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Update on Community Mental Health Transformation and Crisis Transformation Programmes for AHAL Scrutiny Board, 9th July 2024

Introduction and Purpose of Paper

This paper sets out a focused update on progress across two of the three cross cutting workstreams within the All-Age Mental health Strategy for Scrutiny board. The successful implementation of these workstreams is central in delivering the outcomes within Leeds All-Age Mental Health Strategy across the identified priorities to achieve the city strategic ambition. Community mental health and crisis transformation are also mandated national NHS policy directives and is also one of the six core priorities set out in the Leeds Health and Care Partnership Healthy Leeds Plan to contribute to achieving the core strategic goal of reducing unplanned care.

Widening proactive access to personalised care, support, and intervention at the earliest point of need is critical to reducing the high rate of unplanned care utilisation evidenced in people with complex and enduing mental health needs through the Leeds Data Model segmentation data . This focus aims to improve outcomes, and experience for individuals, and improve financial efficiency particularly in the context of significant pressures within mental health inpatient services that have impacted sustained challenges in sustainably reducing out of area mental health inpatient placements. The two workstreams are set out separately below in the report to reflect the way scope of each programme is organised. However, it should be read in the context that these programmes are interdependent into the delivery of an integrated primary-community mental health transformed model of care for Leeds. It is also important to emphasise that the work to transform community mental health and crisis provision in Leeds progressing is at a time of significant pressure and challenges across our health and social care system. Achieving the intentions of transformation and meaningful integration of services additionally requires driving culture change that takes time. The impacts and challenges identified in the report should be noted in that context.

1.0 Community Mental Health Transformation Programme

1.1.Specific requirements have been set out by NHS England in *The Community Mental Health Framework* (2019), the *Mental Health Implementation Plan 2019 / 20 – 2023 / 24*, and the *Roadmap for Community Mental Health Transformation* (2023). NHS England published a 'Roadmap' for transformed community mental health services in 2022, with an updated version published in May 2023.

1.2. Transforming Community Mental Health(*link to animation*) for Leeds is a partnership of NHS organisations, Leeds City Council, the Voluntary, Community and Social Enterprise (VCSE) sector, and service users/people with lived experience coming together to transform how primary and community mental health services are currently organised and delivered for adults and older people with ongoing and complex mental health needs. Whilst this national programme is primarily targeted at adults with complex mental health needs, this also incorporates improving access and pathways for young adults in transition from Children and Young Peoples services. Simply put, we are re-shaping the care offer for the adult SMI population, with more joined up and holistic care, with timely access to personalized interventions, and with specific attention to the impact of wider determinants on people's mental health and recovery.

1.3.Our vision in Leeds is to ensure that people access the right care and support at their earliest point of need and have wide-ranging support closer to home so they can live as healthy and fulfilling lives as possible in their community. The principles of the new model of care we have designed are that people will be able to: access care and support when they need it, manage their condition, or move towards individualised recovery on their own terms, and contribute to and participate in the communities that sustain them, to whatever extent is comfortable to them.

1.4.There is a strong body of evidence that accessing interventions for mental health needs in the community, and remaining at home, achieves better longer-term outcomes for individuals. The implementation of the new model of community mental health care aims to provide access to integrated community support and interventions that enable and maintain recovery.

1.5.To achieve this in Leeds, the approach included a specific focus on redesigning the model of community mental health care to reinforce and enhance integration through the following design principles:

- Dissolving the barriers between primary and secondary care, and between different secondary care specialist teams
- Strengthening cross-sector collaboration and integrated working with local authorities and VCSE partners
- Moving from a generic 'care coordination' model of care to a proactive intervention-based delivery.
- Optimising data and information sharing across organisations.
- Maximise continuity of care
- Adopting the principle of inclusivity as opposed to exclusions/criteria.
- Informed by data and qualitative insight understanding of communities to address the racial disparities, social determinants of complex mental health needs, and to reduce the health inequalities within specific local populations.

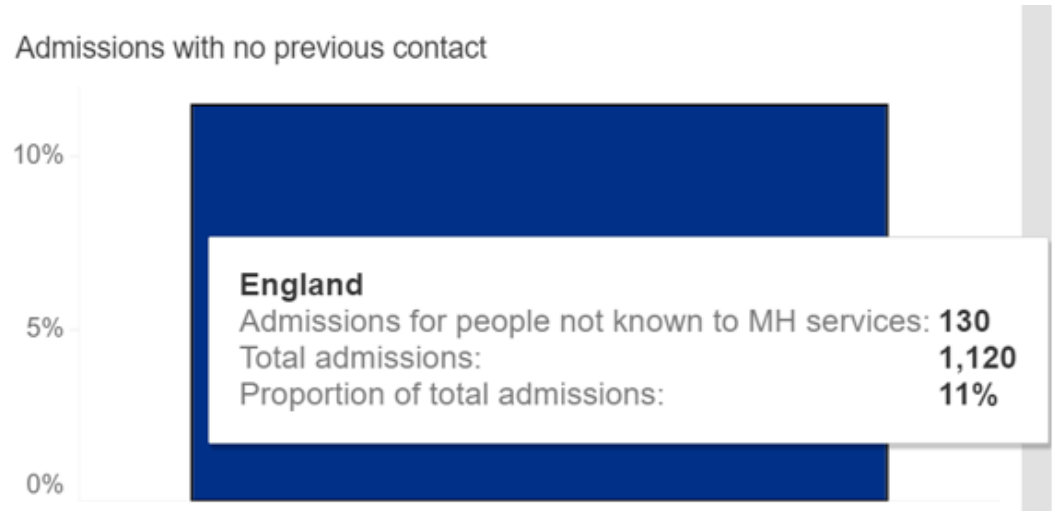
We will know if we have 'transformed' the community mental health offer in Leeds if we achieve the following four key outcomes:

Outcome	We will know we have achieved it if...
Accessing high quality support	The community mental health system across West Yorkshire is transformed so people and their communities can access high quality community based mental health support.
Supporting care options	People and their communities understand the options for support and can access what they need, when they need it and services which will work with them to agree the best options.
Providing innovative, effective, and evidence-based care	People and their communities work in partnership with a responsive workforce that provides innovative, effective, and evidence-based care that places the individual at the centre of decision making.
Partnership working	All partners work in a seamless way to provide people and their communities with the personalised care they need as one health and care system.

