Leicestershire Partnership
NHS Trust

# LEICESTERSHIRE, LEICESTER AND RUTLAND HEALTH OVERVIEW AND SCRUTINY COMMITTEE – 15 OCTOBER 2020

## STEP UP TO GREAT MENTAL HEALTH PROGRAMME

## REPORT OF LEICESTERSHIRE PARTNERSHIP NHS TRUST

**Purpose of the Report**

1. The purpose of this report is to provide an update to the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee on progress with the Step Up to Great Mental Health improvement programme, share feedback from the recent Clinical Senate review, seek the view of the Committee on the proposed service improvements and investments, and the continuation of engagement and the planned consultation process ahead of implementing our improvements.

**Background**

2. The Committee has previously received updates and presentations on the relatively weak position of mental health services in Leicester, Leicestershire and Rutland compared to other systems in terms of performance, waiting times, excessively long waits and outcomes. We have also provided updates to the Committee on the development of our improvement plans. The Committee has encouraged the health system to bring pace and clarity to the plans and to make best use of the available national investment to address the identified issues.

3. Step Up to Great Mental Health (SUTG) is the Leicester, Leicestershire and Rutland (LLR) STP programme designed to improve mental health services. The SUTG programme has four key elements:
   - Neighbourhoods;
   - Integrated community services;
   - Urgent and Emergency Care;
   - Inpatient.

4. The neighbourhood workstream ('Getting Help in Neighbourhoods') is focused on developing strong and clear mental health offers in each neighbourhood (PCN) area with seamless transitions to wider community support when needed. There is currently work underway to

develop two pathfinders (one in the Aegis PCN in the city and the other in North Charnwood in Leicestershire County). The inpatient (Therapeutic Inpatient care) workstream is focused on sustaining the improved flow in inpatient services, improving the inpatient environment (removing dormitories) and increasing the therapeutic offer/experience when people are admitted.

5. However, the service improvement proposals in this paper focus on our improvement and investment plans for Integrated Community Mental Health services and Urgent and Emergency Mental Health services.

6. We have followed a four-stage engagement and proposal development process over the last three years:

<u>Stage 1</u>

- More than 1,000 people contributed their comments and suggestions to set the overarching principles.

<u>Stage 2</u>

- Service users, carers, staff and partner organisations built on the overarching principles in four separate one-week workshops to develop high-level pathways for mental health and learning disability services.
- The workshops focused on access, assessment, treatment and discharge.

<u>Stage 3</u>

- Detailed design via 74 workshops with service users, carers, staff and partners.
- Focusing on what services should look like, how they should run and the resources they need.
- Resulted in 13 design features published in a draft document in April 2019.

<u>Stage 4</u>

- Future state vision developed tested against nationally mandated models, data analysis, best practice, learning from other Trusts, an external review of Psychological services, the availability of workforce and investment.

**Co-designing and developing our plans based on the engagement process feedback**

7. We have used the feedback from patients, service users, carers, staff and other stakeholders from the engagement events to inform our plans. Some of the key themes and the response to them in our plans are set out in the table below:

**Access**

| Feedback | Addressed in our plans |
|---|---|
| Timely access | The Central Access Point (CAP) is designed to avoid delay at the point of referral or self-referral. |
| 24/7 support | The Central Access Point and Urgent Care Hub will be a focus for investment to build 24-hour, seven-day support. |
| Easy access | Feedback focused on offering a range of direct access points which we will do via telephone, digital and face-to-face offerings. |
| Not being bounced between services at the point of access | The Central Access Point and increased focus on a multi-disciplinary team initial assessment will make the right referral and avoid hand offs. |
| Strengthened access and referral point | We are investing on a stronger Central Access Point and the staff involved in initial assessment with service users. |

**Assessment**

| Feedback | Addressed in our plans |
|---|---|
| Clear and transparent assessment process | We will have a significant focus on multi-disciplinary assessment which is formulation driven based on individuals' needs. |
| Equal say for service users | The focus of the multi-disciplinary assessment will be to develop individualised plans with service users, carers and families. |
| High quality single first assessment | We are investing in the Central Access Point and the assessment capacity in our Community Treatment and Recovery teams to significantly improve the quality of first assessment and making the right first step in treatment. |

**Treatment**

| Feedback | Addressed in our plans |
|---|---|
| Service users should understand their | We are expanding the breadth of our offering through our Community Treatment and Recovery |

| | |
|---|---|
| choices and have a high level of involvement | teams including taking a wider community view with VCS partners. The integrated community services model has a focus on developing individualised plans with, rather than for, service users. |
| There needs to be more consistency in the therapeutic interventions | The integration of our services will expand the therapeutic offering through Community Treatment and Recovery teams. The integration of teams that are currently silo-based will improve consistency. |
| Treatment should commence without long delay | We are taking several actions to eradicate the long internal waits linked to hand-offs and excessive individual caseloads. We will invest to improve the quality and timeliness of the initial assessment which will reduce hand-offs. We will also move to team caseloads with hub and spoke models to move the greater volume of support to community settings. |
| Convenient to service users | The new Central Access Point and Urgent Care Hub will expand to provide 24/7 support to service users. We will also integrate and expand our community teams to provide a greater range of support in community settings. |

