current services and to co-design a future, needs led service which adheres to these principles. This approach embraces the continuous engagement commitment set out within the Welsh Government Guidance on Engagement and Consultation for Changes to Health Services. The guidance outlines a two-stage process when dealing with substantial changes to health services, a formal engagement process followed by a formal consultation process:

- Stage 1, formal engagement, took place from 1st October 2015 to 31st January 2016 and the feedback from this was used to inform the option development and appraisal process.
- Stage 2, formal consultation, took place from 22nd June 2017 to 15th September 2017 and the results of this work are included within this report.

HDdUHB has been advised and quality assured by the Consultation Institute throughout stage 1 and 2 of the consultation process and has been awarded 'Best Practice' status at each stage. The entire process underpinning this consultation has been subject to stringent quality assurance through robust governance arrangements throughout. These adhere to the principles laid out within key Welsh Government strategy guidance and wider legislation and guidance including:

- Together for Mental Health 2012
- The Social Services and Wellbeing (Wales) Act 2014
- The Well-being of Future Generations Act 2015
- The Equality Act 2010 (Statutory Duties) (Wales) Regulations
- The Mental Capacity Act 2005
- The Human Rights Act 1998
- The Welsh Language (Wales) Measure 2011
- Welsh Government Guidance for Engagement and Consultation on Changes to Health Services
- National Health Service (Wales) Act 2006
- Convention on the rights of the child (UNCRC)

4.2 Internal and External Assurance

Internal assurance for the programme was provided by the MHPG, which met on a monthly basis and included the following responsibilities:

- Advising on the shortlist of service reconfiguration options for full evaluation and presentation to the Health Board
- Assuring the Transforming Mental Health programme process and outputs, and approving the deliverables
- Ensuring the appropriate governance and risk processes are in place to mitigate the risk of future legal challenges

External assurance was provided by the Consultation Institute for the options development and consultation processes. The Consultation Institute is an independent not for profit body that was

founded to promote best practice in public consultation and engagement. The Institute works with clients facing challenging exercises, providing advice and guidance through each step of the process. HDdUHB's Transforming Mental Health Programme engaged the institute at an early stage, prior to formal consultation, to build a process that was fit for purpose. Over the last 10 months the Institute has been working with the programme in its Quality Assurance (QA) role. Those who sign up to the Institutes QA process work to meet the Institute's standards throughout and aim to achieve good or best practice recognition.

QA has six stages, each requiring sign off from the Institute's Assessor:

- Scoping – the basics of the consultation are agreed
- Project plan – when the consultation activities are set out and organised
- Documentation – ensuring that all hard copy and electronic versions are fit for purpose
- Mid-point review – to assess whether all relevant views are being collected
- Closing date – to finalise plans for analysis, feedback and to influence outcomes
- Final Report – to confirm the institutes endorsement of the consultation

The Transforming Mental Health process to date has received 'Best Practice' status from the Institute throughout the process.

4.3 Formal Engagement

The MHPG agreed an engagement plan to provide a structured approach to the management of engagement with key stakeholders, with the following core objectives:

- Ensure timely and accurate information is shared with internal and external stakeholders regarding change
- Ensure information is provided in an appropriate and accessible format
- Provide opportunities for views to be expressed and shared into the organisation
- Provide adequate time for proposals to be considered and commented upon
- Consider the feedback during the decision making process

Stakeholder mapping and analysis activities helped identify who needed to be involved in the engagement activities and the most appropriate methods to engage were identified.

Various methods of engagement were employed to enable multiple platforms of involvement from all target audiences. A range of activities were offered in order to provide the opportunity for staff, service users and stakeholders to consider changes, share their views and participate in shaping the future, these included:

- Group facilitated workshops and meetings
- One to one; face to face meetings
- Digital communication – email, survey monkey and live Facebook event
- Handwritten free text responses

Over 100 activities were undertaken during the pre-engagement and formal engagement periods to ensure optimal participation and involvement from the public, service users, carers, staff and stakeholder groups.

Throughout the engagement process HDdUHB worked closely with West Wales Action for Mental Health (WWAMH) to ensure that an independent service user and carer perspective on alternative models of care was used to inform any service transformation.

The University of Wales Trinity Saint David were commissioned to analyse the engagement feedback. This engagement evaluation report was finalised following a stakeholder feedback event to test and confirm the emerging themes set out in the report, and both the draft and final reports were shared with the Community Health Council (CHC) and WWAMH.

Common themes were identified. These included:

- Access to information, facilities, transport and to out of hours care
- Understanding when people need emergency help
- Staffing issues
- The challenges and benefits of living in a rural area
- Working closer together.

4.4 Options Development

The feedback from the engagement evaluation report was presented to the Board of HDdUHB on the 2nd June 2016. This was used to develop a number of service model options for the consultation.

Between June and November 2016, a multi-stakeholder Options Development Group was formed to distil and shortlist options. Representation included service users, carer representatives, the CHC, Police, NHS Staff, WWAMH, Carmarthenshire, Ceredigion and Pembrokeshire County Councils. The group followed best practice advice on developing options from the Consultation Institute and was guided by the Senior Equality and Diversity Officer for HDdUHB.

The group worked to undertake the following core tasks:

- Outline current services provided across the three counties
- Provide an overview of the status quo including service mapping of current provision and buildings utilised, and an overview of staffing and roles within the service.
- Develop a scoring criteria and weighting for option appraisal
- Develop options that take into account the themes identified from the engagement period
- Develop a clinical case for change

The group used what had been learned from stakeholders, service users and carers in the engagement process and the engagement analysis document to draw up a list of weighted scoring criteria. These were:

- Transport and location
- Service responsiveness
- Information and understanding
- Expertise (level of)
- Service user and carer outcomes and experience
- Ability to meet current or projected demand
- Statutory requirements

- Evidence-based practice/guidance
- Crisis management
- Equality and inclusivity
- Protected characteristics and additional related considerations
- Affordability
- Workforce
- Sustainability
- Delivery – joint/integrated
- Level of co-production/co-design

The Options Development Group used feedback from the stakeholder events to:

- carefully review the weighted scoring criteria it had developed to make sure it accurately reflected stakeholder views and
- score the seven shortlisted options

From September to November 2016 the seven shortlisted options were tested at stakeholder focus groups and engagement events, and at two options scoring workshops. The group considered the feedback and fully reviewed the weighting of the 17 scoring criteria and made sure the scores took into account all the stakeholder feedback.

Following discussions with the Consultation Institute in December 2016 it became clear that the extensive co-design approach had resulted in the development of a consensus model. Up to this point the consultation documentation had been developing around taking two options forward for formal consultation. Both options featured:

- A Single Point of Contact for mental health support across the counties
- 24/7 Community Mental Health Centres in each county
- Specialised assessment and treatment units

Following advice from the Consultation Institute, the MHPG made a recommendation to consult on a proposed co-designed service model which included the above three elements. The HDdUHB gave their approval to commence public consultation at their Public Board meeting on the 22nd June 2017.