Now we are testing and expanding new ways of working, we would expect to see benefits and cost reductions associated with a more proactive care model that stimulates a "left shift" of activity, with reductions in unplanned care.

As a key measure of success we are tracking numbers of people admitted to acute beds that are unknown/not accessing community services as a proxy measure for effectiveness of proactive community intervention in avoiding hospital admission. This links to both quality outcomes and experience for service

users and making best use of finite financial resources, with out of area mental health inpatient bed utilisation being a significant cost pressure, and quality impact.



1.6.Two key components of the new model of care identified within the NHS mandated specific requirements:

- Redesign of "core community model" – a proactive, integrated model of primary and community mental health care for adults and older people with complex and ongoing mental health needs (typically referred to as 'severe mental illness' or 'SMI') – what we, in Leeds, have been referring to as 'integrated community mental health hubs.

- Improved pathways for specific 'cohorts' of people, including adults and older people with: an eating disorder/disordered eating; complex emotional needs associated with a diagnosis of personality disorder and/or people with complex psychosis.

2.0 Approach to developing a New Integrated Primary and Community Mental Health Model of Care

2.1. To develop the new integrated primary-community mental health model of care, a design group was established and utilised information generated from a 90-day learning cycle. This involved 6 workshops with representation and participation from a wide range of organisations across Leeds and people with lived experience. Further liaison with partners where required followed these. There have been further workshops to discuss elements of the model design within Local Care Partnerships and an Involvement Network for people with lived experience and carers.

2.2. Throughout the model design, implementation, and mobilisation phases we have been committed to involving people with lived experience, including carers, in the design and delivery of services. This has included, ensuring that we increased our efforts to understand those people whose voices are 'easy to ignore' so that we can design and deliver services that are responsive to the needs and characteristics of different groups and communities to reduce inequalities in access, experience, and outcomes .

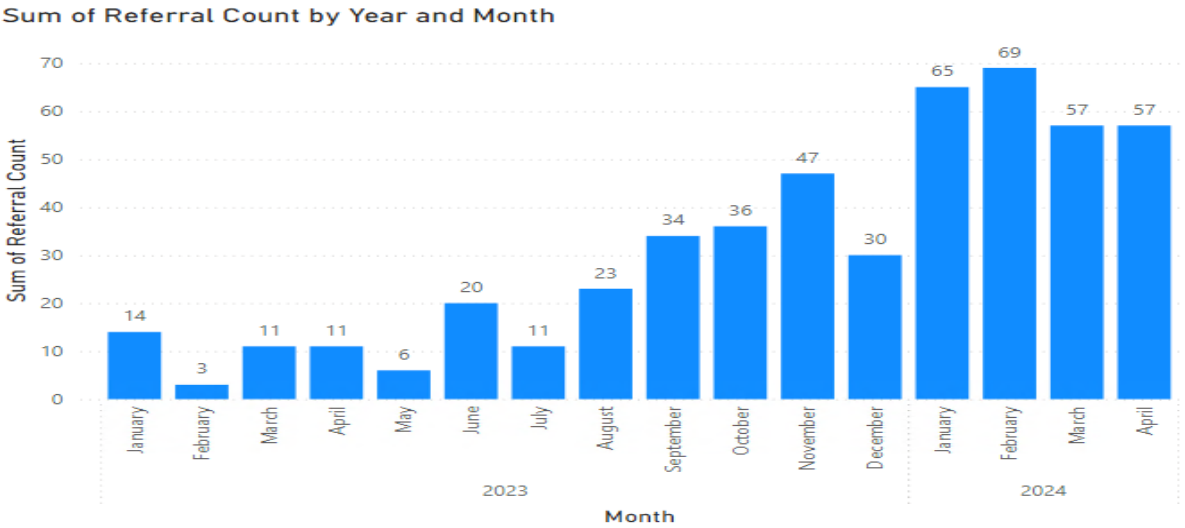
2.3. The new integrated primary and secondary community mental health model now mobilised for testing, will operate in what we are calling Integrated Community Mental Health 'Hubs'. The "hub" teams will be made up of people currently working in Community Mental Health Teams, mental health practitioners and support workers currently working in Primary Care Mental Health (part of Leeds Mental Wellbeing service), mental health social workers and a range of third sector roles with a focus on meeting people's needs in a holistic way, including peer support.

2.4. The community mental health hub aims to enable access close to people's communities, are aligned to local care partnerships (LCPs), and designed to meet bespoke local population needs. Targeted new investment into VCSE organisations, and particularly grassroots organisations/groups, has been an underpinning strategic investment approach to reaching previously underserved communities. This approach aims to improve provision of bespoke and culturally competent care and support offers within communities, to improve equalities in access, experience, and outcomes.

2.5. In progressing the model development in Leeds, we have expanded our community-based support and investment through the targeted funding from NHS England ringfenced to deliver this priority. Within 2023/24 the full year total committed funding through the programme was £4,669k. £2,685k was committed to schemes delivered by Leeds & York Partnership NHS FT. This included £1,769k made up of clinical roles and some programme delivery resource and £916k relates to the Emerge service that provides access to improved pathways for access to specialist intervention and support for young adults (18-25) with more complex emotional needs. Of the total 2023/24 investment, voluntary & Care Sector Enterprises received £1,418k (30%)

2.6. As a national NHS mandated priority for mental health, we have used the associated additional Service Development Funding (SDF) investment from NHS England to expand community-based support and grow the workforce. Including:

- Introducing a new primary care therapies team providing psychological therapies for people who fell between NHS Talking Therapies (IAPT) and secondary care. Between February 2023 and March 2024, 111 people were referred into this service with the main reason being for trauma, responding to an unmet need in existing service provision and a known gap between NHS Talking Therapies and secondary care. Referrals to this service continue to increase as shown below, contributing to increasing access to a range of 1:1 and group psychological therapies directly from primary care . This underpins a focus to shift the culture of mental health services from managing risk to delivering outcome focused interventions that enables recovery and maintains wellbeing.



- Expansion of peer support provision and introduced new Community Wellbeing Connector roles who work with people with SMI (not time limited) to support them to access care, support and community-based recovery and wellbeing offers. 286 referrals have been made to the service between February 2023 and March 2024.

