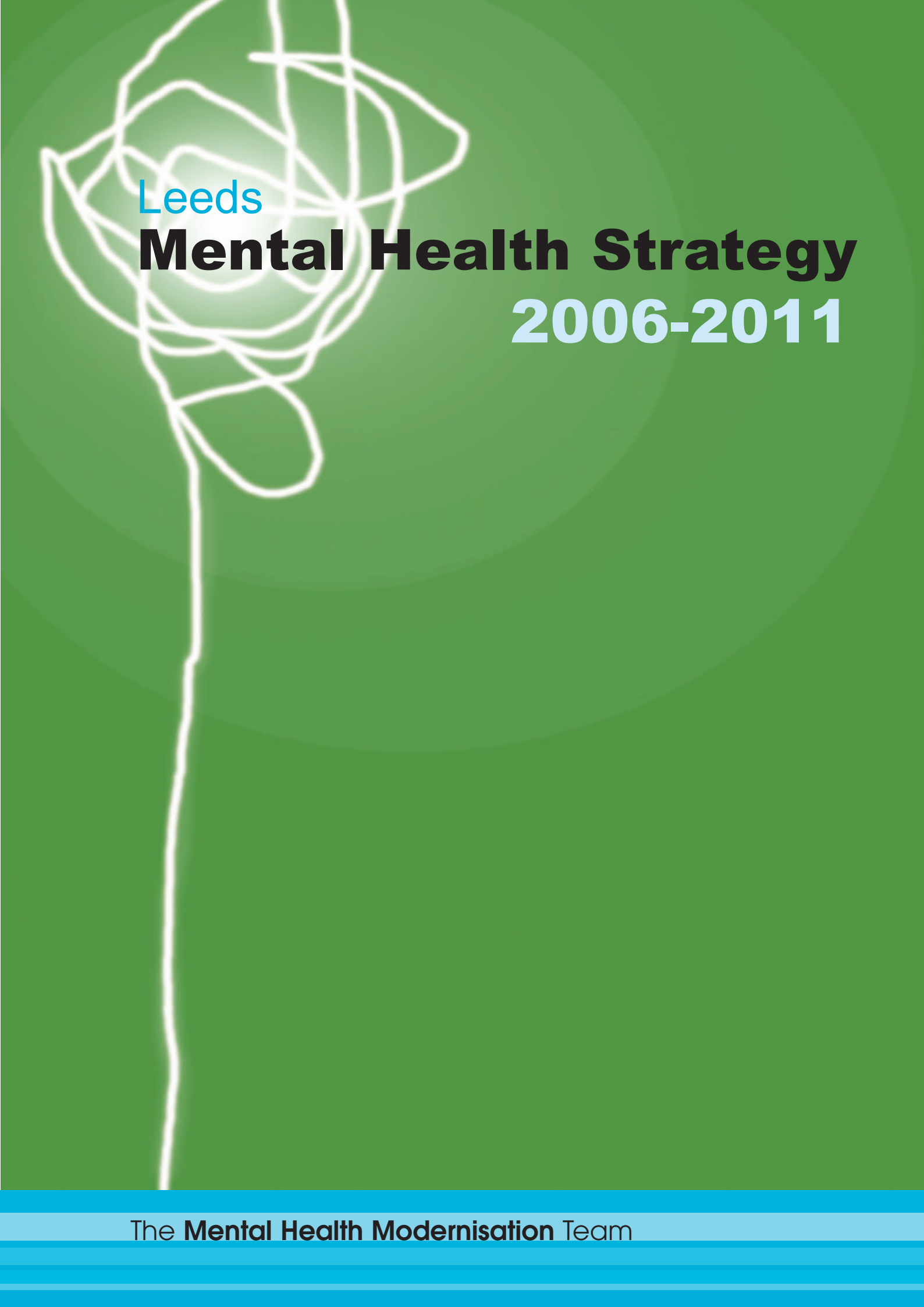

Leeds
Mental Health Strategy
2006-2011

The **Mental Health Modernisation** Team

Contents

Thankyou to the following organisations for providing photographs:

Artlink West Yorkshire
Leeds Irish Health and Homes
Skippko Arts Team
St Anne's Community Services
Touchstone
The Positive Images Collection - Older People

1. Introduction

1.1 The context:

Leeds health and social care community published its last mental health strategy in May 1999. It was a partnership document agreed between service users, their carers, commissioners and providers of services. The aim of that strategy was to "improve and protect the mental health of the people of Leeds, reduce inequalities in the mental health of the people of Leeds and ensure effective and efficient use of resources for mental health".

The strategy responded to national polices and expectations and used these to meet local needs. A key aspect of the strategy was the creation of a city wide mental health service model based on extensive consultation and discussion between partners in the city. The service model described under five tiers was an attempt to distinguish between settings for interventions and specialisation of services.

The old strategy and the service model have been used over the last five years to inform service change and investment. During this time the mental health partnership (Leeds Mental Health Modernisation Team) has conducted ongoing reviews which have influenced the development of strategies and plans, which in turn have supported the ongoing development of services in the city. The following are key reviews and strategies that have been undertaken:

- Local Implementation Plans;
- Comprehensive Service Review;
- Local Modernisation Review;
- Local Delivery Plans;
- Local Service Reviews and audits addressing particular service priorities.