4.5 The Consultation

The public consultation was open for a period of 12 weeks, from the 22nd June to the 15th September 2017. Consultation methodologies were designed to be as accessible as possible. They provided opportunities for communities and individuals served to share their views on the proposals. Opportunities included an open consultation questionnaire, available in hard copy, electronically and in easy read format, as well as a series of meetings and drop-in events. There was a commitment to meeting people where they felt most comfortable therefore meetings and drop-ins were arranged at a variety of existing groups and meetings.

Hwylus Cyf and Mela, bilingual communications and consultancy agencies, were commissioned by HDdUHB to undertake the independent analysis of the consultation feedback. They also facilitated five workshops across the three counties to encapsulate the views of a wide range of key stakeholders.

4.5.1 Consultation Feedback and Analysis

A consultation document and questionnaire based on the co-designed proposed consensus model was developed by the MHPG, in conjunction with the Consultation Institute. This was available through a variety of formats. An electronic version is available at this web address:

http://www.wales.nhs.uk/sitesplus/documents/862/TMHSConsultationQuestionnaireFINALWEB.pdf

Further feedback was also gathered through a series of planned meetings and drop in events across the three counties. These meetings were planned to encapsulate the views of as many people as possible, with particular regard to individuals from protected characteristic groups. These were arranged by HDdUHB and facilitated by key stakeholders involved in the process, including members of WWAMH and the three Local Authority partners.

4.5.2 Continuous Review of Feedback

There was a process in place throughout the consultation period to review the feedback and reflect on the proposals. In order to achieve this, senior members of the MHPG met on a weekly basis to review and analyse broad themes, concerns, or questions as they arose throughout consultation. A report on the emerging themes and actions on how the proposals were adapted or developed in light of these remained live on the consultation web page during this period. This was shared with the MHPG and with the Consultation Institute.

A number of service users had developed an 'Alternative Questionnaire' in parallel with the formal consultation process. The HDdUHB are committed to continued engagement with this process to ensure that all views are heard. HDdUHB have given conscious consideration to a wide diversity of views that have been expressed throughout the consultation, and will continue to do so throughout the implementation phase. Every effort will be made to ensure that flexibility remains in any proposals and that people's voices continue to be heard and reflected within all future developments.

4.5.3 The Consultation Responses

There was a broad range of feedback responses. It was estimated that at least 1171 people engaged directly with the consultation.

HDdUHB engaged with people by:

- Producing a comprehensive project plan, communications plan and consultation plan (appendix 1) which received "best practice" accreditation from the Consultation Institute
- Distributing over 2,000 hard copy and electronic documents to our key stakeholders and accessible locations in our communities
- Attending over 53 meetings and 17 drop in events including consultants meetings, GP clusters, Public Services Boards, meetings with county councillors, Equality Carmarthenshire, Pembrokeshire Youth Forum, Aberystwyth Student's Union, Ethnic Youth Support Group, Nursing and Midwifery Team meeting and Local Mental Health Forums
- Hosting a live Facebook event where people could ask questions
- Supporting 5 workshops hosted independently by Hwylus to facilitate more detailed discussions around the proposals

- Reaching over 3,000 followers for the Facebook Q&A event (with 400 post clicks and 80 reactions; with 6,500 total followers/opportunities to see/engage)
- Reaching over 129,000 followers in terms of our social media activity:
  - Facebook = over 59,000+ reach (with over 3,900 post clicks/event views and over 1,000 clicks on 10 Facebook adverts (5 English/5 Welsh) and
  - Twitter = over 70,000+ reach (with 1,300 engagements)
- Receiving over 13,000 visits to our dedicated TMH consultation webpages and an additional 1,200 visits to the key documents listed on those webpages
- Issuing 6 bilingual press releases to all media outlets in Carmarthenshire, Ceredigion and Pembrokeshire, which received over 1,200 visits to our news page/press releases and all 6 press releases were shared with our 10,000 staff via our internal global email.
- Achieving coverage by 12 local media outlets with a combined circulation (print and online) of over 306,500.

(NB: the figures above are for the whole consultation period and include both English and Welsh statistics)

A breakdown of the following responses was recorded:

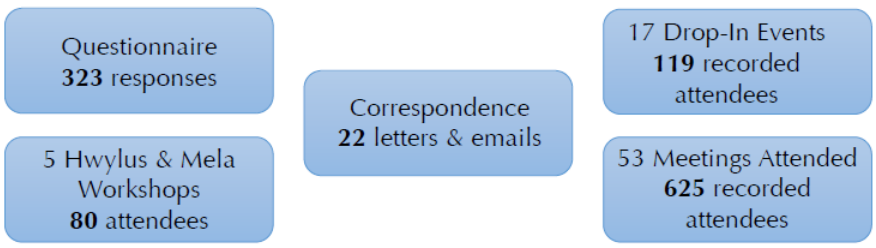

Figure 6 - Summary of the Consultation Responses

All responses to the questionnaire received were mapped geographically. This demonstrated a wide geographical spread, including responses received from parts of Glamorgan, Gwynedd and Powys - please see figure 7. The Executive Summary of the consultation analysis is included in appendix 2.

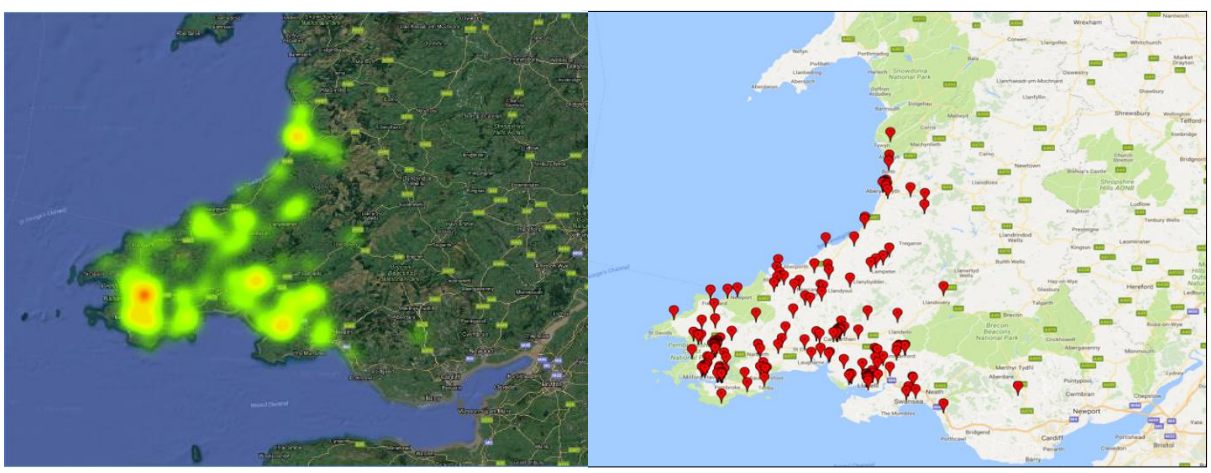

Figure 7 - Maps demonstrating the breadth and concentration of responses

4.6 Feedback from the Consultation Analysis

The feedback detailed in the consultation analysis conducted by Hwylus Cyf and Mela set out the key themes which have emerged across all strands of the consultation, and these are summarised in this section.