- Distributed £628,000 of grant funding to 24 small to medium community organisations with the aim of increasing community-based support for people with complex mental health needs through a

transformation grants funding scheme ,delivered in partnership by Forum Central and Leeds Community Foundation.Guidance to underpin the delivery and targeting of the transformation grants funding has been developed. This has been directly informed through lived experience involvement activity, feedback from the Transformation Involvement Network, and engagement with 109 third sector organisations/ community groups in Leeds to understand how we can better serve people within the scope of Community Mental Health Transformation. People with lived experience are directly involved in the decision-making process and represented through the grants award process as panel members. At a recent celebration event we heard the immense impact on people with complex needs through strengths-based approaches - this will be captured through the end of grant reports, a toolkit for organisations and a film.

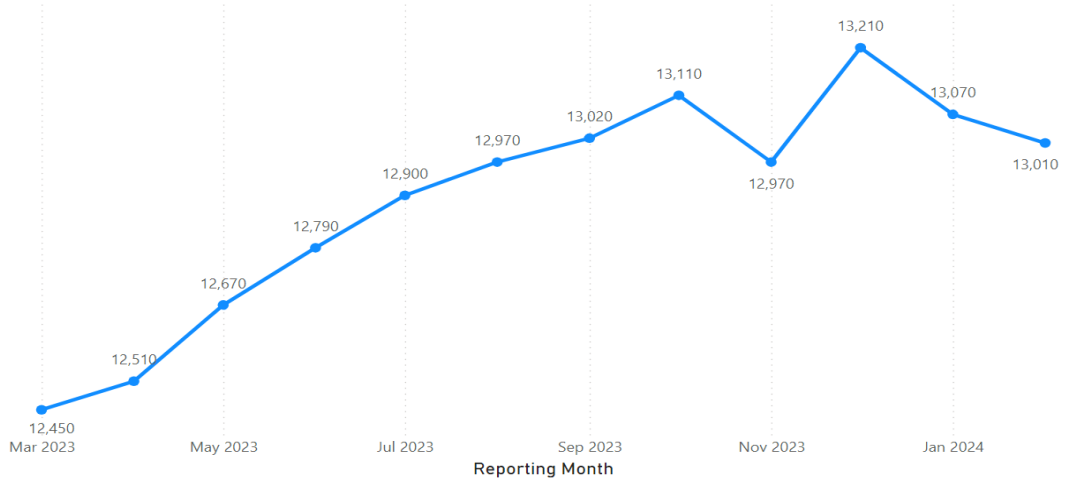
2.7. Further work was completed across the partnerships, to develop governance processes for the newly formed 'Early Implementor' teams in preparation for phase 1 testing and refining of the newly designed model of care operationally. This brought with it challenges due to differing existing delivery and contractual requirements, individual organisations each having their own internal governance and decision-making processes and there not being a 'lead provider' within the multiagency delivery model being tested. Positively all partners have collaboratively developed and signed a Partnership Agreement that defines agreed ways of working and has enabled mobilisation in March 2024 to test key components of the new model of care within the early implementer sites. Whilst progressing to this stage has not been achieved within the timeline anticipated, the additional work has made progress in addressing some key partner governance concerns that ultimately puts the mobilisation on a stronger initial footing to ensuring safe and effective care as this mobilises further. The agreement signed has agreed both joint management arrangements and data sharing agreements within this. However further work is still required to identify infrastructure solutions for ICT/digital to enable sustainable working across multiple record keeping systems, and access to estates as we further mobilise. The Leeds Health and Care Partnership are offering support through both the Integrated Digital Service and the 'One Leeds Estate' Board.

2.8. A newly formed Community Mental Health Transformation Partnership Board is now established and in operation. This Board is chaired by Dr Christian Hosker, Medical Director from LYPFT and Chair of the Leeds Health and Care Partnership Mental Health Population Board , with the inaugural meeting having taken place in May 2024. This marks a positive step in transitioning the community mental health transformation from a design programme to a mobilisation and delivery phase ,led collaboratively through partners. The Community Mental Health Transformation Partnership Board will oversee the operational impacts to make best use of resources, key performance indicators and evaluation of the outcomes. The first external evaluation report, that is being undertaken by NICHE, is due to be ready for September 2024. The ask of the partnership board will be they assured of Impact and progress to scale up delivery to the wave 2 Local Care Partnerships and PCNs.

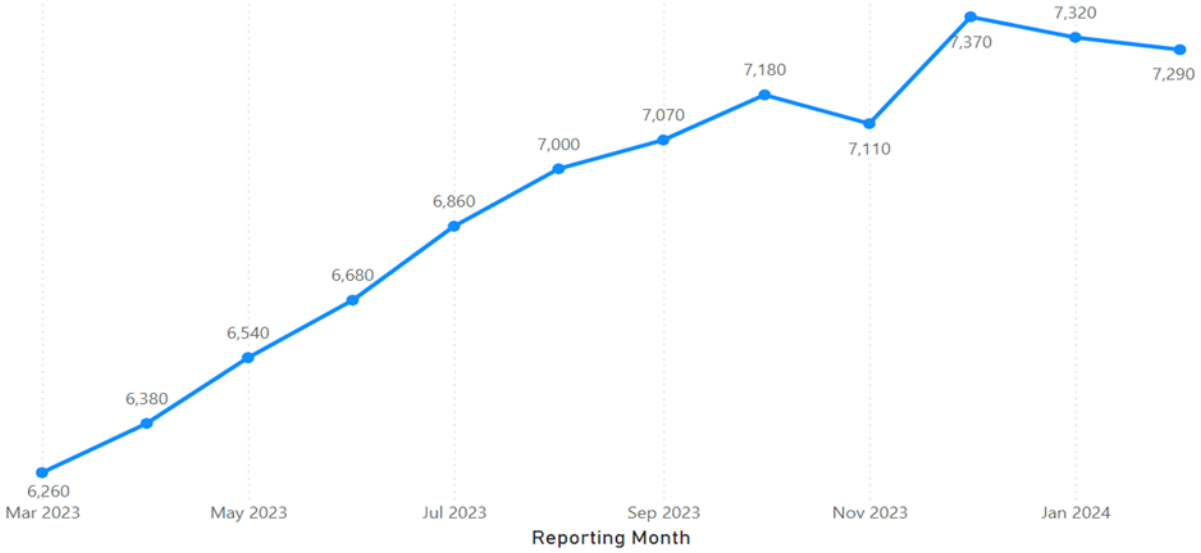
2.9. There is a nationally mandated target to increase access to community mental health services. This is measured by rolling 12 months of the number of people on a Community Mental Health Team caseload having had two or more contacts (on the rationale that they have been triaged and assessed and are on a caseload to receive one of more care "interventions"). Leeds achieved 20% above the target in 2023/24. We have seen an expansion of the number of people accessing community mental health services through increases in demand in existing services, but also through new services available to people through expansion in the programme such as Primary Care Therapies, Community Wellbeing connectors and peer support.

