West Yorkshire and Harrogate
Health and Care Partnership
Mental Health, Learning Disabilities & Autism

Mental Health, Learning Disability and Autism Strategy v0.10

1. One in four people across West Yorkshire & Harrogate will suffer from poor mental health at some point during their lives and those will a severe illness can die up to 20 years early. Having a learning disability increases the likelihood of experiencing deprivation and poverty, and having autism limits the chances of people being able to work and look after their own health.

2. We want to reduce the variation in healthy life expectancy for people with these conditions compared with the wider population. Our health and care organisations are working together to provide high quality services and tackle the wider social determinants of poor mental health. By using our collective expertise, money, staff and facilities we can improve outcomes; seeing fewer people in crisis, fewer people reliant on inpatient services and fewer people left behind without the support they need to lead a fulfilling life.

3. This strategy recognises that across WY&H we have excellent areas of practice and innovation to be proud of, yet it also demonstrates to patients and service users, the public and health and care professionals where more work is needed. It describes why we are making the improvements to services in our local places and across the system, what will be different as a result, and how the Partnership plays its role.

Why one strategy for mental health, learning disability and autism?

4. For many people, mental health problems begin in childhood but stay with them and their families for life. Poorer mental health is associated with higher rates of smoking and substance abuse, decreased social relationships and resilience. And people with autism and/or learning disabilities have much higher rates of mental health illness than the general population.

5. Bringing these distinct areas together under one strategy will help strengthen our understanding of common challenges for people with these conditions. This includes challenges faced by individuals and their carers, helping services make reasonable adjustments for people who need it, and ensuring access to physical health services, education and employment opportunities. Yet we must also continue to address the unique needs of individuals with mental health conditions, learning disability, autism or other neurodiversity. This strategy tries to be clear where appropriate on this distinction.

6. We want to provide good healthcare. Mental health care is often disconnected from the wider health and care system, and as a result, people do not always receive coordinated support for their physical health, mental health and wider social needs. However, just as important is the need to promote good mental health, recognising social factors and the impact they have on keeping people with a mental illness, learning disability or autism well, particularly during

transition or change within individual people's lives. The Yorkshire & Humber Learning Disability and Autism Operational Delivery Network sets this relationship out here:

7. There is also the need for the whole health and care system to address the stark health and social inequalities faced by those who suffer with mental illness, or those with learning disabilities and/or autism. And some of this requires a conscious shift in how care is considered, away from traditional hospital settings and into the community where possible, where support can be provided more appropriately. This requires strong infrastructure, such as good quality housing, recreation opportunities and education. These ambitions underpin all the work described in our strategy and influences how we engage with other programmes of work within the Partnership.

What are we trying to achieve?

8. A lot of work is needed by a lot of different organisations in partnership with service users to transform care. This is described in later chapters, however at its simplest over the next five years we want to:

   - Invest more money into mental health services; for people in crisis, mothers and partners post the birth of a child, children and young people, and for a range of common and severe mental illnesses.

   - Eliminate the need for people with a mental health condition or learning disability needing to stay in hospital beds outside of West Yorkshire & Harrogate

   - Reduce the number of people with a mental health condition, learning disability or autism who unnecessarily attend A&E or who must be taken to a 'place of safety' by police

   - Reduce our suicide rates through a 'zero suicide' approach to prevention

- Develop new ways of providing specialist services, such as eating disorders, specialist care for children and young people with emotional, behavioural or mental health difficulties or services for criminal offenders and those at risk of offending

- Reduce waiting times for Autism/ADHD assessments so that people get the support they need more quickly

- Increase the number of people with a learning disability who can live in the community with support, rather than in hospital settings

- Provide complex mental health care and rehabilitation in our communities so people no longer go far away from home for care

- Ensure that when people with a learning disability require hospital care and treatment that this care is based on their needs and of the highest standard

- Improve the physical health of people with mental health problems and people with a learning disability/autism; reducing the incidence of early death or poor health compared with the wider population

9. Annex A presents a high-level 'dashboard' of measures which we will use to assess overall programme success.

How does our partnership work now?

10. The Partnership is made up of all the health and care organisations that support local people. It is not the boss of the partners; it is their servant. And this is crucial. It allows the power and energy to remain aligned to statutory accountabilities and to be given to the Partnership when it matters.

11. Most of the transformation relating to mental health, learning disability and autism will be delivered by the 6 local places (Bradford & Airedale, Leeds, Harrogate, Wakefield, Calderdale, Kirklees); across health, local authority and voluntary sector services. Each place has a Local Transformation Plan which is overseen by the Health and Wellbeing Board and is accountable for service delivery.

12. WY&H activity is overseen by the Mental Health, Learning Disability and Autism programme board. The programme board brings a variety of commissioners and providers together across health, care and the voluntary sector to:

    i. Support each place to share good practice, learn from one another and collaborate to strengthen most services at a local level;

    ii. Broker collective agreement across all places on how they work together, so there is standardisation in how some services are provided for all people across WY&H;

    iii. Lead the reconfiguration of care in unique cases, where it makes most sense to provide services across WY&H, rather than in each place

13. The programme is committed to co-producing new ways of working with service users (individuals with lived experience and carers) and sets the expectation that each place should do the same. It also acts as the advocate for mental health, learning disability and autism across all other work in the Partnership, acting as a champion for service users so that their needs are considered when other programmes of work are redesigning care.

14. One role for the programme is in providing assurance that commissioners are meeting their obligations on mental health investment. Since 2017/18 the proportion of funding to be spent on mental health services has been expected to increase. From 2019/20 there is a national expectation that all Clinical Commissioning Groups meet the Mental Health Investment Standard and we undertake analysis on this, reporting to the wider partnership and to NHS England.

15. To support the transformation agenda the four main NHS providers of mental health, learning disability and autism services[1] have formed a collaborative to support closer working, including the establishment of a Committee-in-Common. This allows decisions to be taken collectively on reconfiguration, and ratified in organisational boards, which is critical when decisions result in changes to the services provided by each organisation.

How will our partnership evolve?

16. Our ways of working together are still quite new and there is some way to go to reach our ambition of truly collective decision making. However, change is happening at all levels of the Partnership.

17. Each local place is committed to moving its governance and decision-making arrangements beyond the historic transactional commissioner/provider split, instead forming local alliance arrangements whereby commissioners and providers take collective ownership for how funding is used and where it is targeted. The Wakefield Mental Health Provider Alliance is an early example of this, and we will share learning, benefits and challenges with this approach.

18. Through the provider collaborative we are starting to blur the boundaries between individual statutory organisations, offering more peer support than ever before and moving to a model whereby we recognise 'one workforce' across West Yorkshire & Harrogate, making it easier to recruit and retain staff, sustaining services that were previously in competition with one another.

19. We are also increasingly taking decisions at a WY&H level. NHS England is giving overall responsibility for commissioning specialised mental health services at a population level to provider collaboratives. This means that our collaborative will have the means to transform care across the wider system for those services that are low in volume but high in complexity, like adult eating disorders, specialist children & young people's care and specialist services for offenders. We will become clinically and financially responsible for this patient population, pooling risk across the partnership, becoming more resilient to changes in demand, and have the flexibility to make savings to

[1] Leeds and York Partnership NHS Foundation Trust. South West Yorkshire Partnership NHS Foundation Trust, Bradford District Care NHS Foundation Trust, Leeds Community Healthcare NHS Trust

reinvest in community services.

20. Likewise, we are exploring with our Clinical Commissioning Groups in each place whether there are decisions which in the future would be better scaled up, to be taken at a WY&H level. And though this isn't a 'one to one' relationship these are likely to cover the areas where the current programme is seeking to either standardise ways of working or reconfigure services, rather than those services where we support the sharing of good practice.

21. Beyond mental health, learning disability and autism the wider Partnership is developing its role in relation to system-wide quality and performance. And we expect our programme to do the same, working with NHS England & Improvement to establish effective escalation, challenge and support mechanisms.

22. All of which means that the Mental Health, Learning Disability and Autism programme, our provider collaborative, our local places and the Partnership are on a journey towards new ways of working. This requires trust and confidence in one another as we move from an era of competition and contracting, to one of collaboration and collective decision-making. To support this, we will value the knowledge we have, being open and honest about what works and what doesn't so we can learn lessons, doing so in partnership not just across organisations, but with service users and our local communities. We have already identified areas where co-production is vital to ensure effective transformation, but we need to do more. We will recruit individuals with lived experience to work alongside our clinical and operational teams, steering our programme of work over the next few years.

How is this strategy organised?

23. Mental health, learning disability and autism (or other neurodiversity) are all different. This strategy seeks to be clear when we are describing work related to each of these individual areas. However, if we had approached the strategy in three isolated parts, we might have missed some opportunities to describe common challenges or plans.

24. For this reason, the strategy is structured into two overarching chapters. Chapter 1 focuses on the support needed to keep people well, and Chapter 2 focuses on access to high quality care when people need it. And we cover mental health, learning disability and autism within each. We recognise the boundaries between the two are not black and white, and arguments could be made for moving some sections between each chapter. However, this approach helps balances the tension between separation and connection of work.

25. Within each chapter we reflect on the national expectations relating to mental health, learning disability and autism, and our own local plans. We take each topic area in turn, providing some national and local context. This is done by pulling data and intelligence from a variety of sources, such as local Healthwatch engagement, Public Health data and performance information at a point in time. For ease we aggregate and summarise this to give an overall picture and we know in some instances the data quality is patchy. So, whilst the thrust of the messages remains true the precision of the numbers should

be viewed with caution.

26. We then establish what our programme's role is for each topic; is it about supporting places to share best practice? Is it about helping to standardise services? Or is it about collective reconfiguration? Inevitably most relates to the first of these and there is a lot happening at place level that we allude to. However, we have deliberately stopped short of describing here all the separate activity happening in each place, as this is the role of Local Transformation Plans.