4.6.1 The Proposed Model of Care

There was qualified support for the proposed model of care, with strong support for a 24/7 service. The questionnaire results highlighted that 61.2% of survey respondents either *agreed* or *strongly agreed* with the proposed co-designed model. 25.8% of respondents either *disagreed* or *strongly disagreed* with the proposed co-designed model. Please see figure 8 below for breakdown by area.

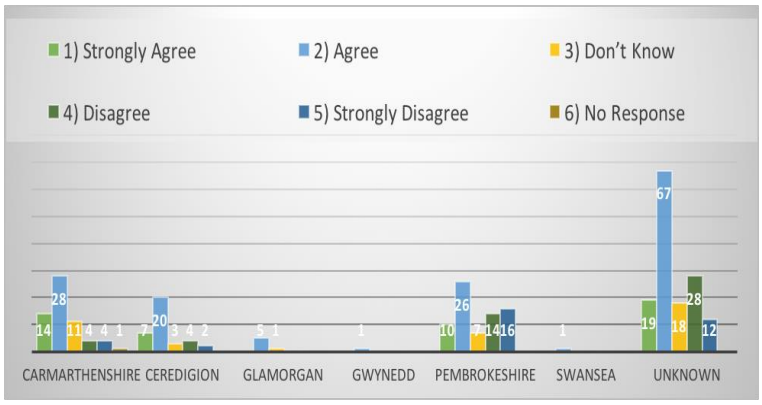

Figure 8- Consultation Questionnaire Responses - agreement with proposed co-designed model

These quantitative figures were reflected in the analysis of the sentiment of additional meetings attended by HDdUHB staff and partners. Where the model was discussed in drop-in events, 90% of recorded discussions on the model were interpreted as positive towards the proposed model by Hwylus. Additionally six of the twenty correspondence items confirmed this view.

Some respondents from Pembrokeshire and Ceredigion did raise concerns about centralisation of acute services in Carmarthenshire and the accessibility of these services on public transport. Further, the issue of bed numbers and service capacity at the new Community Mental Health Centres and at the Central Assessment and Treatment Units is repeated across all strands of the consultation.

4.6.2 Community Mental Health Centres

The introduction of Community Mental Health Centres (CMHCs) was welcomed across all strands of the consultation. There was support for the CMHCs to be known as "wellbeing centres", open to all and offering a wide range of holistic activities.

Whilst there was no specific question to gather opinions on the CMHCs in the questionnaire, in the meetings attended by HDUHB staff over half the conversations hosted were positive and this topic elicited the most positive feedback in the written correspondence received.

The exact locations for each of the Community Mental Health Centres are important to the success of these proposals. In Pembrokeshire the location has already been identified, with some concerns that service users may have existing pre-conceptions due its current use as an inpatient unit. Therefore, the look and feel of these buildings is crucial. It was expressed that they should be embedded within communities both in terms of physical access and their integration with other local services.

Concerns were raised about the number of hospitality beds proposed for the centres, with many feeling that four would not be sufficient. This was discussed strongly in the staff and stakeholder

engagement workshops and was one of the common concerns raised within the questionnaire. The issue was raised in a Facebook *Question & Answer* session and in several of the written correspondence items received by the Health Board.

The management of the beds will also be a key consideration, with many querying the process for evaluating who would be eligible for hospitality and ensuring there were provisions in place to avoid 'bed blocking' situations should the Central Assessment and Treatment beds become full.

4.6.3 Assessment & Treatment Units

Across all parts of the consultation, there is a general understanding of the need for high-quality acute in-patient services in the region. However, some respondents argued that the proposals would lead to a loss of 'local expertise'. Some respondents in Ceredigion and Pembrokeshire questioned the reasoning behind the decision to locate both the Central Assessment Unit and the Central Treatment Unit in Carmarthenshire.

Whilst consideration was given to the challenges facing the sustainability of the current care model and the reasons behind centralising specialist services, there was concern about the location of the Central Treatment Unit in Llanelli. People questioned its accessibility, particularly from Pembrokeshire and Ceredigion and the impact on the ability of family and friends to visit loved ones receiving inpatient care. This was strongly raised in the engagement workshops, and was the most commonly raised issue of concern on the proposed model in the questionnaire.

The centralisation of services in Carmarthenshire was an issue that was repeatedly raised in written correspondence received by the Health Board. Isolation from families and friends of individuals requiring inpatient care was highlighted, due to practical difficulties in reaching the planned Central Treatment Unit in Llanelli via public transport from towns and villages in the north, west and east of the region.

4.6.4 Single Point of Contact

The introduction of a 24/7 Single Point of Contact (SPOC) was welcomed and positive responses to its introduction were echoed across the consultation, with an appreciation that a well-functioning single point of contact would underpin the success of the new model.

In the consultation questionnaire, 55% of respondents indicated that they would favour a SPOC per county. In meetings attended by HDdUHB staff, seven meetings noted a preference for a county based service, with three preferring a central service for the Health Board. In the engagement workshops, there was rarely a consensus view on whether it should be a one per county or centralised service.

The consistent narrative was that the SPOC should be staffed by professional, empathetic staff with strong local knowledge. The need for a widely advertised single number that can be used by anyone was raised, to increase the accessibility and visibility of mental health services.

Respondents in the engagement workshops and drop-in sessions called for one, easy to remember telephone number across the three counties. The consultation questionnaire respondents were keen for the service to offer a variety of ways for the public to get in touch, with a telephone service identified as the preferred choice.

Equalities groups highlighted the need to be able to accommodate individuals with hearing and sensory loss needs.

4.6.5 Future Ways of Working

Exploring new ways of working, by potentially using social enterprises, were identified in the consultation document. In the questionnaire, 72% of respondents agreed or strongly agreed with the opportunities to use social enterprises.

Benefits were recognised to service users, both in terms of using the services provided by a particular social enterprise, or by being actively involved in the running of them. In additional meetings attended by HDdUHB staff, around 70% of the conversation was positive. No negative comments were identified through the thematic analysis of the drop-in events or in written correspondence relating to future ways of working.

There was a genuine enthusiasm for involving voluntary sector teams within the CMHCs, but issues of management, financing, governance and confidentiality need to be carefully considered. There is widespread appreciation that a more joined-up approach would be beneficial for service users, families and carers, and staff working within mental health care.

4.6.6 Workforce

Joint working across the service was welcomed across many of the consultation strands. In the consultation questionnaire, over 60% of respondents reached gave a positive indication to the roles mentioned. In the staff engagement workshop, a collaborative approach was welcomed, providing that there were clear lines of roles and responsibility.