Our planning assumption for 2024/25 is to achieve an additional 5% activity above our current baseline.

NHS E Rolling 12 months - Total people on caseload in all community services



NHS E Rolling 12 months - Total people on caseload in all transformed community services

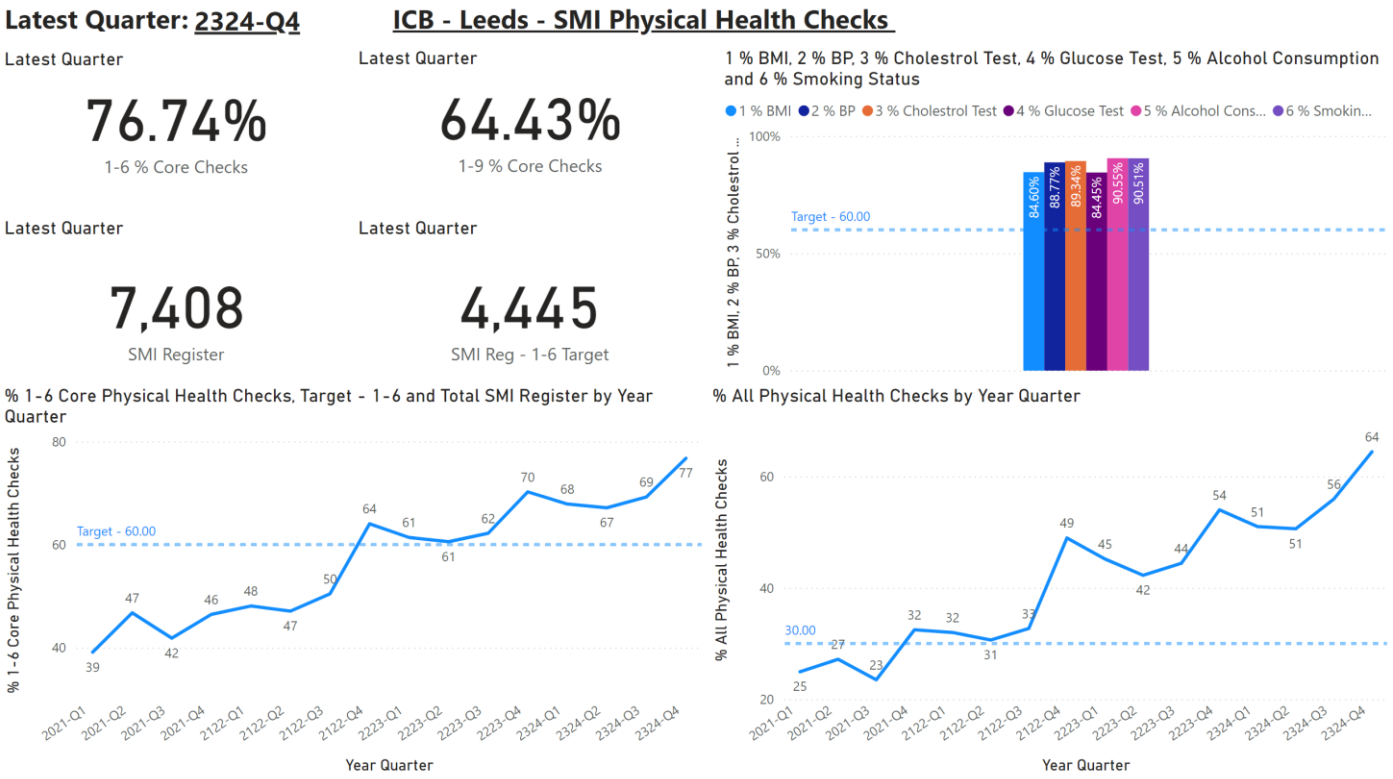


For the NHS England metric of the total number people on caseload in all **transformed** community services we have also seen an increase. Primary Care Mental health is considered and already transformed service as integrated with and directly accessible within Primary Care. As many other areas in the country don't have this , they are setting up similar services through community mental health transformation programmes. In Leeds we will soon see the addition of CMHT Working Age adults' data in wave 1 PCN's who have started testing the model.

2.10. Improving physical health for people with SMI – access to annual health checks

People with complex and enduring mental health need are one of the plus groups within the national Core20PLUS5 programme to reduce health inequalities. Improving access to Physical health checks is one of the identified clinical areas within the Core20PLUS5 programme that require accelerated improvement and is also a key requirement within the community mental health transformation programme.

Leeds continues to perform well on the NHS England requirement to increase access to physical health checks for adults on a GP SMI register (in response to the significant inequality of premature mortality for people with SMI). We have increased more targeted support for those not accessing physical health checks, including introducing primary care-based roles and outreach provision through SDF investment.



3.0 Embedding the Integrated community model:

3.1. We established "early implementer" integrated community teams from March 2024 across 3 LCPs/4 PCNs (HATCH, Leeds Student Medical Practice and the Light and West Leeds). The plan is to test and learn from changes and evaluate impacts of changes with a view to embed and scale up across Leeds during 2024/25.

Specific changes introduced include:

- Co-location of teams 'anchor days', to facilitate improvements in multidisciplinary working and providing a sense of belonging for the team. There is positive feedback from practitioners with a peer support worker commenting.
    - *"I needed to talk to someone's key worker. We were in the same building. We had a conversation, and I was able to move forward with the required support".*

Further feedback has also been received from the teams on how positive it is to be working in partnership, examples being:

Things to celebrate:

- *I think staff have worked so hard in connecting with one another, both professionally and socially, such as WhatsApp Groups, communal lunches, and a tuck shop. I think individuals' willingness to tackle change has shown how positive it can be. In East we've experienced a real sense of connection, friendliness, and respect for each other's roles.*
- *The anchor days in general have been a positive place to engage as a wider team, bringing various services together. We've been able to support joint appointments, have warm handovers face to face, with more much more ease.*

The challenges that have been overcome:

- *Getting staff to begin to move from thinking we're individual teams and moving towards a larger service with different offers.*
- *Facilitating services to work together as a team when we've been separate to one another. I believe we have worked well in our anchor days. I think the first anchor day brought staff together well.*

- *"I was so nervous about coming onto an NHS site for the first anchor day, I now miss the days that I am not working with the team"*.