1.2 A strategy for change

Over the last five years Leeds has witnessed several key changes in service planning and delivery. A city wide Modernisation Team for mental health has sustained the development of a partnership approach to service planning which has withstood major organisational change. Important baseline information has been established about the way services are provided and basic commissioning systems have been put in place. Guided by the old strategy, investment has moved more into the community and a mixed economy of care has been developed. Leeds has been successful in meeting and exceeding national targets and objectives, which have been validated by review bodies, such as the Commission for Health Improvement and the local Strategic Health Authority. A major reprovision programme has been successfully delivered by the local Mental Health Trust. The Modernisation Team has been able to secure a reasonable level of funding to implement changes that have been required as a result of the National Service Framework and NHS Plan. Many innovative services in the community have been established. Service users and carers have been supported to be more involved in the planning and evaluation of services. These can be seen as successful results of the previous strategy.

Self assessments and external reviews confirm that the majority of the obligations coming out of the National Service Framework and the previous strategy have been met. The health and social care environment is changing and is different to what it was five years ago. The demography of Leeds has seen changes and will continue to change. Expectations from service users and carers are different to what they were five years ago. All of these changes point to the need for a new and renewed strategy for mental health.

There are major challenges ahead across the health and social care sector. Recent Department of Health publications (such as *the Social Care Green Paper* and *Creating a Patient-Led NHS*, published in March 2005) define the role of health and social care agencies as facilitators of care in an environment where service users and carers are central to the way services are shaped and delivered. The emphasis is on supporting people in the community and giving them the control over care options. "The NHS has the capacity and the capability to move on from being an organisation which simply delivers services to people to being one which is totally 'patient'-led" (*Creating a Patient-Led NHS*). Another national driver is the Public Health White Paper *Choosing Health*, which highlights people with mental health problems as one of the target groups for support if their health and wellbeing are to improve. This is another national driver that will shape the interventions that this strategy will implement.

In order to meet these challenges the case for change within mental health planning and delivery of services becomes clearer. The level of change needs to be much more far reaching than what the partnership has achieved to date. A lot of work undertaken by the

partnership through reviews, needs assessments and audits gives information about what services users want from mental health and generic services. In the absence of an up-to-date strategy it has been difficult for the partnership to effectively respond to these needs.

A further consideration has been the needs of older people with mental health difficulties. Planning and delivery of services for older people has to date taken place in parallel to those for working age adults. It is the intent of this strategy to integrate wherever possible the planning and delivery of services for those of working age with those of older people with mental health needs.

This strategy therefore has been created to address needs and environmental changes that have been described above. It has been agreed by members of the mental health partnership (Leeds Mental Health Modernisation Team, see appendix 2) in consultation with others (see appendix 3) and aims to set a direction of travel for the next five years. It is set within the context of the challenges described above and provides a framework for action based on an agreed vision and guiding principles.

2. The overall vision

The Government's vision is for a patient-led NHS (*Delivering the NHS Improvement Plan*), where "the starting point is the principle that everyone in society has a positive contribution to make and they have a right to control their lives" (*Independence Wellbeing and Choice - Social Care Green Paper*).

The overall vision of this strategy is to improve the health and wellbeing of people with mental health problems and their carers in ways that are determined by them, and to promote mental wellbeing of the population as a whole.

The commitment to take this further in Leeds is embodied in the following statements:

- People experiencing mental health difficulties will be supported to maintain their lives in the community with dignity and independence, and improve their quality of life.
- People experiencing mental health difficulties will be viewed holistically with a coherent way into services. Care plans will be easy for service users and carers to understand and negotiate to change as appropriate.
- People experiencing mental health difficulties will be given improved information about possible solutions and the journey of care / recovery / transformation will be in their control.
- Services will be needs led, defined by emerging new strategies that are constantly checked by service users for relevance.
- Services will be provided in a seamless way, underpinned by single assessment, effective sign posting, clear triggers for appropriate interventions and clear pathways for specialist services.
- There will be greater understanding of mental health and wellbeing in the wider population. People will be able to seek help when they need it and be supported appropriately.

3. Guiding principles

Any strategy must be based on a set of values, principles and philosophy to underpin service planning and delivery and help shape the direction of services for the future. These should be part of the language and behaviour of staff and part of the expectations of service users and carers.

The following guiding principles are intended to act as a foundation for the future. They should become part of the way the partnership operates and how it should be judged for what it delivers.

- **Services adopt a positive and hopeful recovery perspective,** seeking outcomes that promote good health and wellbeing in individuals.
- **Services work within the social model of disability** in order to tackle disabling barriers, and challenge and root out age discrimination.
- **Prevention of mental health problems and promotion of mental health** should be a priority in delivering support and interventions.
- **Services are guided by transparency of purpose** for users and carers. Good information gives service users a clear expectation of different interventions and possible outcomes. Services are clear how they fit within the overall joint service system and work with clear social and vocational outcome measures.
- **Service planning and delivery will address the needs of all communities** in Leeds, in particular black and minority ethnic communities and women.
- **Services ensure that no harm is done** to users, carers or communities as a consequence of action and intervention, with no needless deaths, no needless distress, no ensuing disability, no unwanted delay and no waste of resources.
- **Services offer the lowest level of intervention possible** compatible with meeting needs. Service users are involved in assessing their own needs and choosing appropriate interventions. The aim is to sustain users within as normal a setting as possible and at an appropriate level in terms of prevention, primary care support, intermediate support and acute intervention within the whole service system.
- **Services assess risk with the person concerned,** in an open and sharing manner. This includes assessment of risk to self and others. Wherever possible the assessment of risk should be done jointly with the service user and should consider any concerns of carers.
- **Services acknowledge that mental health problems may be complex and multifaceted.** They require complex responses drawing on a range of perspectives, disciplines, knowledge and expertise, where there is mutual respect and tolerance of different contributions, and where different perspectives are integrated to offer holistic solutions and whole person outcomes.