**Discharge**

| **Feedback** | **Addressed in our plans** |
|---|---|
| Signpost broader community groups and activities | A higher proportion of our investment is focused on expanding the role of the VCS to support service users to identify a wider range of community-based activities to support their mental health and well-being. |
| Clear service contact point | The Central Access Point and the Community Treatment and Recovery teams will provide clear contact points for service users available if they need to re-contact a service or seek additional support. |
| A helpful and informative website would help people to navigate available support better including self-help guidance. | Our UEC and Integrated Community offerings will be underpinned by high quality online support available to service users, their families and carers, and to wider professional groups. |
| Early planned discharge | We are increasing the focus on recovery and discharge rather than maintenance of service users. |

| | |
|---|---|
| | We will remove long internal waits so that service users move to treatment, recovery and planned discharge more quickly. |
| A focus on individual recovery | We will focus the initial MDT assessment on developing individual treatment and recovery plans. We are integrating our community teams and focusing more of their work on recovery. We are expanding the breadth of our treatment offer to better support individual recovery. |
| Introduce non-clinical role to teams to help connect service users and clinical staff | We are building on the new Peer support worker roles that we have recruited and expanding the numbers to support people across different services. We will also work with Turning Point and other VCS organisations to develop non-clinical navigator roles and broaden the support offer options available to service users. |
| Multi-disciplinary teams - integrate health and social care teams to improve joint working | We are bringing a number of our teams together to break down barriers and to improve joint working. We will use a Multi-disciplinary team approach to initial assessment and to support treatment and recovery. |
| Introduce Peer Support Workers | Our proposals include investment to build upon the Peer Support Workers we have introduced. |

**Progress since the last discussion with the Committee**

External review

8. Earlier in 2020 we commissioned a short external review of the process and materials developed to date. The review recommended that we needed to draw together the various strands of planned investment and improvement into a coherent programme of change overseen by clear STP governance. We have followed a programme plan working towards a Clinical Senate review of the clinical models and this discussion with the Committee on our future engagement plans ahead of approving our proposals and moving to implementation.

Strengthening our governance, plans and narrative

9. We have established a Step Up to Great Mental Health Steering Group overseen by the Mental Health Partnership Delivery Board which is

chaired by the Chief Executive of Leicestershire Partnership NHS Trust (as STP lead for mental health).

10. We have drawn together more detailed proposed plans and are much clearer on the overall narrative, links between the various service change plans, the impact on the LLR specific challenges of making these changes and our investment plans.

Confirming our investment plans

11. We have recently agreed our Mental Health Investment Standard plans as a system. These plans are submitted nationally to confirm how we intend to use the additional available investment to improve mental health services. Our plans focus on strengthening Urgent and Emergency Mental Health services and Integrated Community Mental Health services. In essence, the MHIS will support us to recruit additional staff to deliver these improved models of care. The recruitment will build NHS teams while also expanding the provision of wider community-based posts with Voluntary and Community Sector partners.

Clinical Senate review

12. On 2 October our service investment and improvement plans were subject to a detailed review by the East Midlands Clinical Senate. A Senate review is designed to provide independent external validation of our proposed clinical models. The Clinical Senate review focused on Urgent and Emergency Mental Health pathway improvements in the morning and Integrated Community Mental Health service improvement plans in the afternoon. The Senate will produce a full written report but helpfully provided headline feedback on the day of the panel confirming that we have a compelling vision, positive and coherent plans and they highlighted the strength of our co-production approach.

Temporary Covid related changes

13. The LLR system made a series of temporary service changes under national mandate in response to the initial Covid outbreak in spring 2020. The mandated service changes were aligned with our local improvement plans and have demonstrated a positive impact with excellent service user, partner agency and staff feedback, while running in their temporary form. We plan to make these changes permanent and have investment proposals to further strengthen them in partnership with others.

14. We introduced a Central Access Point and Urgent Care Hub for the LLR system. We have evaluated both of these temporary mandated service changes and the feedback has been overwhelmingly positive. We assessed the impact of having a dedicated mental health point of access for people in crisis rather than entering the health system through A&E and the impact on referrals into our mental health inpatient wards.

15. By having the Central Access Point (CAP) as the new front door to mental health services we have already seen a marked reduction in the number of patients being put through for a full mental health assessment. Since the introduction of CAP in April 2020 to August 2020 there has been 41% reduction in patients coming through to community teams as a referral for assessment. The majority of these patients have either received support from our triage clinicians or been signposted for support within the community.

16. The analysis of the outcomes of introducing the CAP show us that 44% of patients who called the CAP did not require secondary mental health input and were supported into alternative help/assistance. With the further work we are developing in partnership with Turning Point we estimate that this number will increase further as we will be able to carry out short solution focussed interventions to support callers as well signpost to self-help and other support networks in their local communities.