27. So, whilst we provide support to places to share good practice this is not where we focus most of our energy. We leave places to deliver in the way they see fit unless we can add value by tackling common challenges together. Standardising services does take more collective organisation to bring people together, so the programme is more actively involved here. Reconfiguration of services requires big decisions to be made and absolutely could not be done without the active role of the programme.

28. The table below provides a summary of each level and the topic areas within them:

Supporting our places to share good practice	Helping standardise how services are provided	Considering how we configure services across WY&H
• for children and young people with a learning disability • for children and young people with autism or other neuro-diverse condition(s) • Mental Health Support Teams (MHSTs) in schools and colleges. • Support young carers • Children & Young People in Special Residential Schools. • Targeted services for adults with autistic spectrum disorders and ADHD • Reasonable adjustments across all services for people with a learning disability and/or autism • Provide Individual Placement and Support • Provide mental health support for rough sleepers. • Provide smoking cessation support to those with mental health conditions. • Support those with mental health conditions, learning disability and/or autism to age well. • Support adult carers • Support improvements in both physical and mental health needs • Achieve Improving Access to Psychological Therapies (IAPT) standards • Undertake physical health checks for people with a severe mental illness	• for children and young people with autism or other neuro-diverse condition(s) • how learning disability and autism health-checks are undertaken • reduce suicide and provide suicide bereavement support • deliver primary and community care for people with a severe mental illness • provide a comprehensive 0-25 mental health service for children and young people • share their hospital beds, reducing the amount of time people spend in hospital and preventing people from going outside of WY&H for treatment • Targeted services for adults with autistic spectrum disorders and ADHD	• psychiatric intensive care • rehabilitation for people with complex needs • adult eating disorder services • specialist hospital care for children and young people with emotional, behavioural or mental health difficulties • forensic mental health services • perinatal mental health services in hospital • problem gambling services • specialist services to align with the needs of veterans and sexual assault and referral centres • community services for people with a learning disability to reduce our reliance on inpatient beds • assessment and treatment beds for people with a learning disability

• Provide specialist community perinatal mental health services • Provide a comprehensive service for people in mental health crisis • Deliver early intervention for people suffering from psychosis • Provide comprehensive support for children and young people in a crisis • Provide appropriate services for children and young people with an eating disorder • Ensure appropriate medication for children and young people with a learning disability and or ADHD • Learn from the deaths of people with a learning disability. • Deliver personalized care for people with a mental health condition • Deliver personalized care for people with a learning disability		

What will enable the strategy to be implemented?

29. Whilst we focus primarily on specific areas of work relating to mental health, learning disability and autism it is important not to overlook the common issues which will help or hinder transformation. There are three areas of importance here; workforce, digital and engagement.

Workforce

30. Across mental health, learning disability and autism we have a sustainability challenge around our workforce, whether that be paid staff, carers or volunteers. For the WY&H population of 2.4 million people we have roughly 8,700 people formally working in mental health or learning disability services; over 2,500 are nurses, nearly 500 medical staff, 500 allied health professionals (such as physiotherapists, occupational therapists and dietitians) and over 900 scientific and technical staff. And as investment increases, we need to recruit, train and retain as many people as possible to meet demand.

31. We also need to better recognise the skills and support that can be offered by Voluntary & Community Sector staff, often upstream of traditional care services but providing an important role in delivering services close to people's homes and in personalised, caring ways. The increased availability of social prescribing within Primary Care Networks will be a significant factor in access to VCS services over the coming years.

32. These staff need to be the right people, with the right values, trained in the right way, and who expect the individual to be at the centre of their care, with services tailored to their own personal needs. Our local Healthwatch engagement highlighted the importance of having compassionate and respectful staff, highlighting how the wrong approach can make things worse: 'I once had a very bad experience with an NHS mental health professional who was very brusque with me. I was extremely vulnerable at the time due to being at my lowest point during chemotherapy and this lady suggested I should try harder to pull myself together because this approach worked with a friend. She decided I didn't have a mental health issue even though I felt suicidal at the time'.

33. Nationally NHS England has identified for mental health (but not for learning disability or autism) expected increases in staffing numbers, and these have been broken down where relevant in later sections. However, working with Health Education England we are clear that some of our biggest risks are in nursing, and project that by 2021 we could have a 15% deficit in learning disability nursing, and a 10% deficit in mental health nursing. Likewise, there are limited numbers of individuals with specialist skills in assessment/diagnosis of Autism or ADHD, or the skills in mainstream care services to make reasonable adjustments. We are therefore working across WY&H to better understand the common challenges across the system and tackle such risks:

    i. Recruitment – we are developing specific mental health and learning disability nursing campaigns, increasing the number of undergraduate training places, developing new roles in general practice (nursing and psychologists) and flexible employment across WY&H rather than to specific individual organisations.

ii. Retention – we are developing better progression opportunities for junior staff, supporting the resilience of staff by increasing the availability of Mental Health First Aiders in care organisations and improving how teams' function across organisational boundaries.

iii. Skill-mix – we are using the Partnership to upskill physical healthcare professionals on basic mental health training, training West Yorkshire Fire and Rescue professionals to support people in crisis and embedding peer support as a core component of the mental health workforce

34. Need to add something about workplace culture and support/flexibility for staff within organisations and the responsibility at place level…

35. And as we reference in later sections, we also need to pay much closer attention to the role of unpaid carers (approximately 260,000 across WY&H) not just to give them support to help loved ones with mental health conditions or a learning disability, but to be able to access both psychological and wellbeing support to maintain their own personal resilience too.

Digital

36. Ensuring that transformation in mental health, learning disability and autism is underpinned by the broader NHS ambitions for digitally enabled care is a challenge across all WY&H services. We are working through our provider collaborative in the first instance to develop a system-wide digital strategy by 21/22 that describes how this technology supports the transformation agenda.

37. We are starting from a reasonable base, though recognise more needs to be done in collaboration and across NHS, local authority and voluntary sector boundaries. As a provider collaborative we are consistent in the move to more mobile forms of working, with each organisation adopting newer technologies to enable this (through smartphones, virtual desktops and laptop use) at the point of care. And we recognise the potential benefits of closer digital integration, particularly in sharing real-time information on capacity and demand to support better use of beds and service expertise across WY&H.

38. During 19/20 each organisation is finalising the replacement of existing Electronic Patient Record systems and whilst these differ by provider there are opportunities to share common configurations and to work together on training packages for bank staff so that they understand each system in each organisation. In terms of functionality this upgrade means each provider can implement digital flags relating to learning disability and autistic patients, allowing clinical staff to make reasonable adjustments at appointments. A consequence is that during 19/20 we anticipate a drop-in adherence to the Data Quality Maturity Index target of 90% but will be more confident of meeting the 20/21 onwards target of 95% following a year of operation with the new systems.

39. There are also opportunities to work collaboratively on future contracts and we are considering how best to combine resources to improve specialist input and drive more competitive deals on ICT infrastructure and services.

40. We are also considering the effective use of patient portals, allowing interactivity between patients and their clinicians via electronic means. Local HealthWatch engagement highlights this with views from patients such as 'I believe a text or email service for people wanting to reach out for help with their mental health would be beneficial to people who find a telephone call or appointment daunting'.

41. This sort of initiative may be particularly powerful for certain user groups (such as those with autism) and work will take place on a service by service basis regarding what information can be made available, linking into the wider work led by the Local Health and Care Record Exemplar programme. We will co-produce solutions to communication across WY&H with people with mental health conditions, learning disability and autism, considering how digital technology can be best deployed. We expect to see significant advances in this field by 2022/23.

42. Where individual providers have innovated, we are learning from one another to share good practice. For example, Leeds & York Partnerships NHS Foundation Trust utilises Everbridge software for major incident alerts on staff smartphones and the other providers are considering the same to increase consistency at times of high service volatility. LYPFT has also deployed electronic prescribing in acute settings which can be mirrored across other providers and expanded into community care. Bradford District Care NHS Foundation Trust is adopting robotic process automation to reduce reliance on paper and South West Yorkshire Partnership NHS Foundation Trust is exploring being a pilot for 'software smartcards' to allow easier clinical access to necessary systems.

43. What is common across all providers in the collaborative and extends into local authority and voluntary & community sector organisations is the need to ensure adoption of digital technology is owned and understood by frontline staff. We need to get better at understanding how new technology is being used so we can target training requirements and use of digital champions within each organisation – particularly for the generation of staff we are seeking to retain for whom digital innovation is often perceived as a threat rather than an opportunity.

Communication, Engagement and Co-Production

44. As a Partnership we are committed to meaningful conversations with people (including staff), on the right issues at the right time. For mental health, learning disability and autism this is particularly important because people with these conditions can struggle to get their voice heard. The majority of the work to co-produce improvements will be undertaken in each place, however as a Partnership we will ensure that all WY&H wide work is designed and delivered with those people who have lived experience of services, with dedicated representation from service users or identification of specific staff whose responsibility it is to get the views of patients and staff to co-produce new ways of working. We will summarise our current engagement plans in a forthcoming communications and engagement strategy, to be published on the Partnership web pages.

45. Add examples of co-production work here (ie from NCMs)

46. For those services where reconfiguration decisions will be taken, we will ensure that we not only involve service users and staff in the development of proposals, but also undertake formal consultation with those affected, paying particular attention to marginalised groups, tailoring our communication to reach the broadest possible audience. Partly this means tailoring to those with complex needs and their carers. But it also means ensuring that we use our local expertise in each place to reach Black and Minority Ethnic groups.

47. We know for example that in certain places, such as Bradford our percentage of BME mental health service users is significantly higher than the England average (59.3% vs 11.2%) and at a system level we need to be conscious of the different demographics in each place. BME groups are more likely to be diagnoses with mental health problems, be admitted to hospital, to experience poor outcomes and to disengage from services[2].