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- **Success criteria are aligned** so that the success of services is based not only on organisational performance in isolation but against service user expectations and impact on other services.
- **Success criteria and outcome measures for individual care plans should be determined by the service user.**
- **Joint approaches to planning and delivery** should become the norm in providing support and services.
- **Service evaluation** should be integral to planning and delivery of services and should bring together commissioners, providers, service users and academics in partnership to achieve the best possible result.

4. Links to other strategies and workstreams

This strategy needs to be seen within the context of other key strategies in the city, notably the Strategic Services Plan (Making Leeds Better), Vision for Leeds 2, Leeds Housing Strategy, local implementation of strategies for older people, National Service Framework for Older People, Children and Adolescent Mental Health Services Strategy, Valuing People Strategy, Black and Minority Ethnic (communities) Mental Health Strategy, Women's Mental Health Strategy, Supporting People Strategy and the Drugs Treatment Plan.

Wherever appropriate the implementation of this strategy will contribute to the progress of other strategies and workstreams. It will also look to these workstreams to respond to the needs of people with mental health problems and contribute to the implementation of this strategy.

5. The future model of care and support

5.1 Changes needed

The changes envisioned by 2011 are radical and far reaching. The key features are:

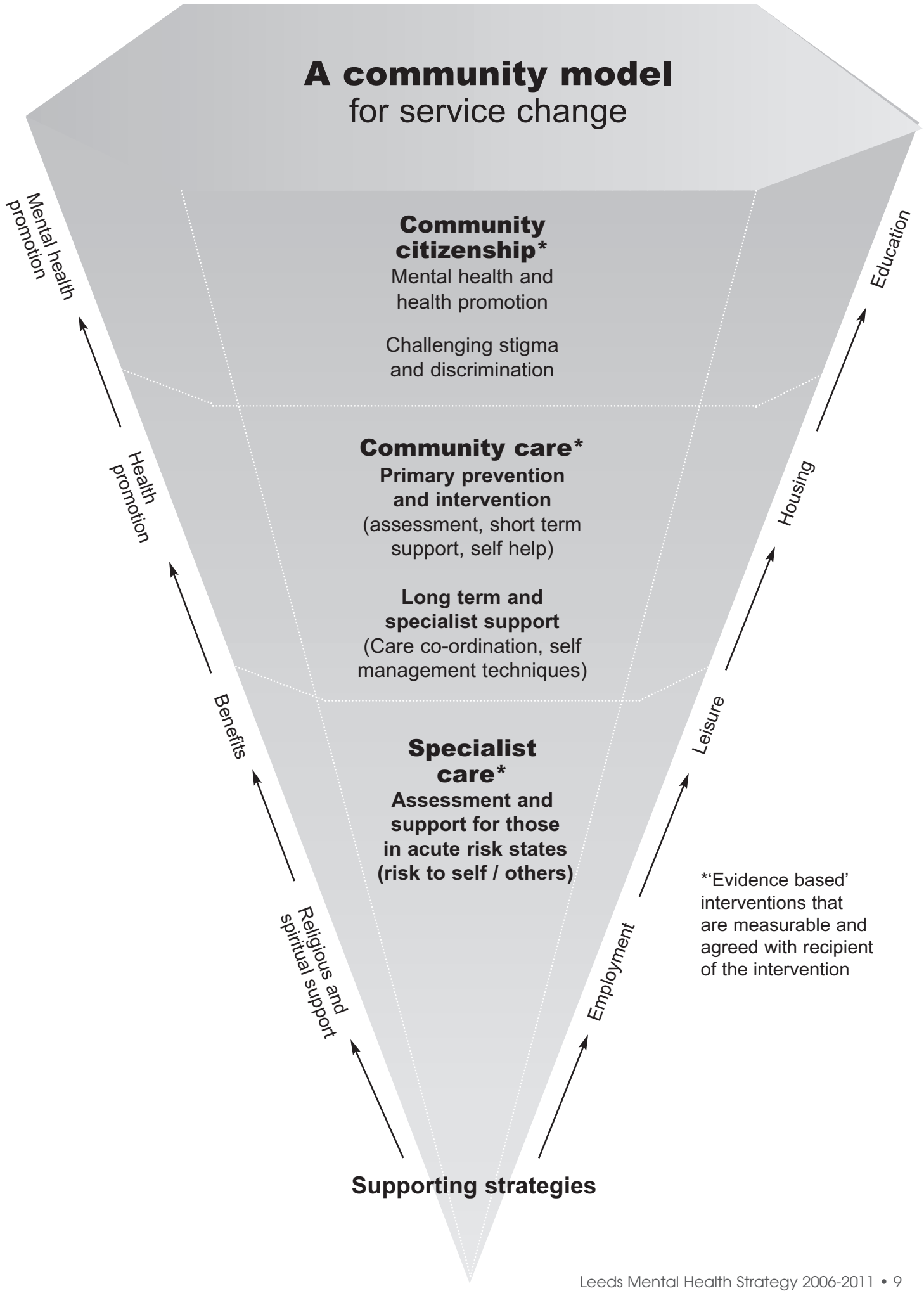
- needs led services, defined by emerging new strategy, constantly checking out relevance with service users;
- services that offer choice from a service menu;
- services based on a step care approach, with capacity to step in, out or move within the overall service system;
- services working collaboratively using a single assessment process with regular reviews, with one point of entry into specialist services, effective signposting and clear triggers for intervention with consistent responses by professionals.

Overall this is a new model of whole system care based on the guiding principles that will achieve the vision outlined in section 2.