17. The next stage of the Central Access Point involves the integration of the crisis line (and its voluntary sector staff) with the Leicestershire Partnership Trust professionals. This will then be different sector staff working as a Multi-Disciplinary Team (MDT) to introduce new needs-based support and assessment approaches to help best support individual needs.

18. We are planning to invest further in the Central Access Point and the Urgent Care Hub in 2020/21.

**Proposed Urgent and Emergency Care service improvements**

19. For Urgent and Emergency Care, our plans are to invest in a proper urgent and emergency care pathway that provides earlier support to patients, proactively manage vulnerable people, provide planned support outside of the criminal justice system and acute emergency departments.

20. The NHS Long Term Plan sets an ambition for more comprehensive crisis pathways that are able to meet the continuum of needs and preferences for accessing crisis care, whether it be in communities, people's homes, emergency departments, police or ambulance services. It also frames that there should be 'no wrong door' approach to supporting people so that they can get or be supported to the right help to meet their needs irrespective of the point of access.

21. We will work with partners to increase capacity, improve traditional models of crisis care and deliver comprehensive accessible local crisis care pathways. We will work with the voluntary and community sector, police, ambulance service and A&E departments.

22. More detail of our Urgent and Emergency Care proposals and investment plans are set out in Appendix one.

**Proposed Integrated Community Services improvements**
**Integrated Community Mental Health services**

23. For Integrated Community services, the plans in LLR are to deliver the national Community Mental Health Framework and in so doing address the underlying and longer-term problems in our system. The LLR system faces the same challenges as those set out in the national framework document and seeks to deliver the same benefits. The national framework published in late 2019, sets out a case for change, describing a range of common issues with community mental health services. These are all present in LLR:

- Fragmentation of separate specialist teams with associated quality and resource problems;
- Multiple assessments for the same person to fit service rather than service user;
- Exclusion through rigid service specifications and/or arbitrary thresholds;
- The need to improve access to appropriate care;
- Unnecessary deterioration leading to more acute presentations due to delays and waits;
- Lack of personalised support;
- Problems in moving between services – 20% drop out rate when people's care moves;
- Problems with transition for young people moving into adult services;

- Stagnation in the development of Community Mental Health Teams due to high acuity and caseload and lack access of psychological services;
- Poor use of resources and inequitable caseload;
- Reductions in services for people who need longer term care in the community.

24. The national framework sets out a number of goals for the introduction of a new model of community mental health services. These align closely with the goals of Step Up to Great Mental Health:

- Access to mental health services where and when people need it
- Individualised approaches to managing conditions and recovery
- Breaking down barriers between mental and physical health
- Integrated care
- Place and neighbourhood-based service offerings
- Increased roles for the voluntary and community organisations and social enterprises
- Local collaboration
- Working together to maximise the support offered to people when and where they need it
- Meeting people's needs in the community
- Reinvigorating and simplifying community mental health provision

25. The main focus of the service changes we plan to make are to better integrate teams that currently work in separate silos resulting in handovers, sometimes lengthy internal waits and extended journeys when patients pass between teams.

26. We also plan to change the offer to service users in terms of the support that they can expect to receive and improving local access to more integrated services. Community mental health services need to be simpler and with a stronger psychologically driven focus on care and treatment. Within a model that can allow flexibility and that uses best practice from the learning of the past, service users should be cared for without hard onward internal referral and the inevitable delays and push back.

27. More detail of our Integrated Community Mental Health service proposals and investment plans are set out in Appendix two.

## Proposed next steps

28. The validation of the clinical models and agreement of the Mental Health Investment Standard recruitment plans puts us in a strong position to move to the final stages of engagement, consultation and then implementation of our service improvement plans.

29. Our proposal is to continue with our engagement approach as we finalise our plans in a Business Case in October and November 2020. We would then move to an NHS England pre-consultation panel. On receipt of approval to consult, we will undertake a 12-week public consultation. The responses will then be reviewed and considered and a decision made by our Boards ahead of any implementation.

## Recommendation

30. The Committee is asked to:
    - note the progress in finalising our plans to improve and invest in Urgent and Emergency Mental Health Care and Integrated Community Mental Health services;
    - note the themes that emerged from our engagement with patients, service users, carers, staff and other stakeholders that influenced our plans;
    - note the positive feedback from the Clinical Senate review of our plans;
    - comment on the proposals to improve mental health services in Leicester, Leicestershire and Rutland;
    - comment on our plans to continue the process of engagement as we develop our business case and consultation material ahead of moving to consultation.