There were mixed responses relating to workforce in the written correspondence received with a few strongly negative comments about safeguards. Conversations around workforce in meetings attended by HDdUHB staff were reported as 70% positive, highlighting the advantages of integration. In drop-in events, 80% of the conversation was positive around workforce, where using multi-skilled groups in the CMHCs were cited as an excellent idea.

The staff engagement workshop highlighted the need for good governance, with patient safety at the heart of working arrangements. It was noted that HDdUHB should be mindful of the need to consider any additional support needs for peer mentors involved in the service.

4.6.7 Transport

There is strong support for the idea of working with voluntary sector partners to develop a new community transport model within the consultation questionnaire responses. This was also seen as a positive development by some of the attendees at the engagement workshops, if suitable local delivery partners can be found.

Transport is a theme that was a clear concern from those who engaged in the consultation. The rural geography of HDdUHB and poor public transport links have been identified by all as a barrier to accessing support and care. There was strong support within the feedback to building services on existing community and third sector infrastructures. Throughout all channels, respondents have highlighted challenges in accessing the Central Treatment Unit in Llanelli from towns in the north, west

and eastern parts of the Health Board area. Positive responses were received where respondents felt that HDdUHB had acknowledged these issues and was exploring possible solutions.

Within the staff workshops, the ability to commission appropriate services was raised, but solutions were offered in terms of developing hybrid models, pool car drivers and collaboration with the voluntary sector. At some of the meetings people spoke about difficulties based on the transport network of the region, in addition to concerns raised about the accessibility of the Central Treatment Unit from areas in Ceredigion and Pembrokeshire.

Opportunities to provide solutions to this issue have been welcomed within the questionnaire, where 85% of respondents agreed with the proposals, although issues were raised relating to capacity within existing WAST services. Distances of travel and patient safety for those in acute mental distress was highlighted strongly in the qualitative sections of the questionnaire, and within written responses.

Consideration to the needs of friends and family to visit loved ones, especially where travel costs are a barrier was raised in the questionnaire and through written correspondence. Positive responses were received in meetings attended by HDdUHB staff and in written correspondence where the Health Board had acknowledged the difficulty around the issue and was exploring solutions to this. Themes raised within the correspondence relate to urgent and out of hours' response times and opportunities for volunteer transport schemes.

4.6.8 The Use of Technology and Digital Health

In both the questionnaire and the engagement workshops, there was a positive response to using digital tools to promote self-care and raise awareness of the services available, especially from younger respondents.

Equalities groups highlighted the need to ensure that the needs of groups such as those with sensory loss, literacy problems, or learning disabilities are accommodated. It was recognised that older people may not adopt these tools. Whilst there is strong support for adopting digital health tools, it was recognised that this should not replace the face to face care and support currently available.

Attendees at some of the HDdUHB arranged meetings pointed out that lack of reliable high-speed broadband and mobile reception, particularly away from major population centres, could be a barrier to the take-up of such tools. HDdUHB staff highlighted the need for an urgent upgrade to digital and information technology to match the expectations of the proposed model.

4.6.9 Summary of Findings

A consistent view emerges from across the various consultation strands. There is qualified support for the proposed co-designed model of care across all strands, with a recognition of the need to modernise mental health services, welcoming a 24/7 care model.

It is important to note that whilst there is overall support for the changes, a few key issues of concern were raised by those who supported the proposed model. These relate primarily to the number of beds and planned service capacity, and the centralisation of the Central Treatment Unit in Llanelli, which was perceived as a relatively inaccessible part of the Health Board area.

The proposals have the qualified support of most individuals and groups who took part in the consultation. Key issues for consideration have been highlighted by participants which will need to be reviewed by HDdUHB when implementing the model.

4.7 Considering the Consultation Analysis Feedback

The independent consultation analysis report produced by Hwylus Cyf and Mela was distributed to the MHPG members for consideration and feedback, including the CHC whose response is included in appendix 3, as key statutory partners, and summarised below.

4.7.1 Formal Response from Hywel Dda CHC

The Hwylus independent consultation analysis was shared with the CHC in order that they could provide a formal response as part of their duties around service change in their role as the statutory patient voice. They have been closely involved with the process throughout engagement and consultation and note that the MHPG has worked in an inclusive way, listening to the voices of service users and key partners.

They welcomed the approach that HDdUHB adopted during the engagement and consultation phases. They reported that they had not seen a more comprehensive attempt to gather views and co-produce a new NHS service model and noted the 'good quality dialogue and real positivity' throughout the engagement process that demonstrated a substantial appetite for change amongst the public.

The CHC reported that the response to the consultation had started to elicit some divided opinions as positive views held by some were met with concerns raised by others. They have therefore provided eight conclusions for HDdUHB to take into consideration as implementation progresses. These are highlighted below under the headings used by the CHC.

Co-production and flexibility in implementation

Conclusion 1

HDdUHB are expected to make a clear commitment to continued inclusivity, co-production and flexibility through (and after) any implementation process.

Conclusion 2

There is an expectation for HDdUHB to take a "gateway" approach to implementation, ensuring that no changes are made before it is safe to do so and before stakeholders are confident the changes are right. Nothing must be removed before a replacement service is established.

Accessing services

Conclusion 3

The Single Point of Access system must be robust, must flex to need and learn quickly, possibly taking on learning from other organisations. It must be tested with ordinary people, developed appropriately with stakeholders and publicised comprehensively.

Conclusion 4

HDdUHB are expected to provide clarity and illustrate how transport will meet need.

Conclusion 5

As with transport, demonstrating a commitment towards accessible support across communities in Hywel Dda is important for public confidence in the model.

Ways of working

Conclusion 6

HDdUHB are expected to lead discussions as part of its implementation planning around new ways of working; maintaining a co-production approach with the people who have provided ideas and their own vision around how services could work. They are expected to work with GPs and relevant stakeholders to link existing services into cohesive networks.

Community Mental Health Centres

Conclusion 7

HDdUHB are expected to involve people in the design of the CMHCs. Where likely locations for CMHCs have been identified, if there is opposition to those locations, further and open consideration of other options is expected.

Measuring success

Conclusion 8

HDdUHB is expected to develop meaningful measures of success as discussed in the consultation. When the time is right, external expert scrutiny will be a necessary addition to HDdUHB's evaluation plans.

4.7.2 Interpreting the Consultation Analysis

The MHPG acknowledge the range and richness of the views that were received and analysed as part of the consultation. There is a qualified support for the proposed co-designed model and an acknowledgement from the CHC of HDdUHB's commitment to maintain co-production values at the heart of the work throughout the process.

The independent analysis of the data highlighted that there was qualified support for the proposed co-designed model and identified where new ideas were suggested, risks were highlighted and geographical differences in preferences noted.

4.7.3 Engagement on the Consultation Analysis and testing the results

In order to be awarded 'Best Practice' status by the Consultation Institute for the consultation, the HDdUHB was required to demonstrate that it had:

- Produced a 'Fair Interpretation' of the consultation response
- Demonstrated how that has helped to learn or understand the impact of the proposals
- Demonstrated how the responses informed any recommendations.