5.2 A whole systems model

The previous strategy, which reflected national policy, was seen as a strategy for changing service delivery and it did that well. This strategy will address service user need in a radical way. The approach to support and interventions are more important than the configuration of services. Service users will be provided with the type of support they need, regardless of where they live, by agencies working together towards a common goal. The balance of activities / support / interventions will move from specialist and acute mental health care settings to primary and community care settings. Care will move much closer to people's living environments and they will be in control of how that care is provided.

Opposite is a representation of such a model which looks at a shift of emphasis from secondary / specialist / acute care interventions to primary and community care interventions. The model addresses the question, "What do people need at different times in their lives?" rather than asking what services are needed. This will come later, with services based on needs.


A community model
for service change
Community citizenship*
Mental health and health promotion
Challenging stigma and discrimination
Community care*
Primary prevention and intervention
(assessment, short term support, self help)
Long term and specialist support
(Care co-ordination, self management techniques)
Specialist care*
Assessment and support for those in acute risk states (risk to self / others)
Supporting strategies
Mental health promotion
Health promotion
Benefits
Religious and spiritual support
Employment
Leisure
Housing
Education
*'Evidence based' interventions that are measurable and agreed with recipient of the intervention

Community citizenship

This describes an environment which we all live in. General health and mental health promoting activities should be available to ensure that people are able to sustain their lives. People should be able to participate in community life and be supported to do this if and when they need it. Stigma of mental illness needs to be addressed so that people can be treated with dignity and equality and get support when they need it in order to prevent escalation of problems.

The following are examples of initiatives and activities that could be available to people to help them cope with their needs in the community:

- attention to people's general healthcare needs, facilitated by the development of Seriously Mentally Ill registers at GPs;
- mental health promotion initiatives, facilitated by the implementation of 'Choosing Health' and social inclusion activities;
- employment opportunities;
- advice and information, including information on legal rights such as the Disability Discrimination Act;
- education programmes, vocational and leisure activities;
- programmes that impart coping strategies and skills to people in the community, for example in schools or workplaces. This will help them manage difficulties that might arise in their lives;
- parenting and other life skills that might be needed by individuals at different stages of their lives;
- clear signposting to the above in general public spaces, as well as key primary and social care points of contact, for example, GPs' surgeries.

Community Care

Primary prevention and intervention – assessment and support

This describes a stage when people need more focused support to manage concerns they might have about the state of their mental wellbeing. They may still be participating in ordinary community life but need an assessment of their difficulties, then needing interim focused support to overcome them. Support should be tailored to people's needs in relation to employment, childcare and other life style issues. Self help materials and techniques need to be available in generic settings to support people to manage their own difficulties and concerns.

The following are initiatives and interventions that could be available to support people to maintain their mental wellbeing:

- support at a 'pre-assessment stage';
- preliminary mental wellbeing assessments in primary care and other settings, including the voluntary sector;
- transitory support provided by staff such as Graduate Workers in primary care and Support Time and Recovery Workers in the community;
- timely short term support by primary care mental health teams;
- self referral processes supported by clear signposting, along with access to self help and other forms of short term and long term support;
- initiatives that support individuals and families, such as Sure Start, Second Chance School and Early Years Service;
- Neighbourhood Networks, Dementia Cafés;
- support for people moving into residential care or supported living;
- support for people who have become frail, coping with illness and disability;
- psychological therapies.

People who might benefit from this are:

- people experiencing mild to moderate depression;
- people with transitory mental health problems;
- people in bereavement;
- people with relationship problems;
- people experiencing situational problems;
- people with emotional problems which they could resolve themselves with appropriate short term support;
- people experiencing memory loss.

Long term and specialist support

This describes a stage where people who have experienced serious and enduring mental health problems need support to manage their lives in the community and live as independently as possible. This might cover people who are recovering from an acute episode of mental illness or those who have long term problems and need to be supported in using self management techniques. People might also have complex and multiple issues to deal with and need co-ordinated support to live in the community. This stage also includes people who are experiencing their first episode of mental health problems, who need an assessment of their needs and support to overcome their problems. People will need help to navigate their way around services at this stage. One key focus would be the development of robust coping strategies that will help the individual remain in the community and avoid entering secondary care settings.

The following are initiatives and interventions that could be available to people to help them manage their longer term difficulties:

- structured day time activity which includes access to education, vocational training and support with maintaining or accessing employment or voluntary work;
- support with maintaining housing or accessing more appropriate housing;
- mental health needs and vocational / training needs assessments. Appropriate care / support packages primarily through the use of the Care Programme Approach (CPA);
- ongoing specialist support for those who have a care package from the local Community Mental Health Team;
- specialist support for people with complex and enduring mental health difficulties from Assertive Outreach Teams;
- long term specialist continuing support in residential facilities and in people's own homes for people with long term mental health difficulties;
- Expert Patient programmes for mental health;
- self help initiatives, self help materials, service user led initiatives;
- new approaches to community support offered by specialist staff with expertise in mental health and substance abuse, and mental health and the criminal justice system. Services are delivered in an integrated way within mainstream mental health as well as other sectors;
- support from long term conditions workers;
- specialist memory services;
- health promotion and exercise;
- psychological therapies.

People who might benefit from this are:

- people experiencing recurrent or resistant depression;
- people experiencing their first episode of psychotic type symptoms;
- people who have difficulties with managing long term symptoms of psychosis;
- young people and older people who have difficulty managing multiple problems, such as mental health and substance abuse;
- people with mental health problems who have also been involved with the criminal justice system;
- people whose problems interfere with their ability to live independently in the community and at times can become life threatening, for example people with eating disorders, people who self harm and people with dementia;
- older people with mental health and physical health needs.