## Appendices

Appendix 1 - Proposals to develop an Urgent and Emergency Mental Health Care pathway

Appendix 2 - Proposals to develop stronger Integrated Community Mental Health Service

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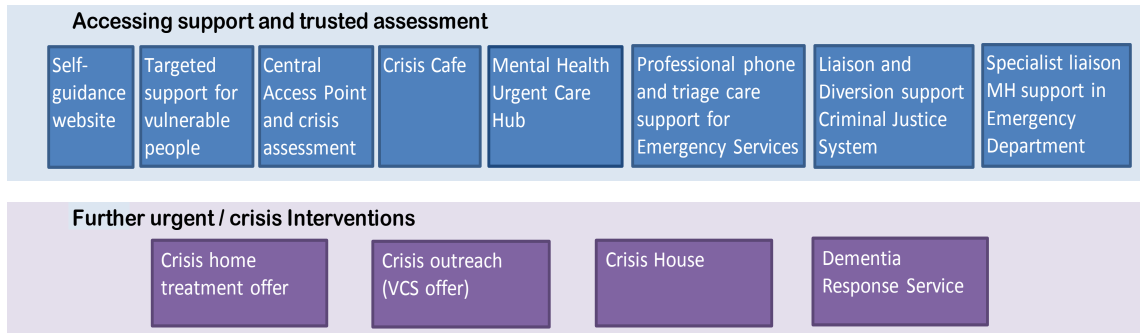
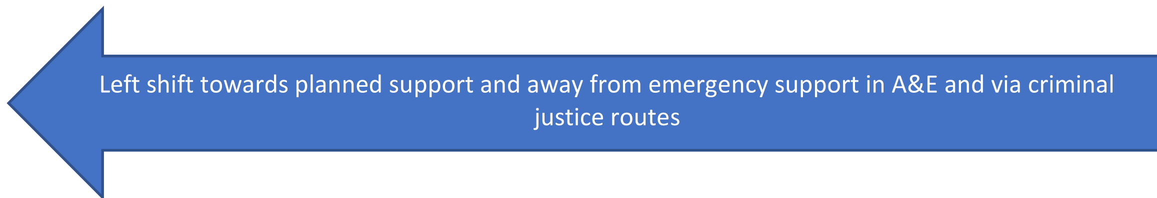
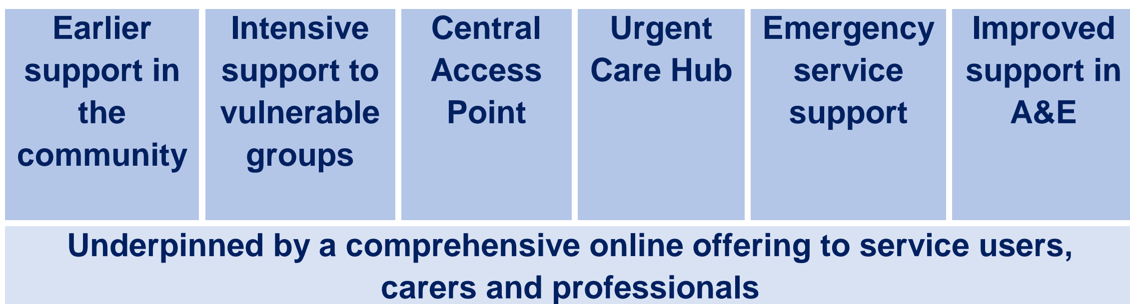
**Appendix one**
**Proposals to develop an Urgent and Emergency Mental Health Care pathway**

Range of access points that all offer 'trusted assessment' and can each lead to further support if required.




The new pathway is drawing people towards as early support as possible to avoid drawing people unnecessarily into the emergency department or criminal justice system.




**Earlier support in the community**

Our plans will improve the offering to LLR residents ahead of an emergency or criminal justice scenario. Strengthening and simplifying the response to people in a crisis is underway and will be developed further with our plans. We will join up and integrate services to support vulnerable people in the community. When people in a crisis come in contact with our services the clinical response will be consistent and needs orientated. We intend to expand and strengthen our Crisis Cafe and Crisis House services. The Crisis

Home Treatment offer will be more consistent and offer greater continuity of care and link with a broader range of support services including those provided by the VCS. We will work with the VCS to develop a range of options for people in the community to be supported through crisis and to respond to the need in a timely manner. Through these actions we plan to reduce the number of people unnecessarily entering secondary mental health services.

We are planning to invest in expanding crisis cafes and a further investment planned each year for the next four years to increase the number of crisis cafes to stretch across large parts of the LLR geography. We also investing into crisis services to increase capacity to provide higher intensity crisis treatment offers when required and to undertake full crisis assessment within 24 hours (or 4 hours where required).

**Intensive Support to Vulnerable Groups**
We will join up and integrate services to support the most vulnerable people in the community. We will improve the consistency and resilience of our services by combining the teams that currently work with the homeless, people in the criminal justice system and custody suites. We will bring together our Liaison Diversion, Homeless and PAVE (Pro-active, Vulnerability Engagement) teams.

We will build on work that is underway to ensure that services are working for all our communities and, in particular, that service users from BAME backgrounds have equality of access and outcomes. We are investing new funding into this pathway in LLR.

The expansion of the teams working with vulnerable groups will enable us to increase our engagement of people going through the criminal justice system. This will help us to:

- Improve access to healthcare and support services for vulnerable individuals and reduce health inequalities
- Liaise with healthcare and support services to deliver a coordinated response, ensuring that the needs of individuals are met
- Divert individuals, where appropriate, out of the youth and criminal justice systems into health, social care, education and training, or other supportive services
- Identify individuals with participation difficulties and recommend measures to facilitate their effective participation
- Deliver efficiencies within the youth and criminal justice systems
- Reduce re-offending and/or escalation of offending behaviours.