48. This is why we are committed to taking account of the forthcoming NHS England patient and carers race equality framework, to ensure that we reflect this in everything we do.

[2] https://www.mentalhealth.org.uk/a-to-z/b/black-asian-and-minority-ethnic-bame-communities

CHAPTER 1: KEEPING PEOPLE WELL

49. The risk of having poor mental health is affected by genetics, personal circumstances and the environment where people live. Poverty, living conditions and the quality of relationships all have a part to play in whether we lead happy, healthy and fulfilling lives. Across WYH there are large numbers of people living in environments that pose a high-risk of mental illness. Bradford, Kirklees and Leeds have higher than average numbers of people claiming jobseeker's allowance, and across WY&H more people live in fuel poverty than the England average[3].

50. We want to build resilience, promote mental wellbeing and deliver early intervention to enable people to increase control over their mental health and wellbeing and improve their quality of life, including placing equal importance on the relationship between mental and physical health. To do this we need to work with the Improving Population Health Programme to get better at using data and intelligence; identifying at risk populations before they reach crisis point.

Early support for all our Children & Young People

51. For a child born today across WY&H there should be no reason why they can't achieve all that they want to achieve. Yet many of our young people find it hard to get the help they need to cope with the life they have been born into.

52. On average more of our young people have mental health disorders than the rest of the country and the same is true regarding school pupils with emotional and mental health needs. And we also have slightly more pupils with a learning disability. The extent of this differs across local areas; low prevalence of mental health disorders and learning disability in Harrogate but high prevalence of mental health disorders in Bradford and Wakefield and learning disability in Calderdale[4].

53. Since 2015, each place across WY&H has achieved real improvements in early help for children and young people with mental health conditions, delivered through the Future in Mind programme. These initiatives at place are vital in supporting the delivery of our ambitions as a Partnership.

54. We want to ensure those with mental health conditions, or with complex developmental needs are given early intervention support in their homes, schools and communities to prevent them from requiring formal care services. This requires multi-agency working and spans our programme, the Children & Young People programme and the Improving Population Health programme.

55. Our approach is not defined by diagnosis. We want to look at the range of wants and needs that each individual young person has and ensure that they are supported to keep themselves safe and well. That is why we are taking a 'whole pathway' approach to services for children and young people, making sure that we don't forget about significant causes of inequality such as the impact of mental health crisis, support for autism and other neuro-diverse

[3] PHE Fingertips Data: Fuel Poverty, Long Term Claimants of Jobseeker's Allowance
[4] PHE Fingertips Data; Estimated prevalence of MH disorders – 5-16, School age pupils with emotional and mental health needs, Pupils with learning disability

conditions and those in looked after care. This includes supporting parents, carers and siblings to look after those children and young people.

56. Yet it can sometimes be clearer and easier to describe the work being done by diagnosis, by age or by the type of service being provided, and we do so below. However, the logic remains the same; all these different pieces of the jigsaw must interlock to ensure we are providing a comprehensive offer to our children and young people.

We are: Supporting our places to *share good practice* in how they provide local services for **children and young people with a learning disability**

57. Nationally, there has been an increase in the number of children and young people with a learning disability being identified within mental health hospitals and across WY&H we have seen a similar increase in children & young people with a learning disability or autism entering specialist mental health hospital services. We also know there has been an increase in the number of children and young people with behavioural challenges being excluded from schools which correlates with increased use of mental health services.

58. Through the WY&H Transforming Care Programme we are supporting places to support early identification and intervention to prevent children and young people going into crisis and family breakdown by:

    i. Developing real-time information on which individuals are at risk of admission to secure services

    ii. Training the workforce to hold Care Education and Treatment Reviews for those at risk of admission and to develop discharge plans for those who are

    iii. Focusing on high-risk areas such as transition, safeguarding cases and young offenders

    iv. Engaging with schools and implementing exclusion avoidance plans where possible

We are: Supporting our places to *share good practice* in how they provide local services for **children and young people with autism or other neuro-diverse condition(s)**

59. Conditions such as autism, Asperger syndrome and pervasive development disorders (known as Autistic Spectrum Conditions (ASCs)) affect social interaction, communication, interests and behaviour, affecting at least 1.1% of the population (equating to around 29,000 people across WY&H), although this number is often considered too low. And we know that getting a diagnosis in early childhood can significantly help both the child and their family.

60. The interplay between ASCs and other conditions is complex. Half of people also have a learning disability, whilst 30% of people with a learning disability also have ASCs. And more than half of people with ASCs also have signs of Attention Deficit Hyperactivity Disorder (ADHD).

61. ADHD often presents in childhood but extends into adulthood, affecting up to 4% of the general population (roughly 100,000 people across WY&H) and means that individuals have difficulty concentrating and can be impulsive and hyperactive which is often viewed as challenging behaviour.

62. If neurodiversity is not recognised then individuals are highly likely to end up being treated for other conditions instead later in life such as anxiety or depression, or personality disorders leading to psychosocial impairment and co-morbidities as a result.

63. There is variance in how providers across WY&H currently deliver their services, including the range of professionals involved in assessment, different referral routes and interfaces with other services, limited support for families waiting for a diagnosis and wide variation in support post diagnosis between health and care services.

64. This is why we are committed to identifying and implementing the most effective ways to reduce waiting times for specialist services, and for the period of waiting for and receiving a diagnosis to be supplemented by appropriate and timely support.

65. Across WY&H we are focusing on:

    i. Making improvements to pre-diagnostic support, considering the needs of carers and family members; piloting work in Leeds, Wakefield and Bradford

    ii. Raising awareness, including the use of digital technology to support wellbeing, working with Yorkshire and Humber Academic Health Science Network to scope a wellbeing app

    iii. Standardising approaches to specific pathway challenges such as requests for second opinions, responses to private diagnoses and communication between services.

66. We are also conscious that nationally NHS England and Improvement are developing a more focused programme of work on ASC which may provide further direction and guidance from 2020/21 onwards. We will ensure we align our work to the national direction at the appropriate point.

We are: Supporting our places to *share good practice* in how they design and deliver **Mental Health Support Teams (MHSTs)** in schools and colleges.

67. Nationally, by 2023/24 Mental Health Support Teams will cover between a quarter and a fifth of the country. However, children and young people in Leeds, Bradford and North Kirklees are already starting to benefit having been awarded ‘trailblazer’ funding by NHS England. These teams provide support for mild and moderate mental health conditions to bridge the gap between what schools and colleges traditionally provide and NHS services.

68. Across WY&H each of the trailblazer teams will operate under NHS supervision to support several schools and colleges, covering around 8,000 children and young people. The learning from these sites will be reviewed across the partnership to identify what should be sustained and what should be replicated elsewhere. North Kirklees has been operational since 2018/19

with Leeds and Bradford up and running by April 2020.

69. These initiatives supplement the work that happens to build greater resilience in children and young people, often delivered by the voluntary and community sector. Such as work across WY&H by Northpoint Wellbeing to support transition from primary to secondary school, Young Lives Consortium providing specialist support for disabled LGBT and BAME young people and Sharing Voices in Bradford to address issues such as bullying, self-harm and abuse.

We are: Supporting our places to *share good practice* in how they **support young carers**.

70. Many carers, including children and young people are hidden; caring for a loved one with a long-term condition, disability or mental health condition and often providing most of the care without formal support and sacrificing their own health and wellbeing as a result. The 2018 GP Patient Survey showed how 21% of young adult carers (aged 16-24) in West Yorkshire and Harrogate are almost twice as likely to live with a long-term mental health condition, compared to 13% of non-carers within the same age group.

71. With the WY&H Carers Programme we are using the 'Triangle of Care'[5] model to underpin a new model of support for mental health and wellbeing of young carers. In 19/20 we have committed to the establishment of carers champions on each Mental Health Trust Board and are undertaking peer review understand the current levels of carer awareness.

72. From 2020/21 we will ensure that mental health, learning disability and autism providers routinely consider the impact on young carers as part of their Equality Impact Assessments of services. And, in conjunction with other programmes (such as Maternity on perinatal care) we will share learning on how both formal and informal carers can be better signposted to mental health support for themselves; so that by 2023/24 we have a comprehensive WY&H offer for all families, preventing mental health decline in carers and providing swift intervention when necessary.

We are: Supporting our places to *share good practice* in how they provide **Support for Children & Young People in Special Residential Schools**.

73. NHSE GOAL: We will work with partners to bring hearing, sight and dental checks to children and young people with a learning disability, autism or both in special residential schools (ie William Henry Smith in Brighouse)

Meaningful support for adults with a learning disability and/or autism

74. On average, adults in England with a learning disability or autism face significant health inequality, poorer access to healthcare and die 16 years earlier than the general population[6][7]. Disability or diagnosis is not, in and of

[5] Ref needed
[6] Independent Mental Health Taskforce to the NHS in England (2016) The Five Year Forward View for Mental Health. Available
[7] https://www.nhs.uk/news/neurology/people-with-autism-are-dying-younger-warns-study/

itself, the reason for this inequality; instead it is a result of services not meeting people's needs. For people with a learning disability and/or autism it can therefore be difficult to stay well and get help when it is needed.

75. Across all places in WY&H we have consistently higher number of adults with learning disability receiving long term support from Local Authorities, when compared to the rest of England. Yet as a proportion, fewer have a health-check with their GP, and more are likely to be involved in safeguarding enquiries[8].

76. Some of our places (Kirklees and Harrogate in particular) have comparatively high proportions of supported working age adults with a learning disability in paid employment, meaning they are more able to live a meaningful life. And across WY&H we want to ensure that all adults with a learning disability, autism or both can live happier, healthier lives within their local communities.

77. Need to establish more on outcomes and trajectories below etc

We are: Supporting our places to *share good practice* in how they **provide targeted services for adults with autistic spectrum disorders and ADHD**

78. Across WY&H each place has a different offer and service model in place for both assessment and diagnosis of ASC and ADHD, however we are committed to improve collaboration across the system, particularly to build resilience in the workforce, ensure the availability of appropriate post-diagnostic support and standardise certain approaches, such as developing shared care protocols with primary care for ADHD medication.