Specialist mental health care

The term 'specialist mental health care' is used to describe the type of support / intervention a person might need when they are in an acute phase of a mental health difficulty. This could be at crisis point or could have developed over a period of time, having got to a state where high levels of intensive support are needed. The period of assessment and intervention at this stage is short with a view to supporting the person back to the community. Care pathways into and within specialist care need to be agreed and clearly explained to service users so that they can navigate their way easily around the system.

The following are interventions and support that could be available to people to help them through acute states of mental health disorders and points of mental health crisis in their lives:

- mental health assessments by specialist staff;
- short term intensive therapeutic interventions by specialist staff to support the individual through a period of crisis and set them up with appropriate 'after care';
- safe and secure in-patient environments for short periods of time. Individuals would receive appropriate medical interventions together with psychological support to stabilise their mental states before they return to the community;
- specialist in-patient facilities for those who need intensive specialist intervention in order to contain acute states of mental disorder;
- appropriate interventions in secure environments leading to immediate management and longer term rehabilitation;
- appropriate interventions and specialist in-patient care for those people with complex mental health and physical health problems, such as liaison psychiatry.

People who might benefit from this are:

- people in a state of mental health crisis where they are unable to cope in the community;
- people with recurring severe depression;
- people experiencing psychotic symptoms that have lead to complete breakdown in community / independent living;
- people experiencing psychotic symptoms that pose a danger to their, or others', lives;
- people who have severe mental health problems and have a history of involvement with the criminal justice system;
- people who need in-patient treatment;
- people with delirium.

Outcome

Each level should be based on clearly defined standardised outcome measures. However, any type of intervention that is used within a level should be tagged with outcome measures agreed by the individual receiving that input.

Interface

The stages / levels have clear lines dividing them; however, the management of interface at these stages will become crucial for smooth transitions. Issues of communication, signposting and joint care will need to be addressed and protocols clarified for smooth transitions to take place. The Social Care Green Paper uses the term 'navigator' of services. It suggests that agencies should provide a navigation function so that people who need support are able to access it at the right times in their lives. Further work needs to be done to implement this approach as a key way to ensure that people are well served at points of service interface.

Evidence based practice / interventions

There are three important sources of evidence that need to be referred to when deciding on interventions that work. The first is information provided by service users and carers to staff / agencies on what works. The second is academic research evidence. The third is national guidance, for example, that issued by the National Institute for Clinical Excellence (NICE).

Locally, the service user and carer evaluation group will provide a consensus on what works and what doesn't, that staff and agencies can learn from. Service users need to be central to the way interventions are constructed on a regular basis, informing implementation.

The University Reference Group that advises the Mental Health Modernisation Team is well placed to provide a commentary and evidence on best practice and service outcomes. This resource needs to be used better.

The co-ordination of NICE guidance and the consideration for local implementation is underway. This will provide a reference point for agencies as they seek to improve their practice.

Sustaining strategies

All of these need to be addressed to provide a holistic service for individuals irrespective of where they live or what their mental health difficulty might be. As Leeds begins to implement the national Social Exclusion report, the day services review and the Leeds Strategy to Reduce Social Isolation and Loneliness of Older People, work with non-mental health sectors and agencies will increase and connections across agencies will be made. Mental health agencies should ensure that they fully consider access to housing, employment, legal services, benefits and other services in all assessments that they make. Information about these services should be made more accessible to all. See appendix 1 for recommendations from the Leeds Social Inclusion Report.

6. The configuration of services needed to implement this model

Configuration of some local services reflects historical investment which was based around hospital care. More recently however, there has been an increase in the provision of services in the community as a response to delivering the National Service Framework for Mental Health. This trend needs to increase as services are provided closer to where people live. This model takes a holistic view of local people's needs and looks at what needs to change in service configuration in order to address these. As the diagram in 5.2 shows, there is a shift away from specialist care and in-patient care to community and primary interventions and citizenship.

When looking at the whole population the configuration of services needs to move away from a tiered approach to an approach that is needs based with the provision of the right combination of interventions / support / care available at the right time and place.

There are risks in taking this holistic approach. People could get lost in the system, not know where to go, or receive different approaches that might contradict each other. For agencies, services might duplicate effort, staff might be working with fragmented information or staff could be challenged to work across organisational boundaries / cultures.

The following building blocks need to be in place for this approach to work:

- pathways to care and support need to be clear;
- a navigation function needs to be in place to ensure people access the right support;
- clear, accessible information needs to be available to the public, staff, service users and carers;
- specialist mental health services need to be clear about their remit and role in the whole system;
- closer joint work needs to be in place between specialist mental health services, primary and community care services and generic services;
- closer joint work needs to take place between working age adult and older people's mental health services.

In Leeds some of these building blocks are in place but more work needs to be done.

7. The workforce

A well supported and trained workforce will be needed to deliver the vision embodied in this strategy. Within the work of the Mental Health Modernisation Team workforce planning, training and development have taken place across all sectors. The Human Resource sub-group of the Modernisation Team has worked across provider organisations to promote joint training and development and has co-ordinated the implementation of new work groups. These include Support Time and Recovery Workers, Graduate Primary Care Workers, gateway workers and Community Development Workers.

National guidance on new ways of working and these new work groups will help facilitate the delivery of this strategy. However, a robust and integrated workforce plan is a prerequisite for successful service delivery. Such a plan should include the voluntary sector, Social Services and the local Mental Health Trust.

The recruitment and retention of service users into posts within mental health and other service settings should be a vital part of a workforce strategy.