A number of post consultation analysis events were arranged for staff and key stakeholders during December 2017 to obtain feedback on emerging themes. These included:

- Staff and stakeholder consultation drop-in events in Aberystwyth, Carmarthen, Haverfordwest and Llanelli
- Community Health Council Meeting
- Stakeholder Reference Group Meeting.

At the events, attendees were asked:

- Does the consultation analysis reflect your views?
- Is there anything missing within the report?
- Do we need to change our proposed model given the outcomes from consultation analysis?

Youth groups and key equalities groups across the HDdUHB footprint were asked for specific comments, ensuring that any decisions made are cognisant of equalities issues. The Senior Equality and Diversity Officer for HDdUHB asked for responses and arranged a meeting on the consultation analysis specifically from Chairs, Vice Chairs and members of equality groups across the three counties. The response to this was poor therefore the Senior Equality and Diversity Officer met with key equality group leads in order to ensure we had an equalities perspective on the consultation analysis.

Feedback from all post consultation events was collated and discussed at a post consultation analysis meeting with HDdUHB, Local Authority, CHC, Dyfed Powys Police and carer representation in attendance. All attendees were encouraged to consider the summary of feedback and how it may influence or alter the original proposals. A meeting was also held with service user representatives who had developed an 'alternative questionnaire' during the consultation phase. This was to ensure that these views were clearly reflected within any refined proposals.

The following summary points were made as recommendations by the group:

Distance and Travelling

The public demonstrated a significant strength of feeling about the difficulties faced with travelling in a rural area, particularly to centralised inpatient units. Travelling beyond Carmarthen is more difficult and often viewed as a psychological barrier to people living in the far north and west of the HDdUHB footprint. This is particularly relevant to some equalities groups, such as those with sensory loss, learning disabilities, or physical disabilities. A business case should be developed to consider co-locating the assessment and treatment units in Carmarthen as this would not only reduce travelling for many people to the Central Treatment Unit but would also reduce the need to transport individuals between the units. Further work should be undertaken, to include local authorities, police and the Welsh Ambulance Services Trust as part of implementation planning.

Many people reading the consultation document felt that the proposed CMHCs would replace all existing Community Mental Health Team bases. It was not made explicit enough in the document that the CMHCs are intended to become a hub for each county and that our proposed plans are designed to make services more locally accessible, embracing existing community networks, micro-communities and local community involvement.

There was recognition that the major HDdUHB development programme, 'Transforming Clinical Services' is gathering pace. This has also highlighted the public's challenges with distances and travelling times. There are opportunities to align the Transforming Mental Health work with this wider programme, however it is recognised that some transport elements will be mental health specific e.g. secure transport services.

'Beds' and Capacity

The public asked HDdUHB to consider whether there was sufficient capacity within the proposed model to account for increasing demands on services each year. It would therefore be prudent to design the CMHCs to allow for an increase in bed numbers if required. There was a notable quote within the consultation analysis highlighting that, under the proposed co-designed model, there would be no treatment beds between Llanelli and Bangor. However, the proposed consensus model returns crisis beds to North Ceredigion as part of the CMHC development. It was also noted that the regional Mid Wales Healthcare Collaborative are considering mental health crisis services to meet the population needs of the area.

Community Mental Health Centres

The consultation document put forward the proposed co-designed plans for a number of buildings or areas for the CMHCs. There is a need to remain clear that co-production will continue throughout the implementation phase with a co-produced options appraisal for each site chosen. The proposed site of the Pembrokeshire CMHC at Bro Cerwyn may have some negative connotations to some individuals as this is currently an inpatient unit and therefore this requires further consideration.

There was further discussion around why the Carmarthen CMHC should only be available 12 hours a day. There was recognition that people accessing services in Carmarthen should not have to approach the Central Assessment Unit at night for an initial assessment and therefore this requires further consideration.

The Centralised Assessment Unit and Central Treatment Unit

There was discussion around a proposal contained within the 'alternative questionnaire' developed by a group of service user representatives. This called for St. Caradog ward in Pembrokeshire to be repurposed as the Central Treatment Unit rather than being redeveloped as the Pembrokeshire CMHC. There was recognition of the challenges faced in the recruitment and retention of professional staff in Pembrokeshire. Further discussion was held as to whether two units could better provide both an assessment and treatment function, however recent evidence suggests that clinical outcomes are better where assessment and treatment functions are separated.

Single Point of Contact

The consultation asked people whether they preferred a single centralised point of contact or whether they would prefer three local points of contact. The response was that people preferred a combination of the two. They wanted a single, easy to remember number that was answered quickly by staff who were knowledgeable, empathetic and kind and understood local issues, beyond what might be provided through a traditional service such as '111'. The MHPG should therefore consider carefully how this combination may be achieved.

Working with Other Agencies, including the Voluntary Sector

There was a recognition that the MHPG should consider how to protect and ensure capacity within the voluntary sector throughout any implementation planning.

Demonstrating Continued Co-Production Values

There was a recognition that any implementation planning must demonstrate that the Mental Health and Learning Disabilities Directorate is continuing to listen to, value, and implement the important contributions made by partners and the public to date. It is essential for the Health Board to continue to be clear where people's contributions have been listened to and evaluated and to describe where these have helped influence the model. Similarly it needs to be made clear where some ideas have been evaluated but are not able to be implemented, and provide a clear rationale for this.

It is acknowledged that many people are keen for the proposed changes to take effect immediately however there needs to be a gradual phased implementation process that will be formally monitored throughout, underpinned by a clear governance structure and overseen by the MHPG.

It was acknowledged that the process to date had heard the views of a wide range of people, including those with Learning Disabilities, sensory impairment and across the age span. Not all of these comments could be referenced in detail within the consultation analysis; however this has demonstrated support for the direction of the model across a wide range of diverse voices in meeting what the public have asked for.

The implementation of the model should carefully consider where parts of the service may fit within the rapidly developing Transforming Clinical Services programme. Links to Primary Care developments, transport and community wellbeing hubs may offer opportunities to better integrate services and help tackle stigma and discrimination.

The above recommendations were discussed with the MHPG and agreement reached to present these recommendations to HDdUHB, as per agreed governance arrangements. HDdUHB is committed to continue into the implementation phase in a fully co-produced way. This is essential as the consultation analysis showed that not all individuals fully supported the proposed co-designed model without some local considerations. HDdUHB will consider how ongoing feedback is regularly gathered and reflected as part of the implementation phase to ensure that a diversity of voices continue to be heard. The MHPG will continue to work in a co-produced way with partners. This has been demonstrated throughout stage 2 of the consultation and will remain throughout the implementation stage with the model being adapted as necessary to ensure the delivery of safe, sustainable, accessible and kind services.