79. To do this we are beginning in 19/20 to increase awareness of both ASC/ADHD with partners in the prison system, probation service and substance misuse services, supporting waiting list initiatives in specific places (such as Bradford) where services have been historically under high pressure and closed to new referrals and are researching the barriers to access for crisis services for people with ASCs.

80. We are also conscious that nationally NHS England and Improvement are developing a more focused programme of work on ASC which may provide further direction and guidance from 2020/21 onwards to support wider alignment and standardisation. We will ensure we align our work to the national direction at the appropriate point.

We are: Supporting our places to *share good practice* in how they **make reasonable adjustments across all services for people with a learning disability and/or autism**

81. National Learning Disability Improvement Standards were published in 2018, following intelligence that some NHS Trusts were failing to support and respect people, sometimes with devastating consequences. Across WY&H we are starting from the principle that if we get service provision right for people with a learning disability and/or autism then our services will also be appropriate for

[8] PHE Fingertips Data; Adults with Learning Disability Getting Long-Term Support from Local Authorities, % of adults with learning disability having a GP health check, proportion of supported working age adults with LD in paid employment %, individuals with learning disability involved in Section 42 safeguarding enquiries

the rest of the population. We will review current delivery against the Improvement Standards across all service providers during 19/20 and 20/21 to identify what is needed to improve our service offer and share these findings.

82. From 20/21 onwards we will ensure all Trusts within WY&H are publishing performance against the Improvement Standards on an annual basis, reporting this to the programme board and we will share the actions that organisations are taking to achieve these standards so requirements can be met by 23/24 at the latest.

83. This includes a requirement that all care providers have considered in their digital strategy how they will deploy a 'digital flag' to identify service users who have a learning disability and/or autism. At a system level we will monitor uptake of this and support continued adoption through shared local ICT platforms such as SystmOne.

We are: Helping *standardise* how **learning disability and autism health-checks** are undertaken

84. The national expectation is that by 23/24 physical health checks for people with a learning disability will be undertaken annually for at least 75% of people aged over 14. We share this ambition and want to ensure the same applies for people with autism too.

85. We will work with the Primary Care Programme to ensure that there is a common set of expectations regarding the requirements of a health check across WY&H, so that by 23/24 all providers organise and perform health checks for people with learning disability and autism in line with the RCGP toolkit[9]

86. In 16/17 across WY&H we undertook marginally fewer health checks (48.4%) than the England average of 48.9%, with highest performance in Bradford (58.4%) and lower performance presumed in Harrogate given the rate in North Yorkshire (42%). Our trajectory for improvement is to ensure a graduated, year-on-year improvement in the number of health checks undertaken for people with a learning disability (X% in 19/20, Y% in 20/21, Z % in 21/22, A% in 22/23, 75% in 23/24).

87. We will also set appropriate trajectories for health checks for people with autism, following the conclusion of the national pilot in X.

88. In line with our wider commitment to making reasonable adjustments for people with a learning disability or autism we will learn from the experiences across the system on increasing uptake of health checks to support other WY&H programmes (such as Improving Planned Care and Cancer) better understanding how to communicate with and improve access for these individuals.

We are: Supporting our places to *share good practice* in how they **deliver personalised care for people with a mental health condition learning disability**

89. Giving more choice and control to service users is important for people with a learning disability because they are often dependent on others such as social

[9] https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/health-check-toolkit.aspx

workers to support their autonomy and independence[10]. This means that care should be personalised and centred around the individual so they can influence what services they use and have more influence over how these services improve.

90. During 19/20 we are working with the Personalised Care Programme to pilot work with a limited number of Primary Care Networks, identifying 'what good looks like' for people with a learning disability regarding personalised care. We will establish care quality markers which identify the difference made to people's experiences and share this impact across the wider system. In 20/21 we will build on this work to recommend actions to support each place to achieve the quality markers, connecting these to the wider learning disability improvement standards.

Multidisciplinary community action to reduce or prevent decline in people's mental health

91. Through our local Healthwatch analysis we know that people in WY&H feel more needs to be done to prevent mental ill health where possible. Views include the need for 'support (for) people whose mental health is failing but is not yet an acute episode' and 'NHS direct involvement with all local community groups' to 'identify possible red flags and where to direct people[11]'.

92. We recognise that the Partnership provides a unique opportunity for collaboration; to understand the causes of mental ill health, the impact on physical health and use our collective expertise to better tackle these causes at their source or at least as early as possible, reducing reliance on formal care services.

93. The statistics also show that compared to the England average more of our people suffer from common mental health disorders and that these conditions affect them over the long term. Yet there is variation across the system too. Calderdale (11.4%) and Leeds (10.9%) have larger numbers of people with a long-term mental health problem (above the England average of 9.1%), whereas Bradford (8.4%) and North Yorkshire (as a proxy for Harrogate – 7.7%) have lower numbers[12]. So, the action taken to address determinants of mental ill health needs to be absolutely rooted in the needs of each place.

94. We are also clear that the determinants of mental ill health are wide ranging and affect different groups in different ways and a particular role for the Partnership is to champion the needs of minority groups; particularly those who have higher rates of mental illness such as Black and Minority Ethnic groups, the LGBTQI+ community and people with a learning disability. Action to address these cannot be taken by our programme alone which is why we work in close collaboration with the Improving Population Health, Primary Care and Unpaid Carers programmes, taking a unified approach to prevention.

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[10] https://onlinelibrary.wiley.com/doi/full/10.1111/hsc.12048

[11] NHS Long Term Plan, #WhatWouldYouDo? People from West Yorkshire and Harrogate and Craven share their views, April 2019, Healthwatch Leeds and others.

[12] PHE Fingertips data; Prevalence of common mental disorders 16+ %, Long Term Mental Health problems 18+ %

We are: Supporting our places to *share good practice* in how they **provide Individual Placement and Support** to enable individuals who experience serious mental illness to find and retain employment

95. Being in work is important for everyone's general health and well-being; it gives us a purpose and an income, promotes independence and allows us to develop social contacts. And for those with mental health problems, being employed can be an important step to recovery[13]. Across WY&H we show a varied picture on employment for our mental health service users.

96. The proportion of people with any form of mental health condition (or a learning disability) in employment is lower than the England average, with better rates in Leeds and lower rates in Kirklees. However, for those with more severe mental illness (on the Care Programme Approach[14]) our rates are broadly similar but with a swing of over 7.5% between the best (Harrogate) and the lowest performing (Bradford City).

97. Nationally, there is an expectation that 55,000 people with severe mental illness will access the Individual Placement and Support Programme (IPS) by 23/24; an evidence-based employment support service that aims to help people find and retain employment. For WY&H this means that we are expanding our IPS provision from our initial sites of XYZ covering X people to Calderdale, Leeds and Harrogate. By X date we will have another Y people accessing support, rising to Y by Z date.

We are: Helping *standardise* approaches to **reduce suicide and provide suicide bereavement support**

98. Historically, suicide has been the biggest cause of premature death in men under 50 and the biggest killer of young people (male and female) aged under 35 in the UK. The rates of suicide are also steadily rising after many years of reduction and now most frequently affects people in their middle ages[15] . In 2015 Yorkshire & Humber had the highest suicide rates nationally, and across WY&H we are consistently worse than the national average, with particularly high rates in Leeds[16].

99. We know that there are characteristics of our population that partly explain the reasons for this high rate, such as the positive correlation between deprivation and suicide (for example Bradford has 42% of its population living in the most deprived 20% of the country). However, there is still much that can be done, and we have adopted a zero-suicide philosophy across WY&H, where each and every death by suicide is seen as preventable and no longer viewed as inevitable. By 2020/21, we want to see a 10% reduction in suicides across WY&H. And for a 75% reduction in targeted services (mental health services, custody suites) and suicide hotspots by 2022.

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[13] https://www.mentalhealth.org.uk/blog/employment-vital-maintaining-good-mental-health

[14] https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/

[15] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/articles/middleagedgenerationmostlikelytodiebysuicideanddrugpoisoning/2019-08-13

[16] PHE Fingertips; Suicide rate - persons

100. To do this we are working with the Improving Population Health programme and partners across health, police, fire services, councils, prison services, universities and voluntary community organisations to:

a. develop access to real-time information when there is a suspected suicide. This will be live from X and help identify common areas for improvement and specific WY&H risk factors.

b. Use 19/20 trailblazer funding in partnership with Leeds Mind to test services across WY&H:

    i. On prevention for those at increased risk, such as men in the 35-50 age group and military veterans, providing support from pathfinder development workers to establish new pathways, facilitate peer support groups and publicise the range of support available

    ii. On postvention, incorporating peer led support to reduce the risk of suicide in people who have themselves been bereaved in this manner

    We will evaluate these approaches and our approaches to collaboration to consider what models to commit to from 20/21 onwards, ensuring these are fully established by 23/24.

c. Develop a tool to learn from previous suicides, helping identify those most at risk

d. Ensure that the work on suicide prevention links to wider mental ill prevention activity in place, and work to improve community resilience.

We are: Supporting our places to *share good practice* in how they **provide mental health support for rough sleepers.**

101. Between 2017 and 2018, Yorkshire & the Humber experienced an increase in rough sleepers of 19%, with roughly 246 across the whole region[17]. The majority of these in WY&H were from Bradford (24) and Leeds (33).

102. All our places have their own local strategies for supporting the mental health of rough sleepers. However, in line with expected NHS pilot funding from 20/21 we will work with the Improving Population Health programme across our places to share ways of working, learning and best practice.