7.1 Role redesign and new work groups

National initiatives regarding the review of current roles have taken place within the context of new models of service. These have emerged as a result of the implementation of the National Service Framework for Mental Health. The Royal College of Psychiatry, for example, has reviewed the role of psychiatry in the new mental health service system. The Chief Nursing Officer has reviewed the role of mental health nursing. These national initiatives need to be used appropriately to meet local needs.

The following will inform local role redesign:

- a greater requirement for multidisciplinary team working requiring increasing role flexibility across traditional health and social care boundaries;
- the transfer and sharing of skills and roles from what has traditionally been termed secondary to primary care.

The following are some new roles which need to be maximised in order to build capacity in service systems:

- Support, Time and Recovery Workers who will provide practical day-to-day support for service users, helping them move from dependency to independence;
- Community Development Workers who will facilitate an inclusive approach in dealing with health inequalities faced by ethnic minority communities;
- Graduate Primary Care Mental Health Workers who will provide support to people who access primary care and make links between specialist services and primary mental health;

- gateway workers who could fulfil the navigation function, supporting people through various services.

7.2 Workforce planning

Workforce planning should be carried out across services and agencies. It should look at baseline capacity and plan for short, medium and long term developments and environmental change. The aim will also be to have a representative workforce which reflects the community and those who use services. Information collection systems and information technology need to be developed to make planning possible.

7.3 Training and development

The preferred approach to practitioner interventions is the recovery approach, along with a social model approach to disability to tackle disabling barriers. The move to an emphasis on a recovery model rather than a treatment model has radical implications for the education and training of mental health practitioners. Changing ways of working will require a training infrastructure with an emphasis on understanding recovery principles, equality and social inclusion, recognising self determination and service user involvement.

The following will therefore be present:

- minimising acute care;
- moving users back into the mainstream as soon as possible;
- reducing stigma associated with mental illness;
- defining the future skills set for staff;
- greater risk tolerance and acceptance;
- promoting transferable skills within the whole system of care;
- staff understanding the whole system of services and behaving as part of a whole system of care rather than being organisationally driven;
- helping service users navigate their way through services.

Training / education and development should also be available for staff working in non-mental health settings so that they can address people's needs effectively.

8. Implications for investment in the future

Currently approximately 36% of funding goes into community services and 64% into in-patient services (*Department of Health Financial Mapping exercise October 2004, results for Leeds*). A financial forecasting exercise needs to take place which measures the kind of shift in investment that will be needed in order to implement the model proposed in this strategy. There will be implications in future financial investment as the balance of funding moves more into community services. It is important that in any re-profiling of investment, services that are prioritised by service users do not encounter any instability.

9. Partnership arrangements to deliver the strategy

9.1 Partnerships

Implementation of this strategy will need to be managed by a partnership of key stakeholders who are able to bring strategic direction and delegated powers from their individual agencies / groups. A review of current structures, processes and levels of delegated authority needs to take place to ensure that partnership arrangements are fit for this purpose. Links with the Older People's Modernisation Team and its mental health workstream need to be made and future joint work needs to be seen in the light of this strategy.

The partnership that will implement this strategy will need to be clear about its level of authority and delegated powers. Mechanisms need to be in place to ensure that individuals representing their agency / group on the partnership have a level of authority and feedback systems that will enable the delivery of the action plan outlined in this strategy.

9.2 Principles of partnerships

The following principles of partnerships and corresponding behaviours have been developed by the Local Government Training Organisation:

Leadership: partnerships where partners share a common vision and harness their energies to achieve more than they could on their own. They hold a common vision of the difference they want to make and the direction of travel they want to take. They focus on how they can achieve more or better results through collaboration. They facilitate partnership working by increasing support within their own agency / group. Partners' individual objectives are aligned in a common direction.

Trust: partnerships where partners are mutually accountable, share responsibilities, risk and reward fairly and behave in ways which support successful outcomes. Partners understand and respect differences amongst each other. There is transparency in discussions and decision-making processes.

Learning: partnerships where partners continually seek to improve what they do in partnership. Partners seek to learn from each other and from elsewhere. There are regular reviews of the partnership and how it is working so that it can be improved.

Managing for performance: partnerships where partners put in place necessary practices and resources and manage change effectively. The partnership structure fits its purpose. Partners' roles, responsibilities and contributions are clearly defined and accepted. Objectives and action plans are set jointly and owned by all.

10. A framework for implementation

This strategy sets out a direction of travel for mental health services for the next five years. Five key pieces of work need to be undertaken at the outset to determine the level of change that will take place and how it can be managed:

- care pathways for mental health;
- service reconfiguration analysis based on the community model for service change;
- workforce strategy;
- financial profiling exercise;
- commissioning plan.

10.1 Care pathways for mental health

It is important that mental health care pathways are looked at using a whole systems approach including secondary, primary and community care services / settings. To make the work manageable it is recommended that key anchor services / settings are looked at first, for example, a person's journey through primary care settings or a person's journey through a phase of acute mental distress. Some work has already begun under the Making Leeds Better programme to redesign self harm and dementia care pathways. Depression care pathways are being looked at in primary care.

Once current pathways are understood they need to be compared with proposals in the model, then new pathways need to drawn up. A key question to be asked is whether changing pathways will improve access and the journey for service users. The following will be measures of success in redesigning mental health pathways / journeys:

- clarity of pathways to service users and their carers as well as those who have minimum contact with mental health systems;
- reduction in waiting times for key services that currently have long waiting times;
- single assessment processes operating consistently across specialist services;
- consistency of access to services / resources for service users;
- staff knowing what the pathway is and being able to navigate service users appropriately.