- Joint triaging of referrals by Primary Care Mental Health (PCMH) and Community Mental Health Team (CMHT) practitioners. Since this was introduced in August 2023 60 -80 referrals have been redirected from CMHT to PCMH each month. From this we can derive they were 'inappropriately' sent to CMHT, and the joint triage has meant they have then got to the "right service" without having to be first sent back to the GP and the person then having to wait for a further referral to the correct service. This relatively small shift in integrated ways of working within the new model of care is evidencing positive impact on avoiding referrals bouncing round the system, that improves outcomes and experience for people with mental health through more proactive access and reduces unnecessary referral processing activity and costs within the system and increases productivity.

- A new Advice and Guidance pathway has been introduced in our early implementer areas. This allows GPs and primary care prescribers access to advice and guidance from a specialist mental health pharmacist or consultant psychiatrist to help maintain people with complex needs within primary care and wider support within their communities; reducing unnecessary referral and hand-offs into secondary care specialist mental health teams that impact consistency of care. We will be monitoring the impact of this change.

- Introduction of key worker. The keyworker can be anyone within the early implementor MDT team, irrespective of role, seniority, or professional background. The main role of the keyworker is about maintaining supportive and therapeutic relationships, so it should be whoever knows the person best, or in the case of someone new to the service, is likely to build the best relationship with someone.

3.2. Aswell as embedding and testing new of working within the "early implementer" integrated teams, we have also established better links with more specialist community teams within Leeds and York Partnership NHS Foundation Trust (LYPFT). The Crisis transformation is also underway and incorporates a revised delivery model for the LYPFT that co-locates the LYPFT crisis team within the community localities. This aims to forge better working relationships, simplify crisis pathways to ensure that the right level of crisis support to meet needs is accessible at the earliest point, and ultimately to improve outcomes and experience for people with complex mental health needs. It is worth emphasising that whilst the work to transform community mental health services and improve crisis pathways are organised through separate work programmes, there are close interdependencies and these strands of work join to operate within the overall transformed model of care for integrated community mental health services.

3.3 As we have moved from model design to testing and delivery, we recognise how important it is that we continue to have the involvement and engagement of people with lived experience and carers. To reduce duplication and mainstream into delivery we have now embedded the involvement work within the Service User Network in LYPFT, with mechanisms for broader system input and oversight via the People's Voices Group and the Involvement and Engagement Advisory Group which is a sub-group of the Partnership Board. This has the responsibility for ensuring that the programme is seeking feedback and involvement from a diverse range of communities, with a focus on reducing health inequalities, and with a clear mechanism for acting on insight and feeding back.

3.4. Healthwatch have been commissioned to undertake community engagement in preparation for phase 2 mobilisation the integrated community mental health hubs to Beeston and Middleton (Inner South), Bramley, Wortley, and Middleton, Woodsley and Holt Park Local Care Partnership localities. This work gives opportunities for communities in the four phase 2 target LCP areas the opportunity to share their views about mental health, mental health services, their local area and the key aspects of the Community Mental Health Transformation

service model has completed. Healthwatch have utilised a comprehensive engagement approach to achieve rich and targeted local insight was undertaken through a range of mechanisms; face-to-face engagement in community venues, face to face engagement through existing partner VCSE forums in the localities, social media and online communications, collaboration with LYPFT community mental health teams to engage with individuals currently in receipt of secondary care intervention in phase 2 localities , online survey for those who wished, and targeted communication through appearing on Rangoli Radio, a Leeds-based radio station catering to a largely Hindu audience.

3.5. We have undertaken work with VCSE partners supported by Forum Central to develop an approach to collaborative delivery models to reduce the number of individual contracts held by the ICB, strengthen the flexibility offered within outcomes based contracts for VCSE partners, and progress work to establish a VCSE alliance model to strengthen the position of the sector as a key pillar of community mental health transformation and the sector role in co-commissioning on the Partnership Board.

4.0 Next Steps:

Throughout the remainder of 2024 and into 2025 we will continue to learn and evaluate from the wave 1 "Early Implementor" teams and proceed to scale up to the second and third wave of LCPs.

Work has also commenced on the "Focussed Areas":

- eating disorders
- complex psychosis and complex emotional needs
- Personality Disorders
- Children and Young Peoples transitions

This work remains in its infancy at present, with an ask of each of the subgroups to produce a report on the following areas in September 2024:

- Gaps in service delivery.
- Required work and time scales.
- Resource implications.

September 2024	Evaluation of early implementer integrated teams completed and assess readiness for scaling up into other LCPs (including staff and service user/patient and carer feedback) Recommendations from review of pathways for eating disorders, complex psychosis and complex emotional needs and business case development in response
November 2024	Scale up into "wave 2" LCPs
March 2025	Assess readiness for scale up of early implementer teams to remaining LCPs
May 2025	Scale up to remainder LCPs

Crisis Transformation Programme

5.0 Background

5.1.A crisis summit held in January 2020, involving service users, third sector partners, Leeds and York Partnership NHS Foundation Trust, members of the ICB and other stakeholders. This identified the key conditions listed below as being crucial to improve the citizens of Leeds experience of accessing Crisis Support.

- There needed to be more integration across the crisis and acute mental health pathway.
- There needed to be more timely access to services.
- That community-based services should support recovery.
- That the Blue light service pathway needed review.

5.2.The Crisis Summit suggested that there were challenges to ensuring timely access to crisis services as follows.

I. There are several routes into crisis services which are confusing to navigate and create stress and anxiety for those seeking support.
II. There is a need to understand how providers can work better together to create a more streamlined approach and offer.
III. There must be improvements for individuals and their carers to receive a caring, compassionate response from services, ensuring they feel listened to throughout their journey.

5.3 The above demonstrates the interdependencies between the community mental health transformation and the crisis transformation programmes. To address these issues, the Leeds All Age Mental Health Strategy offered an opportunity to work collectively towards addressing these challenges through focussed attention. A specific workstream to address the timely access to services was developed and in the last 18 months all aspects of development work for mental health crisis services have been drawn into a transformation programme.