We are: Supporting our places to *share good practice* in how they **provide smoking cessation support** to those with mental health conditions**.**

103. In WY&H we experience significant health inequalities. Those living in deprived areas are more likely to find it harder to recover from mental health conditions[18], and people with a long-term mental health condition in WY&H are over 13% more likely to smoke[19]. And we also know that smoking remains a

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17 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/781567/Rough_Sleeping_Statistics_2018_release.pdf

18 https://digital.nhs.uk/news-and-events/news-archive/2016-news-archive/mental-illness-recovery-linked-with-deprivation-report-finds

19 PHE Fingertips; Smoking prevalence in adults with LTC Mental Health vs Smoking prevalence in adults

significant risk factor for disease, leading to premature death and is a priority for the Improving Population Health programme.

104. All our places have their own local strategies for smoking cessation. However, by working with the Improving Population Health programme we will help share ways of working, learning and best practice that is specific to those with mental health conditions, to help reduce this inequality. And each of our NHS providers of mental health, learning disability and autism services will be supported to provide smoking cessation for long-term service users.

We are: Supporting our places to *share good practice* in how they **support those with mental health conditions, learning disability and/or autism to age well.**

105. By 20/21 the Primary Care Networks (PCN) taking shape across all our places are expected to be able to assess their population for the risk of unwarranted health outcomes, particularly for those at risk of frailty as they get older. These assessments will help identify targeted physical and mental health support to help people remain as independent as possible for as long as possible.

106. All our places have their own local strategies and will identify through each PCN how best to integrate local physical and mental health support. However, by working with the Primary Care programme we will help share ways of working, learning and best practice.

We are: Supporting our places to *share good practice* in how they **support adult carers**.

107. Our local Healthwatch analysis emphasised how the families and carers of people with mental health issues need support too, including comments such as 'The carer is put under a great deal of pressure during this time, which can make them unwell themselves' and 'the carer must be looked after too as their health is paramount in helping the sufferer to keep going when things get tough'. Carers felt that they were often not as involved as they would like in the care of the person they look after and wanted more information to be shared between carers and staff.

108. As with the previous section on young carers we are using the same 'Triangle of Care' model to underpin a new model of support and we expect the 19/20 commitment to establish carers champions on Mental Health Trust Boards to cover both adults and children and young people.

109. From 2020/21 we will ensure that mental health, learning disability and autism providers routinely consider the impact on adult carers as part of their Equality Impact Assessments of services. And, in conjunction with other programmes (such as Maternity on perinatal care) we will share learning on how both formal and informal carers can be better signposted to mental health support for themselves; so that by 2023/24 we have a comprehensive WY&H offer for all families, preventing mental health decline in carers and providing swift intervention when necessary.

We are: Supporting our places to *share good practice* in how they **support improvements in both physical and mental health needs**

110. People using health and care services commonly find that their physical and mental health needs are addressed in a disconnected way despite the

evidence that neglecting one can damage the other. We know the opportunities presented by integration of physical and mental health have not yet received enough attention and will work with other programmes to address this. Poor mental health is a major risk factor implicated in the development of diabetes, COPD, cardiovascular disease etc. As each place continues to identify other opportunities to work in collaboration we will support services to work together, share learning and standardise practice.

111. Options – Acquired brain injury, healthchecks, cancer etc – need link to IPHM programme here

We are: Supporting our places to *share good practice* in how they **deliver personalised care for people with a mental health condition**

112. NHS England is committed nationally to accelerating the roll out of Personal Health Budgets, giving people greater choice and control over how care is planned and delivered. This includes an expected expansion of this programme by the end of 19/20 to cover wider mental health services, including support for people leaving hospital who had previously been detained under the Mental Health Act. In addition, people with severe mental health conditions or more complex needs, covered by the Care Programme Approach will also benefit from personalised care planning, identifying what is important to them to achieve a good life and ensuring the support they receive is coordinated around what they want to achieve. Anything local here?

113. In primary care, more GPs, nurses and other professionals will be able to consider the personal needs of individuals with mental health conditions and refer people to a range of non-clinical services, such as arts activities, group learning, sports and befriending services. This will be led by Primary Care Networks as they develop their role from 20/21 benefitting approximately 15 in every 1000 people, meaning nearly 1000 people with mental health conditions across WY&H will get social prescribing support from primary care at some point.

CHAPTER 2: ACCESS TO HIGH QUALITY CARE

114. One in 10 children between the ages of five and 16 has a mental health problem and almost one in four adults experiences a mental health problem in their lifetime. For some, mental health problems are treated and never return. However, for others, mental health problems last for many years, especially if not treated properly. And people with a learning disability and/or autism remain more susceptible to healthcare problems, both mental and physical.

115. Getting access to good quality care when it is needed is vital. Untreated, people with schizophrenia are more likely to die from heart disease or respiratory disease, and mental illness increases other risky behaviours such as smoking, drug and alcohol abuse. Notwithstanding the impact on the individual this has significant economic costs to the local and national economy, through lost working days and benefit claims.[20]

116. We want to ensure that health and care services across WY&H are accessible as quickly as possible, for all population groups. This means we need to replicate what works well and invest in both core services and specialist models to do things differently, comprehensively and efficiently.

Mental Health care in community settings

117. 82% of people approached by our local Healthwatch indicated that initial support for mental health conditions, or when trying to diagnose a learning disability and/or autism needed to be available quickly. Waiting lists were felt to be too long with initial assessments not as quick or easy as they could be. Linked to this was the importance that many people were concerned that long waiting lists would lead deterioration in people's mental health:

    'Waiting lists for counselling are extremely long, a family member waited over 18 months which is totally unacceptable for someone struggling with mental health issues.'

118. A further 48% of people felt there was a need for more community mental health support, often delivered outside of statutory services: 'A lot of mental health could be improved with access to excellent local community support (via VCFS sector), social prescribing and nipping it in the bud before it becomes a bigger issue'.

119. We know these issues are important across WY&H because we have greater numbers of people who suffer from anxiety and/or depression than the England average. Yet we also know there is large variation in access to services between our places. By December 2019, 5.6% of people in Calderdale who had anxiety or depression accessed psychological therapies (against an England average of 4.48%), whereas this was only 2.72% for North Kirklees[21].

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20 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/361648/mental-health-access.pdf

21 https://mentalhealthwatch.rcpsych.ac.uk/indicators/access-to-iapt-services-for-people-with-depression-and-or-anxiety-disorders

120. We will work in partnership with the Primary Care programme to address these issues, ensuring that Primary Care Networks, Local Authorities and VCS groups come together with NHS Mental Health Trusts to redesign services in line with the national Community Mental Health Framework.

We are: Supporting our places to *share good practice* in how they **achieve Improving Access to Psychological Therapies (IAPT) standards**

121. IAPT services provide evidence-based psychological therapies (often called talking therapies) to people with mild to moderate anxiety disorders and depression.

122. Nationally there are expectations that all areas of England meet IAPT referral to treatment times and recovery standards, meaning 1.9m adults accessing treatment by 23/24. WY&H is no exception and each of our places is responsible for achieving these targets; our role as a programme is to support learning and improvement.

123. The targets mean that all our places will ensure:

e. 25% of people who have anxiety or depression access IAPT by March 2021 (up from an average of 3.88% across WY&H in December 2019).

f. That 75% of people referred to IAPT services start their treatment within 6 weeks, and 95% starting treatment within 18 weeks (up from an average of X and Y across WY&H in Z date).

g. Recovery of at least 50% of people who commence IAPT treatment (up from an average of X% WY&H in Z date).

124. Our ambition is to have at least 77,500 people in WY&H starting IAPT treatment by 21/22, rising to nearly 90,000 by 23/24. To deliver this improvement and to meet performance standards our places will recruit more psychotherapists so that there is approximately an additional 49 psychotherapists across WY&H by 21/22, or 139 by 23/24.

We are: Helping standardise approaches to how places **deliver primary and community care for people with a severe mental illness**

125. In order to reduce our reliance on hospital beds we need to invest in community services, transforming how they are provided. This means integrating primary and community care so that people with eating disorders, a personality disorder diagnosis or rehabilitation needs get the support that they need, as close to home as possible. Across England there is an expectation that 370,000 people receive care in this integrated way by 23/24.

126. For WY&H this means developing flexible and proactive care models that dissolves where possible the barriers between primary and secondary care, building on relationships between Primary Care Networks and Mental Health providers. And given our population we are particularly keen to develop early intervention initiatives for young adults, helping to create a comprehensive 0-25 service, and better 'complex' rehabilitation across all age ranges.

127. We will work across all our places to test new models, see what works and ensure all places work to agreed principles, reducing variation in how services

are provided and better supporting service users to receive coordinated care across WY&H.

128. These new community care models will also help ensure that each places delivers the Early Intervention in Psychosis (EIP) standards; meaning that WY&H as a whole ensures 60% of people with first episode psychosis start treatment with a NICE-recommended package of care two weeks of referral by 2020/21, and reaches 70% NICE concordance by 21/22 and 95% by 23/24.

129. We expect that over 5,500 people across WY&H will access these integrated services during 21/22, rising to over 16,500 by 23/24. To deliver this we will need to develop multidisciplinary teams, comprising psychologists, psychotherapists, support staff, social workers, peer support worker, pharmacists and more. By 21/22 we expect a growth in the WY&H across these staff groups of around 140 people, rising to 400 by 23/24.

We are: Supporting our places to *share good practice* in how they **undertake physical health checks for people with a severe mental illness**

130. Nationally, the Mental Health Foundation describes how people with mental health conditions are less likely to receive the physical healthcare that they are entitled to, particularly routine checks such as blood pressure, weight and cholesterol. This means it is harder to detect symptoms of physical illness, contributing to people with a mental health condition being more likely to die from cancer, heart disease and other conditions[22].

131. Therefore, it is important to increase access to physical health checks for people with a severe mental illness, and across England there is an expectation that 280,000 people access health checks in 19/20, rising to 390,000 by 23/24. For WY&H this means approximately 13,000 people in 19/20, 16,000 by 22/23 and 18,000 by 23/24.