4.8 Approach to Equality Impact Assessment

Section 149 of the Equality Act 2010 requires public bodies (including NHS Health Boards) to have "due regard" to the need to:

a. eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

b. advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
c. foster good relations between persons who share a relevant protected characteristic and persons who do not share a relevant protected characteristic.

HDdUHB has undertaken a comprehensive analysis of potential equality impacts (both direct and indirect) and can use this to inform decisions, taking account of where actions need to be taken in order to eliminate or mitigate any identified potential negative impacts or enhance any potential positive impacts on those affected by the proposals. In this way, the new model may be influenced by those most affected and shaped to the best possible fit.

It is intended to continue to engage with appropriate representative bodies and individuals to explore ways of eliminating or mitigating any identified potential negative impacts as future service pathways are designed, developed and implemented. Mechanisms will be in place to monitor impact following implementation of the new model in order to further inform how services need to be delivered. Continuing discussions in a frank and open manner will assist HDdUHB in meeting its duty of due regard.

In seeking assurance around a robust equality impact assessment process, advice from the NHS Centre for Equality and Human Rights suggests posing the following questions:

- Is the purpose of the policy change/decision clearly set out?
- Have those affected by the policy/decision been involved?
- Have potential positive and negative impacts been identified?
- Are there plans to alleviate any negative impact?
- Are there plans to monitor the actual impact of the proposal?

If the Board is satisfied that these conditions have been met and there are plans in place to carry out further detailed equality analysis to underpin the implementation of all service developments as they progress, any recommendations may be approved, on the proviso that there will be robust governance arrangements put in place to monitor this.

The proposals set out in this document have been developed following extensive engagement and consultation and with the involvement of key stakeholders throughout the process and on a continuing basis. They are aimed at transforming the way in which mental health services are delivered across HDdUHB, leading to improved service delivery and health outcomes. They offer opportunities for earlier, more targeted interventions, delivered in a more streamlined and connected manner. This will contribute to one of the main aims of providing better access to higher quality mental health services in our communities, helping people to stay well and out of hospital where possible.

In making these positive changes, HDdUHB should be mindful of potential negative impacts and there are a number of emerging equality, diversity and human rights issues which will need to be considered and addressed in the development of service change.

Concerns around infrastructure being in place to support changes, funding, and staff resources, support from staff and other stakeholders, transport and access are key themes for particular consideration. If any one element is not in place, there are risks of potential disadvantages for all protected groups, but particularly those who are disproportionately represented amongst mental

health service users, including (amongst others) disabled people, lesbian, gay, bisexual and transgender people, Black, Asian and Minority Ethnic groups, people who experience socio-economic disadvantage and who may rely on public transport. Distances and time taken to travel as a result of services moving “out of county” and the potential impacts this has on safety, cost and the potential impact on family life are also key considerations. This is set out in the equality impact assessment process undertaken throughout both stage 1 and 2 of the Consultation process.

5. Recommendations and Revised Proposal for Implementation

5.1 Updated Recommendations

A significant amount of feedback was received through the public consultation process and subsequently independently analysed. This has been carefully considered in a co-produced way between the key stakeholders, service users and carers involved in the process.

Following careful consideration of all the feedback received there are a number of areas that require further refinement within the proposed co-designed model. The MHPG therefore recommended that the proposal be amended in the following areas:

- The conveyance/travel plan
- Capacity to adjust to changes in demand
- The location of Central Treatment Unit
- The Single Point of Contact
- The hours of operation for the Carmarthen Community Mental Health Centre
- Clear communication
- Commitment to working with partners in the voluntary sector

5.1.1 The conveyance/travel plan

Further options for providing transport will be developed, considered and explained in further detail. This will include the development of a transport system to assist with transporting service users to CMHCs and inpatient units as well as assisting families and carers to visit loved ones within the Central Assessment and Treatment units.

A focus group will be established to include representatives of HDdUHB, local authorities, WAST, police, service users and carers as part of implementation. Any work should communicate clearly with the Transforming Clinical Services programme to avoid duplication. This will include managing any interim arrangements between now and full implementation of the proposed model.

5.1.2 Capacity to adjust to changes in demand

There will be flexibility in the number of hospitality / recovery beds that will be available in each of the 24 hour CMHCs. Capacity and demand will be monitored throughout implementation and each CMHC will be able to provide more than four beds if required. These will be available as an alternative to a traditional inpatient ward as means of providing earlier intervention to help avoid mental health deterioration and consequent admission, retaining care provision within localities wherever possible.

There will be a continued interface with the regional Mid Wales Healthcare Collaborative in co-designing mental health crisis services within the area. Collaboration will continue with Abertawe Bro Morgannwg University Health Board, ARCH and the Regional Partnership Board. Continued improvements will be made to the way that data is gathered around understanding capacity and demand within services.

5.1.3 The location of the Central Treatment Unit

A business case will be developed to consider the need for a co-located Treatment Unit in Carmarthen. This will have the advantage of reducing travel times for people living in the north and west of the HDdUHB footprint, alleviating considerable concerns about travelling, and will reduce the need to travel between units.

5.1.4 The Single Point of Contact

The public asked for specific requirements around the Single Point of Contact. HDdUHB will work co-productively to identify a means that can provide one, easy to remember number, where individuals will be able to quickly access staff with local knowledge, who are experts in mental health and display empathy and compassion. This will align with and make best use of existing infrastructures across agencies.

5.1.5 The hours of operation for the Carmarthen Community Mental Health Centre

People accessing services in Carmarthen should not have to access an inpatient unit for an initial assessment. There will be a commitment to a continuous review of the flexibility of the proposed model and, if clinically indicated and within workforce and financial means, will allow the development of a 24/7 CMHC in Carmarthen.

5.1.6 Clear communication

There will be more explicit communication of the plans to develop services in more localised ways through the use of technology and local community premises as well as existing CMHS bases. There will be a transparent co-produced options appraisal for each potential CMHC base. There will be clear communication that all local issues are being heard and given careful consideration.

5.1.7 Commitment to working with partners in the voluntary sector

The development of the medium-term strategy for the MHLD Directorate will clearly describe these needs and commission partners to work with HDdUHB with a shared vision for future services.

There will be a gradual phased implementation process that will be formally reviewed and monitored throughout, underpinned by a clear governance structure and overseen by the MHPG.

5.2 The Revised Co-Produced Model

Having reviewed the independent consultation analysis and tested this against the original proposed model the model has developed to include the following:

5.2.1 CMHCs

The CMHCs will retain their original purpose as set out within the consultation as warm, welcoming non-clinical environments. Strong consideration will be given to naming them ‘Wellbeing Centres’. The sites of these centres will be selected through a transparent co-produced options appraisal process.

They will be commissioned in such a way that there will be flexibility in the number of hospitality beds that they can accommodate in order to meet any future demand. Further financial and workforce modelling will be undertaken to determine whether the Carmarthen CMHC can provide services 24/7 in line with the other CMHCs.