5.4. The focus of the Crisis Transformation Program is to create an accessible crisis service, that meets the needs of the people of Leeds, and achieves positive outcomes for those accessing the service.

There are several workstreams that are being delivered as part of the whole program.

- Reconfiguration of Mental Health Crisis Support Pathway (Improving access)
- Optimising Value Review
- Evaluation of Crisis Cafes
- Evaluation of the Crisis Assessment Unit and Oasis (Crisis House)
- Introduction of the NHS 111 MH Crisis Line
- Implementation of a revised police pathway
- Implementation of Crisis Response and Intensive Support Service evaluation and redesign.

The following describes a brief synopsis and update of each workstream.

5.6. Reconfiguration of Mental Health Crisis Support Pathway (Improving access)

This work stream is born out of the crisis summit described above the outcomes to be achieved are as follows.

- Those providing support should be part of a shared network in which information about an individual's support needs is accessible and accepted by services and reflect quality engagement highlighting what matters most to that individual. This is described as ***system-wide accessible information.***

- It is accepted that each point of access has its own criteria for access. There is a need for consistency of skills and competencies those consulted with lived experiences would like to receive in the quality of their engagement with services. This has been described as the ***consistency of skills and competencies*.**

- Points of access where individuals present will vary depending on how they seek support. The environment in which support is offered can play an essential role in the management of people's experiences, supporting the de-escalation of their symptoms. This is described as having a **supportive environment**.

Progress in this workstream has been the slowest as resources have been limited, however, additional support has recently been sourced and plans to accelerate the rate of delivery are underway.

5.7. Optimising Value Review

The aim of this workstream is to review key lines of enquiry relating to the delivery of Adult Mental Health Crisis services; to identify where there are opportunities to make improvements to the pathway that will improve value and outcomes, improve efficiencies and productivity, and or reduce inequalities in access or outcomes for groups of people.

to date the following has been achieved:

- Analysis of VCSE crisis support services data and intelligence in collaboration with providers
- Reviewed LYPFT CRISS and Street Triage data through analysis of Mental Health Services Data Set (MHSDS) data flows
- Delivered a partnership workshop on the 14th of March to review key lines of enquiry identified in data analysis and seek to identify opportunities/actions for improvement to value in the pathway. 28 people attended the workshop including representation from LYPFT, VCSE sector, Forum Central, Leeds City Council, lived experience representatives and Synergi.
- Crisis insight review being completed by the ICB Engagement Team, incorporating insight from data review work and workshop.

5.8. Evaluation of the Crisis Cafes

An evaluation has been undertaken to review service user and staff experiences of the Crisis Cafes operated by Touchstone. This, alongside the optimising value review demonstrated that because of changes to the operating model required during the pandemic that the model of delivery had altered from its original specification. This reduced the capacity and effectiveness of the cafes. Actions are underway to reinvigorate the original specification, to undertake more face-to-face activity and promote the work of the cafes to a wide range of mental health teams and service users.

5.9. Evaluation of the Crisis Assessment Unit

The Crisis Assessment Unit is a 6 bedded facility located within the Becklin Centre within LYPFT. Its remit is to provide an extended period of assessment of an individual's needs within a 72-hour period. However, again because of changes to the operating model required during the pandemic and the increased demand for acute mental health inpatient beds the unit has been utilised as overflow capacity for acute inpatient beds. It has not been possible to determine if the unit designed to avoid acute inpatient admissions and to identify appropriate support services for individuals in the community has achieved its objective. LYPFT have now agreed to ring fence the unit and restore this to its original purpose and evaluate the impact over a one-year period.

5.10. Evaluation of Oasis (Crisis House) and the integrated crisis pathway with LYPFT

The Crisis House names Oasis was commissioned 2 years ago to provide an alternative to hospital admission for individuals experiencing a MH crisis, to support reductions in use of out of area mental health inpatient beds in Leeds. The model has a more targeted focus on those assessed with more acute MH needs ,than the wider range of community crisis alternatives provided in Leeds. Oasis is provided by Leeds Survivor Led Crisis Services in partnership with LYPFT Crisis Service (CRISS). The facility currently has five short stay beds that can be accessed by service users for up to seven days, clinical input is provided by the CRISS. In addition, there are several "day spaces" for service users who can attend the service during each day returning to their own home every evening. The service is delivered within in an integrated pathway and collaborative working with LYPFT crisis team, the access route for Oasis is following an assessment by the LYPFT crisis team - this maintains this provision focused to providing integrated community support for individuals that would have been admitted to hospital in the absence of this robust alternative to hospital admission pathway.

The evaluation recommended that better integration of the teams within Oasis and CRISS was required; that both overnight occupancy and the day service should be utilised more to ensure value. Improvements have been made to the delivery model, the enhanced integrated clinical pathway, utilisation of a single information system. Service users have reported excellent experience and clinical outcomes. The service is also now developing proactive planned care pathways to avoid crisis and re-admission to hospital, for people with the most complex mental health needs being repatriated from longer stay complex mental health rehabilitation out of area beds.

5.11. Introduction of the NHS 111 MH Crisis Line

As part of the Long-Term Plan, NHS England aims to simplify access to urgent mental health support. By 2023/24, anyone seeking urgent mental health support in England will be able to do so via the simple universal 3-digit 111 number. This will place England as a world leader being one of the first countries to set such ambitious plans for accessing mental health care through a universal 3-digit number.

As a result of this the NHS 111 ask and the Interactive voice response, have located to the West Yorkshire Mental Health Helpline to manage those referrals and flow that are not crisis, to relevant service lines using the current online referral form process.

The change requires the technical amendments to the National Interactive Voice Response system that is used by the Integrated Urgent Care NHS 111 to link callers who dial 111 and select the option mental health crisis into existing local mental health crisis/support lines' telephony platforms.

To access crisis mental health support via 111 the caller will have to make a number of selections to ensure they are connected to the right local mental health helpline on the IVR system - dependent on age, location and time of day [due to the proposed model of connecting multiple crisis line providers to the IVR and also complexities with the geography and not being able to rely on geolocation] in West Yorkshire. The call will then be connected to the relevant helpline/crisis team telephony platform where it will be managed in the same way as currently exists if an individual had called the mental health helpline directly.