132. Each of our places will deliver their own local requirements on health checks, including increasing onward referral to recommended interventions, use of personalised care planning, engagement and psychosocial support. We will support our places to learn from one another about what works, making the appropriate links with the primary care programme to inform how Primary Care Networks work to achieve these trajectories.

We are: Supporting our places to *share good practice* in how they provide **specialist community perinatal mental health services**

133. Perinatal mental health problems occur during pregnancy or in the first year following the birth of a child and affect up to 20% of women. In WY&H this means an estimated 47 women per year who suffer from postpartum psychosis, 708 who suffer from severe perinatal depression and up to 3500 with milder forms of perinatal depression or anxiety[23].

[22] https://www.mentalhealth.org.uk/a-to-z/p/physical-health-and-mental-health
[23] PHE Fingertips: Postpartum psychosis estimated number of women, severe depressive illness in the perinatal period, mild-moderate depressive illness and anxiety in perinatal period

134. All our places in WY&H are increasing access to specialist community perinatal mental health services, delivering care to women and their families, supporting parent and infant bonding and providing consultation and advice. We will support places to share what works for them, tracking achievement against trajectories and ensuring appropriate links are made with the Local Maternity System.

135. This means that by 21/22 we will see an additional 2,700 women accessing services, rising to over 3,150 by 23/24. To deliver this we will recruit additional staff, meaning an increase in psychiatrists, pharmacists, nurses, psychologists, occupational therapists and others. In total we expect numbers of staff across WY&H to increase by approximately 27 by 20/21 and 45 by 23/24.

136. As part of the increase in the perinatal mental health service our places will also establish how to extend the period of care available from 12 to 24 months and consider how to better support partners of women accessing specialist community perinatal care, signposting them to other services where appropriate by 2023/24.

137. As a system we will also learn from the national pilots in Maternity Outreach Clinics, and build on our local Healthwatch engagement. We will provide more support for mothers on understanding the interaction between medication and their pregnancy, and improve the opportunities for expectant mothers to discuss their mental health and get support; providing tailored services for women who experience mental health problems directly arising from their maternity experiences by 2023/24.

Mental Health Care in an emergency

138. People in mental health crisis often no longer feel able to cope or be in control of their situation, which can mean people consider taking their own life or seriously harming themselves; needing immediate medical attention. This means that everyone needs to know who to contact in these situations, be taken seriously and be supported quickly.

139. Yet our Healthwatch engagement across WY&H indicates that some people do not receive the help they feel is needed in a crisis, particularly when attending A&E departments, but also that more work needs to be done in partnership between health and other care services to increase the range of services available.

140. We are not unique nationally in the need to improve these services. And as a comparison our system has very similar rates of psychosis compared with the England average (23.3 compared to 24.2 per 100,000 adults)[24]. But there is variation between each place, one indicator for which is the percentage of people in contact with mental health services who have crisis plans in place. Across WY&H this varies significantly from a low of 2.2% in Leeds to 41% in Wakefield and Calderdale, and 78% in Harrogate. So, there is room to learn from one another about what works to prepare for and support people in crisis[25].

[24] PHE Fingertips; new cases of psychosis per 100,000 (16-64) - 2011
[25] PHE Fingertips; service users with crisis plans as % of people in contact with MH services

We are: Supporting our places to *share good practice* in how they **provide a comprehensive service for people in mental health crisis**

141. During 2019/20 all our places across WY&H are continuing to invest in expanded crisis resolution and home treatment teams so that from 20/21 we have 100% coverage. To do this our places are expanding the range of multidisciplinary staff within each service, implementing 24/7 crisis lines, increasing the service to be appropriate for older adults and prioritising support for carers. This means that by 21/22 we expect an additional 60 nurses, paramedics, peer support workers and others will be employed across WY&H, rising to nearly 150 by 23/24.

142. Some of our places already offer alternatives to A&E for people in crisis, often run by voluntary and community sector organisations, such as the Cellar Trust in Bradford & Airedale. Collectively by 20/21 we will see an expansion across WY&H in crisis house/sanctuary models, peer support, employment, accommodation and community support services. As each place develops their own offer, we will share the learning across WY&H.

143. We are also committed to ensuring that crisis services are appropriate for people with autism, either through mainstream service provision or through specialist support across WY&H. Working with people with lived experience and the Yorkshire & Humber Operational Delivery network we will review current crisis provision in 19/20 to ensure services are appropriately skilled in supporting people with autism, making reasonable adjustments where necessary for 20/21 onwards.

144. As a system we also conscious of the need to support better ways of working that are helpful to each place. During 19/20 and 20/21 we are focusing on understanding and improving data flows and quality, establishing consistency in how care planning is undertaken across multiple organisations, exploring new training options for ambulance staff and evaluating the role of mental health nurses within police control rooms.

145. Most acute hospitals across WY&H already have established 24/7, 7 day per week mental health liaison teams who assess people in hospital beds or within the Emergency Department who are experiencing problems with their mental health. In 19/20 the liaison service at Harrogate NHS Foundation Trust will also move to a 24/7 model, meeting national ‘core 24’ standards.

We are: Supporting our places to *share good practice* in how they **deliver early intervention for people suffering from psychosis**

146. Psychosis can cause considerable distress and disability for individuals, their families and carers, often resulting in hallucinations, delusions and a disturbed relationship with reality. Whilst it can take months or years for a final diagnosis it is possible to begin treatment as soon as a provisional diagnosis of first episode psychosis is made, making it important to ensure people can access services quickly and easily.

147. Across WY&H our performance on early intervention (EIP) for people with psychosis has been varied. Performance recently has generally been above the 56% access standard across all places, though we know that we need to

improve this to 60% from 20/21 and ensure all places meet NICE guidelines.

148. Achieving this means each place will ensure treatment starts quickly, families are involved as needed in psychological therapy and combined mental and physical health programmes are put in place for those who need them. The programme will continue to receive updates on EIP and as we get closer to the 20/21 target and help to support improvements in performance where needed through sharing of ways of working in each place.

Diagnosis and care for children & young people

149. Services available to support children and young people's mental health across WY&H are a key concern for our population, particularly regarding waiting times, referral criteria and staffing levels. Engagement via Healthwatch also highlights how individual experiences of care and treatment are not always positive ones, including inappropriate treatment suggestions, concerns over clinical lines of enquiry and a lack of provision for children with autism.

150. More here

We are: Helping standardise approaches to how places **provide a comprehensive 0-25 mental health service for children and young people**

151. At the highest level of specialisation (Tier 4 CAMHS), England has seen a reduction in bed days of approximately 9% since 17/18, a reduction which is mirrored in the WY&H figures. However there remains variation in each place, so whilst we continue to develop unique WY&H specialist services that are beginning to reduce bed usage (see section X) we also need to ensure each place is equipped to provide a more holistic range of care and treatment closer to people's homes and in community settings.

152. There are national ambitions to increase access, with an additional 73,000 0-25-year-olds accessing services in 20/21, rising to 345,000 additional by 23/24. For WY&H this means approximately 215 more young people in 20/21, rising to 2735 by 23/24. To deliver this ambition we will require a significant increase in our workforce, with numbers of professionals in our community services such as psychiatrists, psychologist, nurses, social workers and others increasing by over 100 by 23/24.

153. And we also need to work differently between our places and across WY&H, doing more to consider how we look after the holistic needs of individuals and their families. This is particularly important for those children and young people who have experienced significant developmental trauma in their lives, are in looked after services or have complex mental health needs alongside a learning disability, autism or other neurodiversity.

154. This is why during 19/20 we are taking a 'whole pathway' approach to commissioning, learning how each place currently provides services across health, social care and the voluntary sector, so that we identify some specific, multidisciplinary action we can take, either in each place or across WY&H. From 20/21 we will pilot new ways of working and evaluate these to implement a more substantive service by 23/24.

We are: Supporting our places to *share good practice* so that they each provide **comprehensive support for children and young people in a crisis**

155. Our system performance on access for children and young people's crisis services has been consistently under the existing 32% national standard for 19/20, and in line with increased funding we expect to improve coverage to at least 57% by 21/22 and 100% by 23/24. This performance is not dissimilar to many other areas of the country, but regardless we want to improve the service received for people across WY&H.

156. Improvement here is a requirement for each place and some have a greater journey to go on than others, with Calderdale above current projections, all other areas below and wide variation within this too. Co-production with young people in WY&H has been important in understanding the issues and solutions here, both in the development of the new care model approach through CommonRoom but also local work in areas such as Bradford and Leeds with lots achieved and a lot is being achieved already with innovation such as the TeenConnect helpline in Leeds and the Safer Space and WellBean café in Bradford.

157. Each place is approaching their crisis improvement depending on where their local gaps are and how services currently operate, and some of the service development will be linked to learning from the 'whole pathway' approach described above. And there are WY&H wide developments through the Urgent and Emergency Care programme too, such as the development of NHS111 as a single point of access which will support collective improvement.

We are: Supporting our places to *share good practice* so that they each provide **appropriate services for children and young people with an eating disorder**

158. Eating disorders are serious mental health problems that can have severe psychological, physical and social consequences. Therefore, it is vital that children and young people, and their families and carers can access effective help quickly.

159. Nationally, the performance of services for children and young people with an eating disorder has been improving. 69% of people started urgent treatment within one week in 16/17 and this now stands at 81% (against a target of 95% to be delivered in 2020/21). However, in WY&H whilst our performance was historically better (76%) it has declined to around 74%. There is also wide variation; North Kirklees has increased its performance from 75% to 100%, whereas Harrogate is currently 29%. And we fare better for routine appointments, as a system delivering 85% access within four weeks which is on track to deliver national requirements of 95% by 2020/21[26].

160. What are we doing in place? Summarise from place plans. As a programme we will support those areas that are performing well to share their practice for the benefit of the wider system.