5.2.2 Assessment Unit and Treatment Unit

Existing constraints around capital and estates availability demand that the Central Treatment Unit must first be commissioned in Llanelli. However, a business case will be developed to explore the co-location of this with the Central Assessment Unit. This will include the necessary engagement to ensure continued co-production values throughout the process.

5.2.3 Single Point of Contact

A single, easy to remember number will be commissioned that can be used from anywhere within the HDdUHB footprint to contact mental health services. This will connect to a local service within each county aligned to existing local authority systems and NHS '111'.

5.2.4 Transport

A transport service will be commissioned with partners to allow people to more easily access the CMHCs and central assessment and treatment units, reducing the need for dependence on public transport. The modelling work completed as part of the public consultation will be refreshed during the implementation phase to ensure population need is accurately reflected.

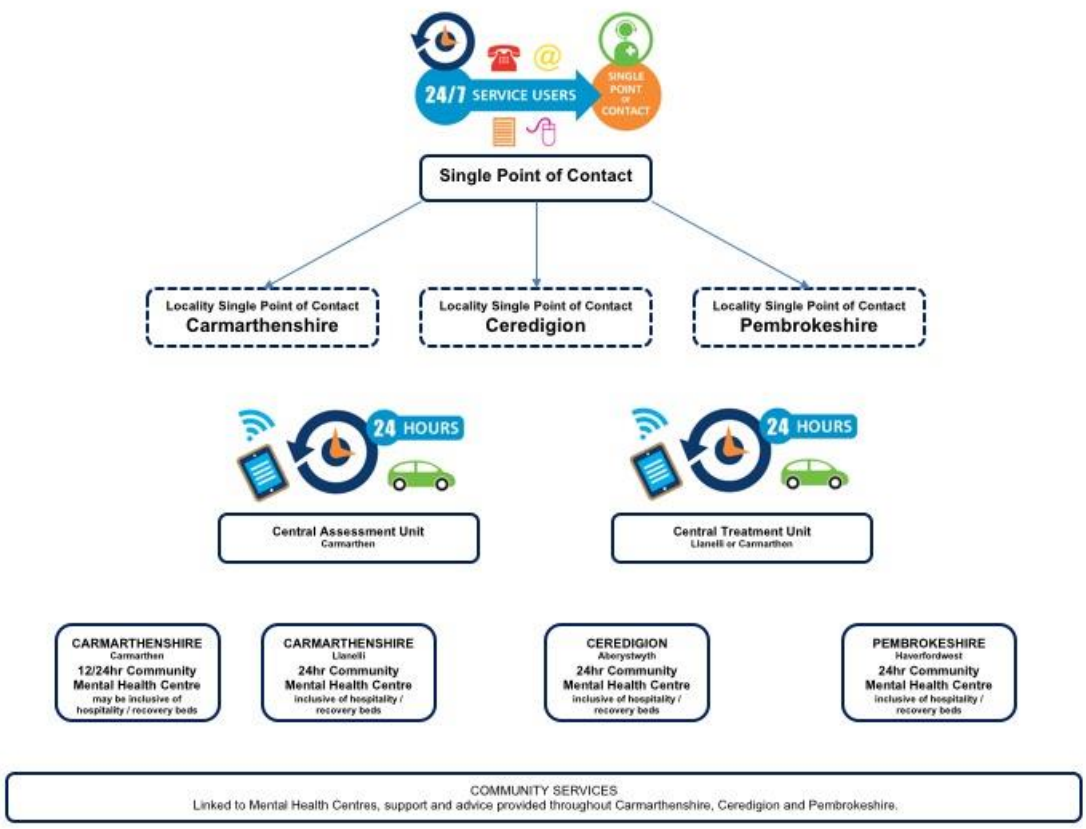

Figure 9 - Revised Co-Produced Model

6. Implementation Approach and Governance

6.1 Implementation Approach

A proposed implementation plan has been developed and is included in table form in appendix 4. The plan provides an overarching, high level view of the implementation with expected goals and timescales that are best estimates at this time based upon outcomes of meetings with operational heads of service, and workforce, finance, planning and estates teams. At this stage of the project, and prior to Health Board consideration and approval to proceed, it is not possible to develop detailed plans. The plan is described in thematic areas which have been approved by the MHPG. These are:

- Workforce Planning
- Commissioning
- Single Point of Contact Development
- Transport Solutions
- Technology Solutions and IT Infrastructure
- Estates and Infrastructure
- Future Ways of Working
- Governance

The indicative timescales contained with the proposed implementation plan are subject to HDdUHB approval and all timescales require detailed work-up with service, finance, workforce, staff side and estates teams. Timescales will also be influenced by a business case scoping meeting with the Welsh Government Capital Team to progress an agreement on the source and timing of any capital funding which will take place following HDdUHB approval. A strategic outline business case (SOC) may need to be developed and agreed to overarch the proposed capital programme.

6.1.1 Partnership Working

Throughout the engagement and consultation process co-production and co-development have remained at the core of the ethos of the programme. HDdUHB and Local Authorities have held a strong commitment towards working in an integrated way to develop and deliver the proposed model. This will continue to be built upon with all partners to ensure all stakeholders are working together throughout implementation to provide integrated services and the best possible mental health care for people.

Implementation of the model and recommendations will be developed together in order that everyone, including service user and carer representatives, have the opportunity to influence and contribute to planning the implementation of the proposed model of care. There is recognition that people have varied requirements for health, social and voluntary sector care and support, and want to address issues that can create health inequalities.

The programme will continue to operate transparently, enabling appropriate and professional scrutiny and challenge across the system by internal and external stakeholders. The risk that comes with a change programme of this size will be managed in a joined-up way, stakeholders supporting each other to ensure delivery, prevent failure and share benefits.

The range and richness of views expressed throughout the consultation period is acknowledged, including those who provided support to the model and those who expressed reservations about aspects of the model.

6.1.2 Efficient Working

The MHPG will develop into the Mental Health Implementation Group (MHIG) for the next stage of the programme once approval is received to progress to implementation of the proposed co-designed model. The multi-stakeholder members of the MHIG have agreed to follow a terms of reference and governance structure (see figure 10) for the implementation phase. Both of these documents provide the necessary structure for the delivery and oversight of the next stage of work. This will enable better planning and design and a best practice approach to delivery with flexible and efficient management of the required work streams.

6.2 Implementation Governance

The MHIG will provide governance and oversight of all aspects of programme development. All stakeholders are committed to providing support and leadership in the development and implementation of the transformation necessary at all levels. They will hold each other to account for delivery, providing robust challenge and independent assurance.

Throughout implementation, dedicated workstreams will have a nominated lead who will champion and be responsible for the planning and delivery of the work required to achieve the vision, see figure 10. These have been carefully considered to provide effective leadership and oversight of the delivery of a number of key areas. These are:

- Workforce roles and cultural change
- Pathways and access design
- Estate, IT and infrastructure design
- Transport and community networks

The programme structure and programme management will ensure that all interdependencies across stakeholders are considered during implementation.