The challenge for LYPFT, will be to ensure that those who do not need an immediate crisis response, will have a timely referral to the correct pathway/ appropriate service. Following consultation with their services and in collaboration with the Mental Health Helpline, the adult triage script and the decision-making matrix was agreed. A robust supervision strategy has been developed where services meet once a week to ensure pathways have been followed and discuss issues that have arisen during the previous week. This helps foster positive relationships, but also safeguard from any potential issues and or concerns.

The system went live in Leeds at the end of April 2024.

5.12. Implementation of a revised police pathway

The service previously known as street triage is a joint service between LYPFT, social care and the police. The purpose of the street triage service is as follows.

- Reduce unnecessary detentions under Section 136 Mental Health Act (S136 MHA) and unnecessary voluntary attendances to A & E.
- Ensure that people whom it is necessary to detain under S136 MHA are taken to the most appropriate place of safety so that care and needs can be managed safely and effectively in the least restrictive environment, conducive to their well-being with strong focus on compassionate care.
- Divert people from Police custody who have a mental illness, where these factors are identified as the main reason for their involvement in the criminal justice system.
- To provide a liaison service between West Yorkshire Police, British Transport Police and Yorkshire Ambulance Service.
- To provide the service to adults aged 18+ responding to the needs of those who present within the Leeds District. Information and advice will be provided to other localities if a Leeds patient presents in their areas.
- Provide information and advice within police negotiator incidents.
- Share sensitive medical information where appropriate to relevant agencies whilst being mindful of data protection issues. Only sharing what is relevant.
- Provide advice in relation to live police incidents involving a mental health crisis.

In addition to this service, the Becklin centre have a S136 suite where individuals can be detained under section 136 of the Mental Health Act by the police whilst their ongoing needs are assessed, and appropriate interventions sought. LYPFT also previously operated a “district Control Room” service offer where mental health practitioners were based within the police call centre to provide advice and support to officers called to situations where people were suspected of being mentally unwell.

A review of these elements of the service has led to better integrated working between the police, the ambulance service, LYPFT and social care. The team are more frequently operating from the police station at Elland Road and more proactive response service is provided by the mental health practitioners whereas previously this was a reactive service. This is leading to a more efficient delivery of the service and better outcomes for service users.

5.13. Crisis Response and Intensive Support Service evaluation and redesign

The purpose and aims of CRISS are as follows:

- Prevent, where possible, admissions and readmissions to hospital care.
- Support urgent crisis assessments and offer intensive support for working aged adults over a 24-hour period and overnight for older adults.
- Provide initial contact within 4 hours and provide assessment function within 24 hours,
- Support timely transfer from inpatient/out of area services including periods of shared care.
- Provide a robust gatekeeping role for inpatient services, the Crisis Assessment Unit, and the Crisis House (Oasis)

In January 2023, a Core Fidelity Review of CRISS was conducted. The Crisis Resolution Team Fidelity Scale is a national tool developed to measure the performance of Crisis Resolution Home Treatment Teams by scoring them between 39-195 from 39 fidelity items divided into 4 subscales: referrals and access, content, and delivery of care, staffing and team procedures, and location and timing of staff. Overall, the service scored moderate fidelity with an overall score of 118 out of a possible 195. The review laid out a list of recommendations and actions arising from the areas which scored low fidelity to improve practice and fidelity to the model.

The Core Fidelity standards that required focussed attention to improve were.

- The Crisis Response Team (CRT) provides explanation and direction to other services for service users, carers and referrers regarding referrals which are not accepted
- The CRT responds to requests for help from service users and carers whom the CRT is currently supporting
- The CRT is a distinct service which only provides crisis assessment and brief home treatment
- The CRT provides clear information to service users and families about treatment plans and visits
- The CRT promotes service users' and carers' understanding of illness and medication and addresses concerns about medication
- The CRT provides psychological interventions
- The CRT considers and addresses service users' physical health needs
- The CRT helps plan service users' and service responses to future crises
- The CRT provides a thorough induction programme for new staff and ongoing training and supervision in core competencies for CRT staff
- The CRT takes account of equality and diversity in all aspects of service provision

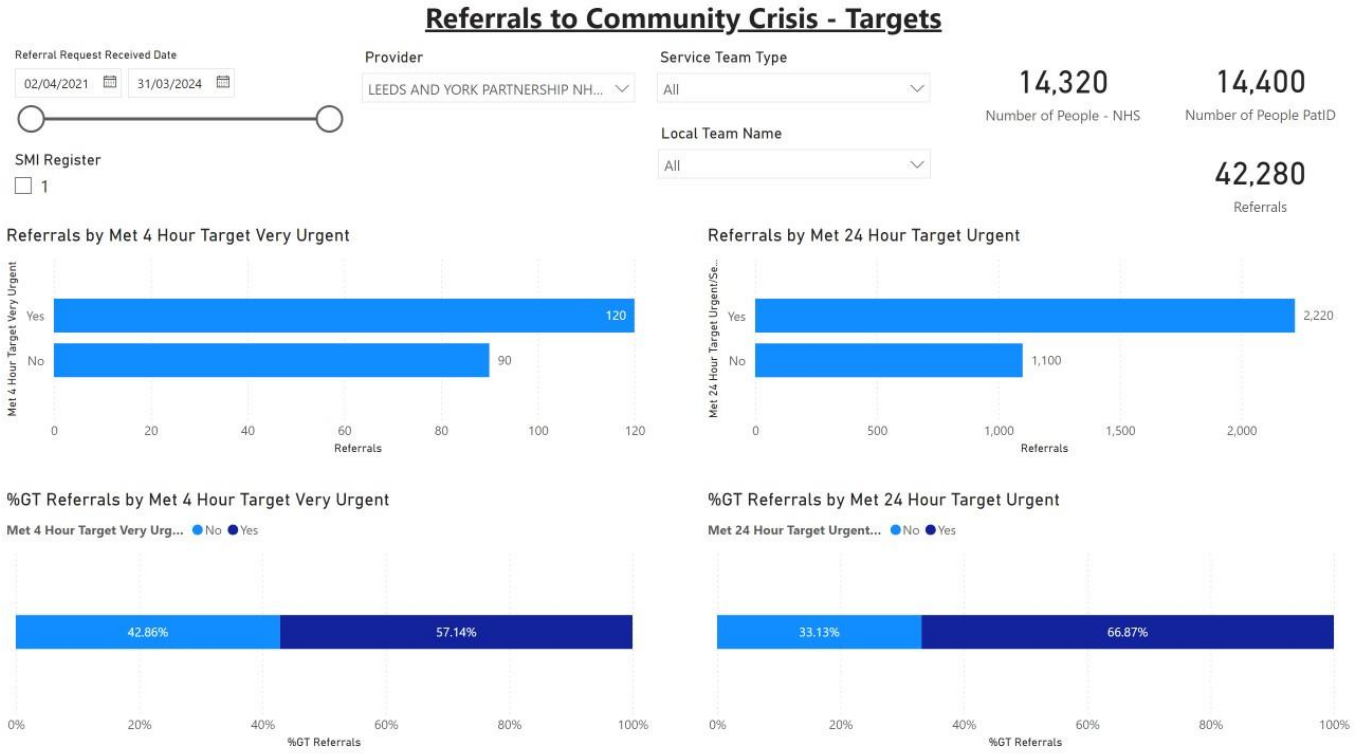
It is the recommendations made within this review which have been used as the rationale behind the proposed changes to the current CRISS model. As a consequence of the recommendations a restructuring of the CRISS model is being undertaken, this will involve reconfiguring the Crisis team into three teams to align with the intensive support teams and the new community mental health hubs leading to better integration and joint working. Separation of elements of work that are not related to crisis have been separated out from the service.