The investment includes increasing staffing at Police Custody suites, Crown and Magistrate courts, and the establishment of an Outreach team to improve

service user engagement, providing handovers to secondary mental health services and forging engagement with partner agencies, such as housing, substance misuse services.

We plan to develop a more rounded dementia support service.  We will bring together the In-reach Dementia team and the Unscheduled Care Older People's teams.

In the future we would like to expand the five-day dementia support service to a seven-day service with extended hours and increased medical input.

**Self-referral via Central Access Point**
As part of our response to Covid, we introduced a Central Access Point to provide a more co-ordinated response guiding people to the right service the first time for routine and for crisis support. This has begun to reduce handovers and hand-offs within the Trust and provided a place for individuals to directly refer themselves for mental health help, signposting and advice. The Central Access Point will also support the reduction of internal waits which are excessively high for some services in LLR. We plan to use some of the Mental Health Investment Standard to develop the Central Access Point in 2020/21 alongside bringing together existing crisis line (delivered by Turning Point) and older people mental health referral hub.

We will develop the Central Access Point further to guide people to a wider range of support in their community working with the voluntary sector to develop the breadth of support available. We will strengthen our partnership with Turning Point to improve the initial contact support through the Central Access Point based on the principle of self-referral and "no wrong door."

The Central Access Point will be further developed to improve access to mental health provision across a range of statutory and third sector organisations. We are working in partnership with Turning Point from the third sector to improve accessibility of resource and improve service delivery between organisations. The services will work together to best meet the needs of the service user, carer or professional through a collaborative delivery model that utilises the strengths of each organisation. Contacts with the service user will be less about medical/diagnostic model and more 'recovery' focused based on individual's perceived needs.

**Making our Urgent Care Hub permanent**
We were one of the first systems in the country to introduce a Mental Health Urgent Care Hub. The Hub provides a safe, professional and appropriate alternative to A&E for emergency services such as the police and East Midlands Ambulance Service to bring people in crisis. The Hub also provides expert advice to other health professionals. We run the Hub on a 24/7 basis and will make it a key permanent feature of our Urgent and Emergency Care pathway. We plan to use some of the Mental Health Investment Standard alongside reallocation of Leicestershire internal resources to sustain the Urgent Care Hub in Leicestershire in 2020/21.

We will develop our urgent care pathway, with full assessment taking place within 2 hours of arrival in the hub. The referral rate into secondary care from the Hub is lower than that from A&E, supporting flow and reducing demand on beds. Our specialist teams have the expertise and experience to manage risk and identify alternative community-based support. The Hub has been very

successful and feedback from service users, partners and staff has been overwhelmingly positive.

**Working with the emergency services**

We will expand our Police triage car support to work with East Midlands Ambulance Service as well. We will also expand the hours that the service is available. This will be achieved by releasing Triage team time through the redirection of advice, guidance and queries to the Central Access Point as part of joining up the different services.

The triage service links closely to the Intensive Support offer to vulnerable groups and the Urgent Care Hub. Together they drive a community-based expert resolution of crisis or emerging crisis situations as opposed to individuals going into criminal justice and/or A&E systems.

**Delivering Core 24 in ED**

We will develop our Specialist liaison mental health teams in emergency departments and general hospital wards to provide 24/7 support and to meet the Core 24 response standards. We will integrate our Liaison, Urgent Care Hub, All Age triage and Frail Older People services into a single integrated Acute Liaison team to deliver the Core 24 and Liaison Access standards in Leicestershire.

We intend to reduce the number of people in mental health crisis presenting at, or being taken to, A&E. The earlier steps in this pathway are intended to move our support to a non-A&E setting and to provide support in a planned way in the community. However, we know that a proportion of people will still present at A&E and we will use national funding to support the delivery of Core 24.

Confirmation of additional funding to support the alignment and expansion to key Mental Health liaison services to achieve the Acute Psychiatric Liaison access targets was confirmed in July 2019, through the NHS E/I Wave 2 bid process. The partnership bid between LPT, UHL and CCGs has been supported through the NHSE East Midlands Clinical Network with professional advice, support and sponsorship being received. The partnership received significant funding for the enhancement of the service to go live from April 2020.

With Covid-19, the management of change for the staff involved was paused for three months. This has now been completed. The enhanced Acute Liaison Service will be operational from 3 November 2020, in line with the SystmOne start date, with a formal launch planned for March 2021.