10.2 Service reconfiguration analysis

Once pathways are understood current configuration of services will need to be analysed to see where there might be duplication and where major gaps in service / support might exist. Current sources of information, such as the mental health service maps and secondary care services activity data, can be used to analyse current patterns of provision and where changes need to be made. Future service configuration will be based on the new model of service and the care pathways that need to exist in the future.

10.3 Workforce strategy

A workforce plan will be needed to respond to the picture the care pathway work and service configuration work will form about the kind of services needed in the future. This will determine the number of workers and the skill mix that will be needed to implement the new model of service. A workforce plan will describe the current workforce profile and a new workforce profile that will match service needs in the future. The gap analysis evident in such a plan will need to be addressed by increasing resources and/or re-skilling staff by providing appropriate training programmes. A workforce strategy should include a training and development programme based on the needs of service users and what they believe works for them.

10.4 Financial profiling

An audit of current spending needs to be made using the finance map, current contracts and activity numbers. This needs to be matched against the results of the service reconfiguration work and the workforce profile.

10.5 Commissioning plan

All the above will shape a commissioning plan for the future which addresses local as well as city wide issues. The commissioning plan will determine how services and settings are provided and managed and individual service user needs are met.

11. Conclusion

This is a strategy for change and heralds a direction of travel which looks at how the needs of individuals can be met, whether they are currently in the mental health system or outside it. The success of the implementation of the strategy depends on how the current system of service delivery can change and whether that change will make significant improvement to the lives of people who need support at different stages in their lives. The next step will be to set up workstreams to begin implementing the strategy and addressing the challenges that the strategy brings.

Part of the duties of the partnership that implements this strategy will be to ensure that reporting mechanisms are clear and that the delivery of the strategy, through the proposed workstreams, are monitored on a regular basis.

Appendix I

Mental Health and Social Exclusion / Inclusion

Leeds State of Readiness Report

Executive Summary

1. Introduction

In 2003 the Prime Minister and the Deputy Prime Minister asked the Social Exclusion Unit to look at what more could be done to reduce social exclusion that is experienced by people who have mental health problems. This was part of the Government's commitment to address the causes of social exclusion and regenerate local communities and economies.

The unit embarked on a project which focused on working age adults and asked two main questions:

- **What more could be done to enable adults with mental health problems to enter and retain work?**
- **How can adults with mental health problems secure the same opportunities for social participation and access to services as the general population?**

After many visits around the country, several consultation exercises and extensive research, the unit produced a report that outlines the current issues and makes recommendations for further work. It also challenges national and local agencies to take forward a series of actions that is believed to contribute to the goal of reducing social exclusion for people with mental health problems.

2. Local response

2.1 Report to PCT Chief Executives and Director of Social Services

The Leeds Mental Health Modernisation Team received the Social Exclusion and Mental Health report in June 2004 and considered its implications. One of the challenges of implementing the report locally is that it needs the support and actions of various sectors and agencies in the city. Nationally, work is being carried forward across Government departments. Locally, for the work to be successful, it needs to be undertaken across sectors, agencies and departments.

At an early stage the team decided that the report needed to be presented to PCT Chief Executives and the Director of Social Services. This was done in November 2004. PCT Chief Executives and the Director of Social Services (at the Modernisation Executive meeting) commissioned the Mental Health Modernisation Team to conduct a readiness assessment for Leeds and make recommendations.

2.2 Work of the local Social Exclusion Group (SEG)

The SEG was set up in January 2005 with a membership that went beyond mainstream mental health agencies. This group decided that a consultative workshop needed to take place to gather together a wider perspective on what was a complex selection of issues. This workshop took place in March 2005. It was well attended and service user voices and views were given a high profile.

The views gathered were worked on further by workshop theme leaders who put together the descriptive chapters contained in the main report. In line with the national report, the Leeds State of Readiness report addresses these five key areas:

- stigma and social exclusion;
- role of employment in mental health and social exclusion;
- role of health and social care in mental health and social exclusion;
- supporting families and community participation;
- getting the basics right in mental health and social exclusion.

The report is a description and analysis of services, partnerships and approaches in Leeds that already contribute to some of the recommendations contained in the national report. It recommends ways of addressing gaps that have been identified through the work that has been done by the SEG so far.

3. Meeting local targets and priorities

3.1

In Leeds the implementation of the report's recommendations will meet many of the requirements emerging out of recent NHS and social care strategies as well as strands of 'Vision for Leeds 2'. The NHS Public Health White Paper *'Choosing Health'* has explicit targets around mental health which the recommendations will meet. The Social Care Green Paper '*Independence Wellbeing and Choice*' sets out the approach to service delivery and social care outcomes for people in the community which some of the recommendations will meet.

3.2

The Health and Wellbeing Strategy under 'Vision for Leeds 2' has five priority areas. The recommendations in the main report address aspects in each of these:

Make sure that social, economic and environmental conditions promote a healthy and positive society.

One of the actions in this area is to provide "benefit advice and training in health and social care". Sections 3.3 and 4.3.2 in this report cover this in full and suggest further action to be taken to improve services. Another action is to improve housing and implement the Supporting People Housing Strategy. Section 7 covers this and recommends further action. Actions around transport are also covered in section 7.

Protect people's health, support people to stay healthy and promote equal chances of good health.

Actions around mental health promotion in this priority area are covered under sections 3 and 4 with further recommendations that will increase social inclusion.

Provide high quality sustainable and accessible services for those who need them...

One of the key actions is about improving information giving by partner agencies. This is covered in sections 4 and 5.

Establish effective partnership working to improve health.

Providing a framework for District Partnerships is a key action. One way of taking forward the recommendations in this report would be through District Partnerships.