The expected benefits that will be achieved are as follows.

- Staff working in each Community Hub can use their local knowledge to improve the care and experience for service users within the local community.
- Improve staff in reach to wards.
- Diverting calls to the Mental Health Support Line will allow the new teams to pick up referrals from service users and avoid delays in responsiveness.
- Improved staffing model will mean that all 3 teams are adequately staffed to meet demand.
- Adequate staffing levels will improve the continuity of care for service users and avoid capacity being stretched.
- Each of the teams will be situated within the same base allowing for improved communication.
- Improved fidelity to the Core Fidelity Scale.
- Ensure the gatekeeping of all inpatient admissions and admissions to the Crisis Assessment Unit.
- Staff will be enabled to provide a trauma-informed approach to care for all service-users.
- Transition throughout the service pathway will be better enabled, with service users receiving high quality place-based care.

As can be seen from the volume of activity being undertaken across the crisis pathway much progress has been made to improve mental health crisis care across Leeds. The variety of providers from third sector, social care and NHS organisations is a critical success factor to the progress that has been made, as is the continued contribution of service users and carers. However, there is more to be undertaken before we have achieved the ambitions set out within the crisis transformation programme. Evaluation of the effectiveness of the changes being implemented will be undertaken to ensure the benefits and outcomes aspired to are achieved.

5.14. The graphs below show referrals into community crisis support across LYPFT crisis provision and Oasis crisis house as an alternative to hospital admission, and the achievements against targets set for assessment within 4 hrs and 24 hours respectively.



6.0 AHAL Scrutiny Board are asked to :

- Note the scope, ambitions, approach, and progress of the work to date.
- Support and endorse the work in Board members' respective roles and communities. We would also welcome reflections and feedback from members on content of the report and relevance to engagement and discussions with their constituents.
- Give feedback and make recommendations on areas for improvement and further developments and/or alignment with other forums and work that we should connect with
- Consider and support an appropriate alignment of resource to support effective delivery of this critical work, in the context of long-term embedding of culture change.

Appendix 1 Full range of suggested indicators against CMH Transformation outcomes

Accessing high quality support: The community mental health system across West Yorkshire is transformed so people and their communities can access high quality community based mental health support.
There is a clear view of what an 'effective' service looks like after the transformation programme
The community mental health system in West Yorkshire has been transformed
The system works collaboratively with the people it supports to transform
Systems are in place that capture learning and feeds it back into service development
The system has a positive culture which staff want to work in
Staff understand their role in the system and the type of support they should provide
The staff and the people they support report that their relationships are based on trust
Feedback to the system from the people it supports is taken seriously and used to improve the support provided
Staff who deliver services report high levels of wellbeing and satisfaction
Staff have the time to provide the support people need
Staff have time for their own self- improvement, reflection and continuing professional development
Staff have access to the right systems and tools to do their job
The workforce is representative of the communities they support
Supporting care options: People and their communities understand the options for support and can access what they need, when they need it and services which will work with them to agree the best options.
Care is accessible to everyone irrespective of disabilities (EG deafness), deprivation, ethnicities and other barriers to access
People can access the care they need when and where they need it
People can shape the services and support they access
Where appropriate families and friends are supported to access support when and where they need it
People provide positive feedback on the support they receive
The support people receive is the right support irrespective of how they accessed it
Providing innovative, effective, and evidence-based care: People and their communities work in partnership with a responsive workforce that provides innovative, effective, and evidence-based care that places the individual at the centre of decision making.
People have a named key worker for their support
Key workers form relationships and navigate people through the system and don't 'just' signpost them to other services
Where appropriate families and friends are included as equal parts of the team supporting people
The care provided is developed in partnership with the person accessing it
The care provided is flexible, compassionate, empathetic, and understanding of people's needs in the widest sense
The system provides support through personalised care planning
Support provided is evidence based and helps people achieve improved outcomes
Support helps people to recover and stay well
Services cease at a time that is appropriate for the person receiving support
The service helps people to stay connected and have positive relationships with those around them
The service supports people to deal with problems in their lives as they arise
People's physical health improves
The support people receive helps them volunteer or get a job

The support people receive helps them access accommodation or housing
The support people receive helps them live their best life
Fewer MH Crisis
Fewer self harm incidents
Fewer deaths by suicide
Reduced health inequalities
Improved healthy life expectancy for adults with serious mental illness
Partnership working: All partners work in a seamless way to provide people and their communities with the personalised care they need as one health and care system.
Multi Disciplinary Teams built around the individual are fundamental to the operation of community mental health
Multi Disciplinary Teams work together to provide the support people need in a co-ordinated manner and reduce duplication
People are managed based on a principle of shared responsibility and trust between the person and the organisations they are working with
Services collaborate effectively to support the people they support
The system has the capacity to ensure everyone has access to quick and equitable care across all skills and specialisms
Organisational and geographical barriers are reduced to a minimum delivering a system with smooth pathways and seamless interfaces
Organisations work together to reduce repetition to a minimum where possible and shares information effectively across the system
The transformation of the system delivers improved value for the community mental health system in West Yorkshire