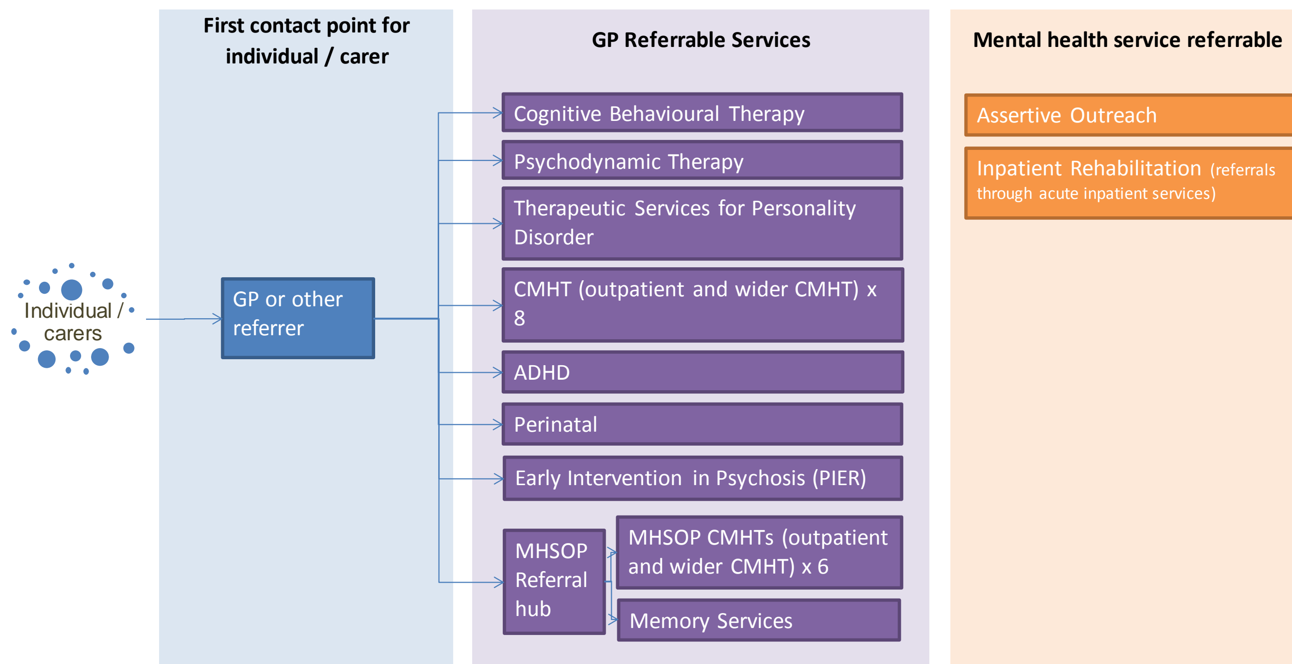
**Comprehensive suite of self-help guidance and tools**
Underpinning the new urgent and emergency care pathway will be a full suite of guidance and tools available to service users, their families and carers, and to other health professionals. There are a number of websites and other platforms that seek to support people with different aspects of their mental health. There is some duplication and there are gaps. There is a lack of broader information to support people to live well in their communities.

We will bring all of the relevant material together in one place focusing on expert guidance and tools relating to mild and serious mental illness, mental well-being and taking a broader view of the contributors to good mental health. This will be directly accessible to service users and also available for staff to signpost service users too. It will initially be constructed on the Leicestershire Partnership Website as proof of concept and then transferred to a 'standalone' platform in the future.

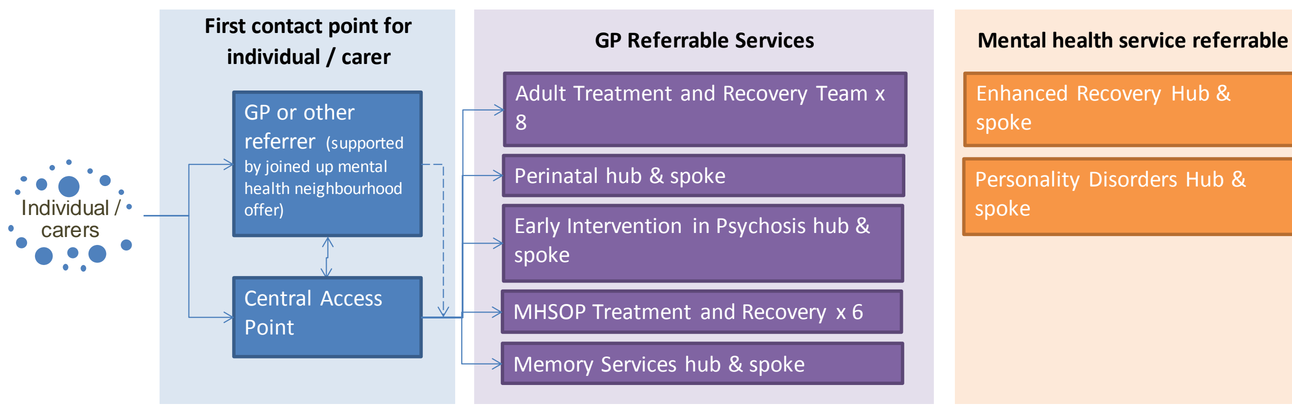
## Appendix two
## Proposals to develop stronger Integrated Community Mental Health Service

### The existing configuration for community teams and the proposed future model

### Diagram 1: Existing service configuration




### Diagram 2: Proposed future state integrated community service configuration




### Establishing Community Treatment and Recovery Teams in LLR

We will bring together our Assertive Outreach support, Community Mental Health Teams and Psychological services into a more integrated and aligned offer and establish eight Community Treatment and Recovery Teams linked to Primary Care Networks.