[26] https://www.england.nhs.uk/statistics/statistical-work-areas/cyped-waiting-times/

We are: Supporting our places to *share good practice* in how they **ensure appropriate medication for children and young people with a learning disability and/or ADHD.**

161. Psychotropic medications are often used to treat anxiety, depression or psychosis but can be used to support people with challenging behaviours and side effects such as weight gain, feeling tired or 'drugged up' are not uncommon. Nationally, the experience of parents, carers, clinicians and young people indicate that medication prescribed in childhood is continued for longer than it should be, which means there is more chance that side effects become detrimental to health and wellbeing. Conversely, some young people do not receive the medication that they should do, meaning their condition is left untreated.

162. Through the national STOMP (stopping over medication)-STAMP (supporting treatment and appropriate medication) campaign, NHS England & Improvement wants to improve the lives of children who are prescribed psychotropic medications, ensuring they get medication for the right reason, in the right amount for the shortest time possible and understand the reasons for their use.

163. All WY&H places have strategies in place to ensure STOMP-STAMP reviews are undertaken, review medication as part of the Care Education Treatment Review process and report progress through general practice performance data.

We are: Supporting our places to *share good practice* in how they **learn from the deaths of people with a learning disability.**

164. We know that because people with a learning disability have poorer physical and mental health, they often die earlier than they should from conditions that could have been prevented, such as pneumonia, sepsis, constipation and epilepsy. Each of our places across WY&H undertakes learning from death reviews (LeDeR) for people with a learning disability to help change how services are provided. As a whole WY&H currently undertakes X% of LeDeR reviews within 6 months and we will increase this to Y% by Z date.

165. Each place also makes links between the role of LeDeR and other national programmes to reduce avoidable deaths such as annual health checks, sepsis prevention and cancer screening.

Mental Health care provided in each place by hospitals

166. Much of the transformation we want to see in Mental Health requires improved community provision and early intervention where possible, yet we also recognise the need to ensure that our mental health hospitals provide high quality, accessible care when they are needed. Mental Health admissions to hospital in WY&H were less than the national average in 18/19, at 252.3 per 100,000 people against 267.1 per 100,000 people. However, there is wide variation across the system, with Bradford City having high admission numbers (410.1) and Airedale, Wharfedale and Craven comparatively low (175.4).

167. Across WY&H we have three main providers of hospital mental health care at Leeds & York Partnerships NHS Foundation Trust, South West Yorkshire

Partnerships NHS Foundation Trust and Bradford District Care NHS Foundation Trust. The mental health provider collaborative recognises the need for these organisations to work together more closely than they have in the past.

168. And we know from our Healthwatch engagement that people feel their needs to be better communication across care providers to prevent people from falling through the gaps. The opportunity at WY&H level is to ensure that patients don't feel the barriers we often create between individual organisations, making their care feel as seamless as possible.

169. One marker of success for the partnership is how well rated each of our hospitals is by the CQC. By August 2019 each of the three providers of adult mental health services was rated 'requires improvement' and by working together we intend to support each individual provider and WY&H as a whole to improve.

We are: Helping standardise approaches to how places **share their hospital beds, reducing the amount of time people spend in hospital and preventing people from going outside of WY&H for treatment**

170. Nationally, there is a drive to improve the quality of all hospital mental health care, including reducing the length of time people spend in a hospital bed so that all providers are at or below the current national average of 32 days by 23/24. This is an ambition we share; however, we recognise that as more services are provided in the community only those who really need hospital care will be admitted, meaning they may be sicker and take more time to treat. So, we need to understand what this ambition really means for our system.

171. This includes developing a wider WY&H understanding on Delayed Transfers of Care (DTOC). The chances of someone being delayed from being discharged home or to other services varied widely from approximately 1 person per day delayed at BDCT or SWYPFT in June 2019, rising to 23 people per day at LYPFT.[27]

172. Collectively we are also very clear that working together means we should be able to eliminate the number of people who leave WY&H for their treatment. The collaborative has already had significant success, dropping from 6005 'out of area placements (OAPs) in September 2017, to just 1930 in February 2019, a reduction of 68%. Yet we still face challenges, this is not a smooth journey and often performance can worsen periodically before improving again for most providers.

173. There is weekly communication across the collaborative and regional NHSE/I support teams to discuss the OAP data. As such we have already seen initiatives such as criteria led discharge be adopted across each provider, new care models deployed including dedicated consultants on wards and pathway and patient flow reviews. However, more needs to be done and in 19/20 we will be doing XYZ, so that we eliminate all OAP in 2020/21.

We are: Considering how we configure **psychiatric intensive care** across WY&H

[27] https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/delayed-transfers-of-care-data-2019-20/

174. Psychiatric Intensive Care Units (PICU) have higher levels of staffing than normal mental health wards and are designed to look after people who pose a high level of risk to themselves or others. Across WY&H we had fewer people subject to the Mental Health Act per 100,000 people than the England average in 18/19, but both Bradford and Leeds as individual places had higher rates.

175. Across WY&H we are therefore looking at the best way to configure our PICU services, particularly given anecdotal views that there is insufficient capacity across the 42 PICU beds we operate across the system. We are also conscious that utilisation is often ineffective due to the gender mix of patients, differentials in admission/discharge criteria and delayed transfers of care, resulting in the need to place people out of area more often than we would like.

176. During 19/20 we are undertaking further bed management analysis and simulation modelling of PICU capacity to provide all WY&H providers with a shared view of the problems and opportunities. We will take the learning from this review to determine what good looks like for PICU provision, so that from 20/21 onwards we begin to develop the business case for new ways of working, ensuring this is up and running by 22/23.

We are: Considering how we configure **rehabilitation for people with complex needs** across WY&H

177. Nationally, there have been concerns raised that people with complex needs (such as XYZ) do not receive the care that they need with significant variation in how rehabilitation is delivered, and the outcomes achieved. Across WY&H we currently have variability across our providers, with some significant outliers in length of stay (>10 years against an average of 30 months for complex cases), no complex provision for females and a high number of out of area placements (101 in 18/19).

178. We are working as a collaborative to redesign complex rehabilitation pathways across WY&H, developing an inpatient and community model at a system level that links coherently to arrangements within each place. This requires close partnership working between health, social care and housing providers. These new pathways will encompass a range of provision from targeted support by community mental health teams, increased involvement from primary care, supported employment schemes and supported accommodation.

179. To date we have undertaken scoping work on clinical need, undertaken best practice and peer review exercises and have been successfully awarded £11m in capital funding to support the transformation needed. We will develop final proposals for the new service for approval in 2020, with services developing during 2020/21 and fully operational by 2021/22.

Specialist mental health care provided across WY&H

180. Across WY&H we provide several specialist mental health services. These cover a range of more unusual or complex conditions and have historically been arranged by NHS England rather than being the responsibility of local places. However, there is a national move to make provider collaboratives such as WY&H more responsible for making decisions about these services,

covering 100% of the country by 22/23. We are therefore working in partnership to develop arrangements for this for those 'first wave' services that will become our responsibility and to create the infrastructure that allows us to take on more responsibility for other services over time.

181. We want to maximise access to specialist mental health care across WY&H, ensuring there isn't a postcode lottery in terms of who can access which service, where and how quickly. And by providing these services on a WY&H level, offering support as close to home as possible

We are: Considering how we configure **adult eating disorder services** across WY&H

182. Eating disorders (such as anorexia, bulimia and others) are serious mental disorders that often develop in adolescence when people are developmentally sensitive. These conditions mainly affect females (90%) and have major psychological, physical and social impact leading to poor quality of life, high health burden and can be fatal. However, the introduction of specialist eating disorder services appears to have improved survival rates.

183. Across WY&H the CONNECT Adult Eating Disorder service (hosted by LYPFT) has been operational since 1st April 2018. The aim was to join up the approach to care and treatment across the system to improve patient outcomes and experience, including the transition from children and young people's services. Since the start of this service the number of admissions to a hospital bed has reduced by 22% and no patients have been sent outside of WY&H for treatment unless they have chosen to. This means the average distance between home and care for service users is now 6 miles, rather than 40 miles (an 85% reduction).

184. To deliver these improvements a new community model and pathway was put in place with any financial savings reinvested in the new way of working. In 19/20 we are developing the model further to strengthen the offer to adolescents in transition, improve our reach to black and minority ethnic groups, expand the psychological therapies provided and provide more targeted support, such as to those also suffering with substance misuse. We are also developing plans for the model to expand beyond WY&H to serve the larger Yorkshire & Humber population from 20/21 onwards.

185. We expect to be responsible for commissioning and providing the CONNECT service from April 2020, following delegation of responsibility by NHSE/I.

We are: Considering how we configure **specialist hospital care for children and young people with emotional, behavioural or mental health difficulties** across WY&H

186. Sometimes our children and young people experience mental disorders, such as depression, psychosis, eating disorders, severe anxiety, or personality disorder that cause significant risk to themselves or others, and at the same time they may also have a learning disability and/or autism. These individuals often require specialist care delivered from or within hospital settings.

187. Our local Healthwatch engagement raised concerns about the damaging effects of having to travel outside of WY&H for inpatient care, resulting in children and young people being isolated from friends, family and community: 'I have spoken to several families with experience of their children being admitted to out of area inpatient care. In every case their child was

traumatized and further damaged by the environment and separation from their families'.

188. Preventing children going out of area is one of the main aims of our 'Tier 4 CAMHS' service, hosted by Leeds Community Healthcare NHS Trust. This service, and its equivalent delivered by Tees, Esk & Wear Valleys NHS Foundation Trust for North Yorkshire (including Harrogate) has developed new ways of working between health and local authority services to help support children and young people in their community where possible, but when admission to hospital is needed that this is done in WY&H, is based on clinical need and is for the shortest time possible.