4. A framework for action

The main report contains many recommendations reflecting the scale of the social exclusion / inclusion agenda and the complexity that needs to be understood before effective implementation can take place. Therefore, the suggestion is that the agenda is managed in a stepped fashion, beginning with a framework as outlined below.

4.1 The aim of a Leeds framework

The aim of a Leeds framework is 'to create ways in which adults with mental health problems can secure the same opportunities for social participation and access to services as the general population'. This framework will need to be jointly worked up into an action plan that can be implemented across the city and across agencies.

4.2 Objectives of the framework

Each of the recommendations contained in the report relate to one of five framework objectives, as follows:

4.2.1 Strategic interventions to meet stated aims.

These are actions that need to be taken at a strategic level to ensure that key recommendations are implemented effectively.

4.2.2 Combat stigma and discrimination and raise awareness of mental health and social inclusion issues.

4.2.3 Support users of services and others in need, to navigate through an array of mental health and non-mental health services.

4.2.4 Develop new partnerships outside of mental health service settings to ensure that all services are responsive to the needs of people with mental health problems.

4.2.5 Build up organisational and staff capacity to deliver the agenda of mental health and social inclusion.

5. Conclusion

The main report outlines the readiness status of Leeds in implementing the national Mental Health and Social Exclusion report. It also goes beyond some of the report's recommendations. This is entirely justified as it is based on evidence of need and service user recommendations for the delivery of better services. Some good practices and services are already being provided in Leeds and this is evident in the report. However, the recommendations suggest that Leeds still has a long way to go to achieve social inclusion for people with mental health problems.

6. Next steps

The report is being presented to the Modernisation Executive, as they commissioned it. The Mental Health Modernisation Team believes that the report needs to be shared with the Local Strategic Partnership (LSP). It is recommended that the report is presented to relevant sub-groups of the LSP for consideration.

Implementation of any agreed recommendations needs commitment and delivery from different partners; for this to happen the LSP needs to consider it and be willing to promote it. The action plan, which is still to be drawn up, needs to be shaped by agencies outside of mental health services, as is clear from the report. This could be done once the Modernisation Executive and the LSP agree the framework for action proposed in this paper and acknowledge the work that needs to be done within the context of wider priorities being taken forward in the city.

Once the Modernisation Executive, Narrowing the Gap Executive and Healthy Leeds Partnership have seen the report, an action plan can be jointly drawn up with collective ownership across agencies. The Social Exclusion Group, under guidance from the Modernisation Executive and reporting to the Mental Health Modernisation Team, is in a position to co-ordinate the implementation of an action plan when it is drawn up.

The Mental Health and Social Exclusion / Inclusion Group
on behalf of the Leeds Mental Health Modernisation Team

July 2005

Appendix 2

Mental Health Modernisation Team Membership List 2005

Name	Representing
Carol Cochrane (Chair)	Leeds North West Primary Care Trust
Mike Evans	Leeds Social Services
Tony Pugh	Leeds Social Services
Ian Cameron	Public Health
Clive Adams	University Reference Group
Tabitha Arulampalam	City Wide Mental Health Team (Leeds PCTs)
Ann Richards	City Wide Mental Health Team (Leeds PCTs)
Alison Lowe	BME Advisory Group
Ingrid Whitton	Leeds Mental Health Trust
John Clare	Leeds Mental Health Trust
David Newby	Leeds Mental Health Trust
Jane Williams/Pip Goff	Voluntary Sector
Karen Newsome/Sharon Allen	Voluntary Sector
Jenny Savage/Terry Simpson	Leeds Involvement Project
Ron Sweeney	User and Carer Reference Group
Veronica Dore	User and Carer Reference Group
Derek Hutchinson	User and Carer Reference Group
Lesley Shilling	User and Carer Reference Group
Debbie Forward	Supporting People
Mark Gallacher	Mental Health Lead - Leeds West PCT
Nick Wood	Mental Health Lead - Leeds North West PCT
Ruth Bell	Mental Health Lead - Leeds East PCT
Lisa Hollingworth	Mental Health Lead - Leeds South PCT
Simon Cluderay	Mental Health Lead - Leeds North East PCT
Jane Wood	Mental Health PEC North East
Stuart McVeigh	Leeds North West Primary Care Trust

Appendix 3

Leeds Mental Health Strategy final draft for consultation - wider distribution list

Name	Organisation
Mick Ward	Older People's Modernisation Team
Susan Rautenberg	East Leeds PCT
Kathy Kudelnitzky	Leeds Initiative
Marcus Beacham	Safer Leeds, Leeds City Council
Lesley Smith (Chief Executive)	Leeds North West PCT
Thea Stein (Chief Executive)	Leeds North East PCT
George McIntyre (Chief Executive)	Leeds South PCT
Chris Reid (Chief Executive)	Leeds West PCT
Liam Hughes (Chief Executive)	East Leeds PCT
Christine Burnett	Leeds Initiative
Chris Butler (Chief Executive)	Leeds Mental Health Trust
Rosemary Archer	Social Services, Leeds City Council
Drew Scott	Leeds Voice Health Forum
Ernie Gray	Housing Strategy Unit, Leeds City Council
Neil Evans	Housing Strategy Unit, Leeds City Council
Trevor Kelly	Safer Leeds, Leeds City Council

City Wide Mental Health Team (2005)

Tabitha Arulampalam

Richard Wall

Ann Richards

Alison Evans

Rachel McCluskey

Suzanne Tate

Nicky Mosso Zolezzi



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NHS

volition
The voice of Leeds mental health voluntary sector

Leeds CITY COUNCIL

Service User and Carer Reference Group

Leeds Primary Care Trusts
Leeds Mental Health Teaching NHS Trust