The focus will be on supporting people to live well in the community through the provision of joined up services where people need them. We will use team assessment, team caseloads and multi-disciplinary approaches in the new community provision, in line with the national framework.
We plan to free up expert time to deliver specialist support, reduce individual clinician caseloads and internal waiting times. We will remove internal thresholds, hand-offs and excessive waits. Current waits for some psychological therapies can be several years, whilst current community teams have little access to formulations or consultation.

We will focus on far stronger collaboration and genuine co-production with service users, families and carers to develop personalised case plans focusing on recovery. There will be an increased focus on co-produced active treatment packages to promote recovery, supported by better MDT working. We will develop our community-based rehabilitation offer and psychologically informed services while integrating NHS services with those from the VCS, social care, housing and employment. This approach will support a flexible, timely and service user focused offer with better outcomes. We will retain six Older People's teams.

Assertive Outreach services were established to provide targeted support for individuals with serious mental illness who periodically disengage from services and, often, wider society. They were established in mental health trusts as part of the National Service Framework over 10 years ago and were set up to provide intensive and assertive support to aid people to re-engage with services and help. Many services experienced patients staying in the AO services for long-term with little flow through services. Alternative approaches to managing the patient group have been trialled in different sites across the country. There have now been several peer-reviewed research articles demonstrating at least equivalent outcomes through managing individuals in general community mental health teams by creating approaches to rapidly step up and step down intensive and assertive approaches.

**Wider Therapy services**
Our separate CBT and Psychodynamic teams will come together in the Community Treatment and Recovery Teams. Our goal is to increase the psychologically informed ways of working across our community teams. We will take a more flexible approach to choice and delivery of therapy and increase the number of people in LLR accessing therapy support.
The Community Treatment and Recovery Teams will manage their caseload as a whole team, working was an Multi-Disciplinary Team (MDT) to formulation of need, care planning, review and treatment. The role of the psychological worker will include a greater focus on supporting staff deliver psychologically informed care in the Community teams, participating in the initial integrated assessment/formulation alongside specific therapy activity.

Much improved initial integrated assessment and formulation will identify with the service user the best pathway for patients and reduce the number of ineffective treatments by better understanding individual needs and circumstances. We also aim is to have less siloed services with a significant reduction in handovers and restarts for patients and associated internal waits. There will therefore be a much greater focus on individual care and having expertise focused on the service user.

**Hub and spoke model for targeted community services**

We will build on the success of our Perinatal hub and spoke model to develop similar arrangements for other community services including EIP, Enhanced Recovery, Personality Disorder support and Memory services.

We will place the majority of service delivery into community settings with a central expert resource to provide support, training and step up expertise and targeted interventions. The focus will be on recovery and supporting the majority of people in a community setting. There will be access to more intensive and specialist support for a smaller number of people (based on acuteness or targeted needs), with a step-down community recovery focus, as per the national framework.

**Current LLR Perinatal model – the first of our community hub and spoke models**

The LLR Specialist Community Perinatal services was expanded during 2018/19 to meet the needs of at least 5% of women giving birth in LLR to reflect SMI prevalence. This service provides a model for other services to develop a hub and spoke approach. The investment, expansion and remodelling of the service has enabled:

- A workforce that is multidisciplinary, enabling the delivery of a range of NICE recommended interventions.
- Capacity to deal with crises and emergencies and assess patients in a variety of settings.
- Strengthened collaborative working with maternity services.
- Links to the local maternity transformation plan to deliver the outcomes of better births.
- Improved links with designated mother and baby unit, reducing LOS, supporting discharge and reducing readmissions.
- The provision of timely pre-conception counselling to women who are well but at high risk of a postpartum condition and those with pre-existing mental health problems.
- Timely access to evidence based specialised assessment and treatment including psychological interventions in line with NICE guidance
- Increase engagement with BAME population.

We plan to invest further in our Perinatal service over the course of the next two years.

**Personality Disorder services**
Some of our longest internal waits are in the PD service. We plan to develop this service to provide more timely structured assessment in line with NICE guidance. We will then offer a three-tier service, with tiers one plus and two working as spokes with our Community Treatment and Recovery teams and tier three forming the hub to those spokes for more specialist support and intervention:

- Tier 1 plus – Understanding and managing emotions
- Tier 2 – Structured clinical management
- Tier 3 – Hub provision – interventions delivered to target and work with those service users who may present with the most significant risks to self (e.g. MBT and DBT)