189. We have already seen some early success in this service; reducing admissions to 124 in 18/19 from 153 in 16/17, reducing the number of out of area placements to 93 from 128 and reducing the distance from home for children & young people to 25.7 miles from 37 miles. However, we want to go further reducing these numbers by 2022/23 to 100 admissions, 20 out of area placements and 25 miles respectively.

190. To support this service, a purpose built 22 bed West Yorkshire children's mental health unit will be built in Leeds, with work beginning in 2019 and the unit to be operational from X.

We are: Considering how we configure **forensic mental health services** across WY&H

191. Forensic Mental Health Services provide specialised mental health and learning disability services for people who may pose a risk to others or who have been involved in the criminal justice system. The Yorkshire Centre for Forensic Psychiatry, hosted by South West Yorkshire Partnerships NHS Foundation Trust currently provides medium secure forensic services across WY&H and beyond.

192. Working together we are developing new ways of working for forensic services, including making better use of community provision where appropriate. This means improving efficient use of current capacity by reducing length of stay in hospital settings, minimising the number of 'transition' points for each service user, making their experience better and reducing out of area placements. This includes repatriating patients who are currently in a WY&H forensic bed but who live in another area back to their local system, so that we in turn can create local capacity for the WY&H population.

193. The changes we are making include creating a single point of access, inpatient capacity plan and bed management system across WY&H, consistent Forensic Outreach and Liaison Services (FOLS) for those with mental health issues, and a similar service for those with learning disability. As a result, we will reduce overall inpatient capacity by up to 12% with the most change in male low secure pathways by 2023/24.

We are: Considering how we configure **perinatal mental health services in hospital** across WY&H

194. The Yorkshire and Humber Mother and Baby Unit (hosted by Leeds and York Partnerships NHS Foundation Trust) provides hospital services so that mothers across WY&H and beyond experiencing severe mental health

difficulties can receive treatment and support while continuing to care for their baby.

195. As further mother and baby units develop across the wider region, and across the partnership as we better understand the impact of extended community support and maternity outreach, we will consider how to maximise the effectiveness and role of the mother and baby unit.

We are: Considering how we configure **problem gambling services** across WY&H

196. Nationally 0.9% of people are classified as problem gamblers but in areas such as Leeds this is circa 1.3%, or 13,000 people with up to a further 8% of people at risk. Problem gambling can lead to serious debt and family breakdown, people losing jobs and even turning to crime or suicide. Therefore, nationally the NHS is expecting to see 15 new clinics for specialist problem gambling treatment by 2023/24.

197. Since September 2019, the NHS Northern Gambling Clinic has been operational in Leeds as a partnership between Leeds and York Partnerships NHS Foundation Trust and GamCare. The clinic operates by promoting awareness of problem gambling amongst local professionals and community groups, providing open access support for people concerned about their (or another person's) gambling and structured treatment options for people with severe gambling disorder. There is a focus on reaching out into under-represented communities such as black and minority ethnic groups, women and those in the criminal justice system.

198. As the service develops, we will evaluate its impact to learn what works, identify what doesn't and improve the service offer so it is well established and forms part of the core offer, alongside other services by 23/24.

We are: Considering how we configure **specialist services to align with the needs of veterans and sexual assault and referral centres** across WY&H

199. Nationally NHS England & Improvement is conscious of the need to reduce inequity in access and care for certain groups. There is an aim to ensure that mental health services provided for veterans, survivors of sexual assault and those detained in Immigration Detention Centres are of the highest quality.

200. In WY&H there are nearly 90,000 veterans, who are entitled to priority access to NHS care for conditions associated with their time within the armed forces. However, we don't always understand the mental health needs of this population meaning that access rates to local community-based services for veterans transitioning out of the armed forces (TILS) are lower than they should be. These services are provided outside of WY&H covering the North of England; however, it is important that we ensure our veteran population is supported to get the help they need when they need it so we will review how this currently happens.

201. For veterans with more complex problems (CTS), the service provided by Leeds and York Partnerships NHS Foundation Trust and Combat Stress provides therapies and advice, tailored to the culture and needs of ex-military personnel. We will continue to work with the armed forces to ensure this service meets the needs of its service users.

202. Likewise, the Hazlehurst Centre in Dewsbury provides support for survivors of sexual assault. As a system we will work together to ensure that by 2020/21 integrated therapeutic mental health support is provided both immediately after an incident and on a continuous basis where needed, including seamless referral into other mental health services. More here locally specific?

203. There are no Immigration Removal Centres (IRC) within WY&H. However, we recognise that there will be residents within our system with mental health conditions (often caused by or exacerbated by torture, trauma or oppression in their country of origin) who end up being placed in IDCs. We will work with prison mental health teams and liaison and diversion services to ensure the necessary support is provided to any potential detainees before they enter IRCs and that this is continued during their detainment, either within an IRC setting or 'remotely' within community settings.

Services for those with Learning Disabilities

204. In WY&H we want more people with a learning disability (with or without autism) to live in the community, with the right support, and as close to home as possible. This also means providing equitable treatment and care, reducing how often people with a learning disability are treated differently, empowering them to lead a normal family life. For example the National Survey of Adults with Learning Disabilities estimates that between 40-60% of adults with a learning disability do not live with their children and we know that young people with a learning disability are at their most vulnerable as they transition from childhood into adulthood when increasingly challenging or risky behaviours impact on the individual and/or their family, making it difficult to cope.

We are: Considering how we configure **community services for people with a learning disability to reduce our reliance on inpatient beds** across WY&H

205. The West Yorkshire Transforming Care Programme (WYTCP) is leading work to reduce our reliance on inpatient beds in line with national targets; so that no more than 30 people, per million adults are cared for in an inpatient facility. To deliver this work we are focusing on several areas; improving early intervention and prevention (particularly for people aged 14-25 years), market development (including affordable housing) and increasing workforce capacity and capability.

206. We are expanding the role of Intensive Support Teams during 19/20 to deliver earlier intervention, increasing their capacity so they can deal with increased complexity and support 8-10 individuals at any one time (up from 2-3 currently). These teams work across disciplines and comprise clinical psychologists, nurses, occupational therapists, speech and language professionals and psychiatrists.

207. In addition, we have developed Forensic Outreach and Liaison Services for people with a learning disability/autism. These services went live in April 2019 identifying those people across WY&H with a learning disability/autism who are currently in secure services who could be cared for in the community where possible. From 20/21 the service will be fully operational, ensuring individuals are effectively supported post discharge or if they have been

referred due to offending behaviour. Some of the interventions will include specialist risk assessment, early intervention, case management, vocational support and in-reach into secure settings.

208. Across WY&H we are also seeking to develop the wider care market, so there is appropriate, high quality provision available for those who purchase care themselves and for state funded services. And we know nationally that making care choices can be difficult, particularly when the market is under pressure with increased cost pressures and restricted state funding. These choices are even more difficult for people with complex learning disability. The WY&H Transforming Care Programme is working alongside the wider Partnership and the Yorkshire & Humber Operational Delivery Network to ensure the needs of the whole population are taken into account so that communities, universal and statutory services actively enable people with a learning disability and/or autism to have a healthy and active life.

We are: Considering how we configure **assessment and treatment beds for people with a learning disability** across WY&H

209. Adults with learning disabilities should be cared for in the least restrictive environment possible. Yet despite improving the availability of community support, we recognise that there will still be occasions when short-term, secure inpatient services are needed.

210. As a collaborative we are working together to specifically review the configuration of our Assessment and Treatment beds, to create a regional centre of excellence, reducing the number of inappropriate admissions or when admissions are appropriate ensuring this is based on clinical need, for as short a period as possible with a planned and effective transition back into the community and reducing the number of individuals being placed out of the region.

211. This means that we are taking the best practice from each of our existing three sites (LYPFT, SWYPFT, BDCT) to consolidate into two sites (BDCT, SWYPFT), becoming one regional bed base. Work to reconfigure the hospital estate will take place during 2020/21, with the new way of working operational from 21/22. This improved way of working will help reduce length of stay so that those 75% of those individuals who are admitted are ready for discharge within 3 months, and 90% within 6 months.

212. We are reshaping the workforce to help with this, part of which is the creation of a Learning Disability regional care navigator role during 19/20 who will be focusing on understanding the needs of individuals at risk of inpatient admission or out of area placement, identifying potential solutions to proactively support them, and highlighting where there are gaps in provision, including skill gaps, across the region

Annex A – DRAFT Programme 'Dashboard'

What are we trying to achieve?	What is the measure?	What is the baseline?	Where do we want to be by 21/22?	Where do we want to be by 23/24?
Core Measure: Reduce the gap in healthy life expectancy for people with MH, LD or A vs the rest of the population	Healthy life expectancy across those groups			
Invest more money into mental health services	All CCGs to meet the Mental Health Investment Standard			
Eliminate people with a mental health condition or learning disability needing to stay outside of WY&H	No. of people with a mental health condition inappropriately placed outside of WY&H			
	No. of people with a learning disability inappropriately placed outside of WY&H			
Reduce the number of people with a mental health condition, learning disability or autism who unnecessarily attend A&E, or who must be taken to a place of safety by police	Number of people in crisis attending A&E			
	Number of people being taken to a place of safety by police			
Reduce our suicide rates	Number of suicides across WY&H			

	Number of suicides in mental health services			
	Number of suicides in suicide hotspots			
Lead provider status for specialized services	AED service delivered as lead provider			
	CAMHS Tier 4 delivered as lead provider			
	Forensics delivered as lead provider			
Waiting Times for Autism/ADHD assessment	Average WY&H waiting times for autism assessment			
	Average WY&H waiting times for ADHD assessment			
Increase the number of people with a learning disability who can live in the community with support	Number of people being cared for in inpatient settings vs in community settings			
Increase the number of people who required complex rehabilitation being treated closer to home	Distance of all service users from home who are undergoing complex rehabilitation			
Ensure that people with a learning disability receive hospital care of the highest	Number of hospitals achieving learning disability improvement standards			

standard, based on their needs				