The consultation process has indicated qualified support for the proposed model however the remaining elements and features of the future service model are still to be co-produced as part of the detailed implementation phase. A number of focus groups will therefore be developed with key partners and other interested parties to ensure that there remains a strong commitment to co-production throughout the implementation phase. These are based on the feedback received throughout consultation and will include:

- Open dialogue
- Recovery
- Helpline
- Designing environments
- Service level agreements and commissioning

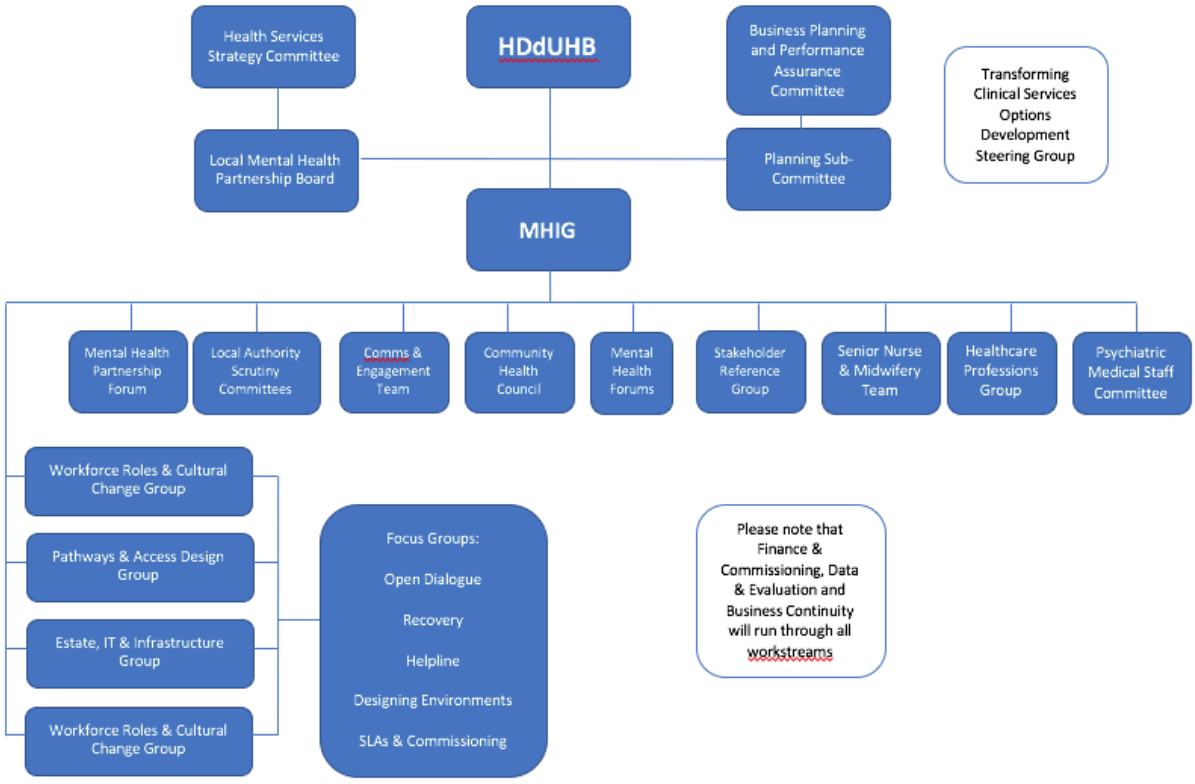

Figure 10 - Mental Health Implementation Group Governance Structure

Service user, carer, community and stakeholder input will be integral to the delivery of the proposed implementation plan. Solutions to areas identified as part of the consultation process will be co-designed with service users and stakeholders. The rationale for decision making will be explained to service users and stakeholders through clear communication and open dialogue.

Opportunities to align with the emerging Transforming Clinical Services Programme will be maximised throughout the implementation stage. Micro-communities and links to existing community support networks will be key to the success of the proposed new ways of working.

An Equality Impact Assessment has been completed and is included and is available through the following web link: www.hywelddahb.wales.nhs.uk/mentalhealth

Equalities issues will be considered throughout the implementation process, supported through a continual assessment of the equality impacts of changes being delivered.

6.3 Key Dependencies

Implementation of the proposed model is dependent upon Health Board approval to progress.

There is a need to ensure that services are able to maintain day to day functioning throughout the transition process to meet the needs of the population, delivered within existing financial means, and adhere to Welsh Government performance targets. Business continuity will be critical throughout the implementation of the plan, with an assurance that adequate capacity will be maintained. This will be consistently monitored by the MHIG, identifying, anticipating and mitigating against any gaps in service provision or increased demand on services.

Delivery of elements of the model are dependent on receipt of capital funding. Capital investment will be required to support the transformation programme with the potential sources being the All Wales Capital Programme (AWCP) and potentially HDdUHB's Discretionary Capital Programme (DCP).

6.4 Key Risks and Mitigation

The MHIG workstreams will provide expert input into the risk register for the programme. Any risks identified outside of the scope of the MHIG will be added to the MHLD Directorate's Risk Register for action. These will be monitored through the Directorate's Business Planning and Performance Assurance Group and Quality and Safety structure.

The risk register highlights the following risks:

Risk	Mitigation
Business continuity	There will be a gradual phased implementation process that will be formally monitored throughout, underpinned by a clear governance structure, overseen by the MHIG and MHLD Directorate governance structure. An Implementation Plan has been developed to ensure there will be no disruption to service provision during the implementation phase.
Capital Investment	A strategic outline business case may need to be developed and agreed to overarch the proposed capital programme. Consequently HDdUHB will progress with the development of a critical path for the proposed implementation programme which will support any required phasing, scope wider opportunities to address funding constraints and allow sufficient time to test solutions.
Public Concern	A co-production approach to the consultation plan and engagement has included involvement of service users, carers and other key partners who have had significant involvement over the past two and a half years. Engagement and co-production will continue throughout the implementation phase with careful consideration of the differing views expressed, overseen by the MHIG. This will ensure that the needs of service users, carers, staff and partners are appropriately considered throughout implementation.
Revenue Costs for New CMHCs	The MHIG will balance out revenue costs within the committed parameters. The risk will be mitigated by community mental health efficiencies as the service moves to more mobile working and better use of existing community resources. This process will be outlined in the business case development within implementation.
Competing Priorities Within Different Organisations	The MHIG is a multi-stakeholder group comprising of representatives of the key organisations. It will meet on a monthly basis to review progress and political pressures which may affect implementation timeframes.

The following impact assessments have been completed:

- Integrated Impact Assessment
- Equality Impact Assessment
- Privacy Impact Assessment screening

These are available, along with the risk register, at the following web address: www.hywelddahb.wales.nhs.uk/mentalhealth

7. Acknowledgements

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Lisa Davies, Principal Project Manager, HDdUHB
Liz Carroll, Interim Director, MHLD, HDdUHB
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Dr Warren Lloyd, Associate Medical Director & Clinical Director MHLD, HDdUHB
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8. Appendices