The Pathway draws from guidance from NICE guidelines 77 and 78 (Antisocial and Borderline 2009), the Personality Disorder Consensus Document (2017) and Safer Care for Personality Disorder (2018).
The NICE guidelines for Borderline Personality Disorder highlight the importance of delivering psychological interventions within a compassionate, transparent, consistent, reliable and enabling environment delivered by clinicians with an appropriate level of competency, supervision and training which will include access as appropriate for specialist trainings such as Structured Clinical Management (SCM), Mentalisation Based Therapy (MBT) and Dialectical Behaviour Therapy (DBT).
The pathway will involve a specialist structured assessment as recommended by the NICE quality statements in (2015). This will then lead to a co-created care plan indicating outcomes which can include engagement with specialist treatments recommended by NICE (78, 2009) as set out below. The pathway will also recognise the importance of the relationship within the therapeutic work so there will be an emphasis on a reliable, trusting, therapeutic relationship between the service user and their pathway worker.
Guidance in relation to psychological therapies for Personality Disorder also emphasise the importance of enhancing the personal agency and autonomy of SUs through taking a recovery oriented and strengths focused approach in a supported and enabling environment. In line with the evidence for what works best SUs will be expected to come to clinics rather than receive home visits and they will have clear goal-focused care and treatment. The ethos of the pathway is to work with service users as capacitious adults (unless clinical assessment indicates otherwise) supporting them to make decisions about their care and to learn skills to help them cope, reduce risk and build resilience. However, this also means that the pathway delivers interventions that require a commitment and willingness to engage from SUs. If a SU indicates that this is something they do not yet feel ready to commit to then whenever possible this will be formulated with the SU and an appropriate care plan will be developed most often as part of a co-created therapeutic discharge from secondary mental health services as holding SUs in services without appropriate intervention can be harmful in its own right.

The pathway whilst providing scope for patient choice, in line with NICE recommendations, does take an overall stepped approach to clinical needs and stages of recovery. As part of this the pathway and it's offers at tier 2 and tier 3 levels will aim to impact on reducing hospital admissions, use of crisis team and use of tier 4 residential based interventions for personality disorder.
The pathway will be evaluated on a rolling basis in relation to demographic data, clinical outcomes, SU satisfaction, Staff satisfaction and in relation to new and emerging evidence nationally and locally. We also aim to have SU involvement as part of governance and co-design.
The pathway will include working with families and carers in assessment and discharge with the permission of the SU. As we develop more capacity within the care pathway we will develop carer and family support and psychoeducation groups. We will look to also work with community resources and forums to enhance the quality and connect our service delivery with PCNs going forward.
The existing therapeutic offer would convert into the Personality Disorder hub. We plan to invest in the hub and spoke model for Personality Disorders.

**The Enhanced Recovery Pathway**

The Enhanced Recovery Pathway (ERP) will aim to support the rehabilitation of people with complex psychosis and other severe and enduring mental health difficulties. The pathway will have both a hub and spoke function which will allow individuals to step up and step down as per their recovery journey. As per NICE guidelines for the rehabilitation for adults with complex psychosis the pathway will offer recovery interventions in the least restrictive environment and aim to help people progress from more intensive support to greater independence.

The ERP will be a recovery-orientated, formulation driven and needs led. Staff in the ERP will aim to foster people's autonomy, help them to take an active part in treatment decisions and support self-management. A recovery orientated approach is in line with the Community Treatment and Recovery Teams therefore offering a coherent approach to both patients accessing adult mental health services and staff working within our pathways and teams. We know that people with serious mental illness tend to have poorer physical health outcomes than the general population. People with serious mental illness experience some of the worst inequalities, with a life expectancy of up to 20 years less than the general population and evidence suggests that the mortality gap is widening. Inequalities in heath are largely due to inequalities in society and it is the unequal distribution of social determinants of health, such as poor housing, poverty, social isolation and unemployment, which drives inequalities in physical and mental health.

Health inequality will be addressed in the ERP as per the recommendations by NICE and Public Health England. This includes clinicians in the ERP working collaboratively with General Practitioners who take responsibility for an individual's physical health needs including health checks. The ERP will also focus on promoting healthy living including smoking cessation support, healthy eating advice, links to neighbourhood groups and activities to increase physical activities and decrease social isolation and offering people an annual health check. The ERP will work in partnership with social services and local housing providers to support people with serious mental illness to access and maintain safe and secure accommodation. The ERP will also work with employment specialists to support people to access stable, good quality and rewarding employment where appropriate.

The ERP will have a spoke function which will include providing consultation, training and time-limited joint working with staff in the planned treatment and recovery teams. The aim is to support those with serious and complex mental illness within their local teams, with their regular staff, to improve quality of life and prevent admission to hospital. We know that black and minority ethnic individuals are over-represented in inpatient settings; we will monitor figures in our services and develop approaches and interventions to reduce this inequality and support people in a community setting wherever possible.

The Enhanced Recovery Pathway will be staffed by experienced rehabilitation specialists from multiple disciplines. The pathway will include senior leaders from psychology, nursing, occupational therapy and medical specialities. We will seek to appoint staff with a range of skills and experience including lived experience (peer support workers), health care support workers, qualified nursing staff, social care and housing specialists. The cost of the pathway will be funded by internal re-investment.