Care Services Strategic Plan

2023 - 2033

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Contents

Summary of sections

This page outlines the sections of this document and page numbers for navigation

Executive Summary

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*Please note this information is accurate at the publication date.

Care Services Strategic Plan - 2023 - 2033   P5

We must make changes to our care services so they are fit for the future and sustainable

Our 'burning platform' for change

To develop this Strategic Plan, we have looked at how we provide care, what is working well and where we could make it even better through speaking with our staff, and importantly, the people who use our services. Through this work we have identified important drivers for change to our care services. These are summarised below.

More people will need mental health care and support in future

We know that the populations we serve are changing. In future, there will be more older people and fewer working age people living in Leeds. This means we can expect higher demand for our older people's mental health services, such as care and support for dementia.

We expect that more people, across all ages, will experience mental health and wellbeing challenges over the next 5+ years due to the impact of the Covid-19 pandemic. This will mean more people requiring our support.

We also must consider potential unknown demand for our services and unmet need. For example, we may not know about the mental health needs of more vulnerable people and communities who may experience poorer access to healthcare than others.

Our services are already under pressure and not all of our care service models are future proof

We proudly provide great care to people who use our services.

However we know that our staff are under pressure to provide more care to more people, some of whom have complex care needs. We also know that there are some areas in our services that should improve to better support staff to provide great care, and to improve outcomes for people who use our services.

As more people will need mental health care and support in future, we must change our services so that we can respond to higher demand and continue to provide great care. The changes we make should be 'future proof' so that our services are sustainable over the long term.

Our care services must change to deliver on national and local strategies

It is important that our Strategic Plan for care services aligns with other mental health strategies so that our services deliver on national and local priorities.

The NHS Long Term Plan is a key national strategy that our plan must align to. The Long Term Plan includes many commitments for mental health, including more mental health care being offered in the community and less care provided in hospital settings. Our future care services should be developed in line with this.

Our local 'place' (Leeds) and Integrated Care Systems (West Yorkshire and Harrogate and Humber Coast and Vale) also have defined priorities for mental health and we have a role to play in achieving these as a key provider of mental health across these footprints.

These are the key reasons why we must change our care services to be able to continue providing great care to people who need it. This Care Services Strategic Plan sets out our ambition for the future and the changes we will make in response to these drivers for transformation.

Further detail on the context and case for change can be found in section 2.

Our new Care Services Strategic Plan sets out our ambition for care services over the next 5 - 10 years

Our priorities and objectives

We have a clear ambition for what we want to deliver in the future, who will deliver care services, where care services will be delivered and how care services will be delivered in the future. These all link to our overarching Trust's vision to provide outstanding mental health and learning disability services as an employer of choice.

People are at the heart of everything we do both those who we partner with to deliver care, and our teams. We will harness opportunities to understand our other health and care partners and population and work more collaboratively together. By doing this, we will deliver high quality care to all of our people. Our ambitions align with our objectives to tackle health inequalities with a specific focus on access, experience and physical health.

To bring our ambition to life, we have refreshed our priorities and focus for the next 5-10 years and have set ourselves objectives to deliver on.

Our new priorities for our care services:

1.
We co-create and co-deliver care services with people who have lived experience

2.
We collaborate with our partners to understand our populations and provide proactive integrated care

3.
We provide high quality, equitable and sustainable care services

Objectives for each priority

1.1. Our care services are led together with people who have experience of using our services, working in partnership

1.2. We contribute to our local economy through wider skills development and employment opportunities for people who use our services

1.3. We lead continuous co-production of care services with our communities and citizens

2.1. We understand who our partners are (both across the ICS and place) and create the right environments to work with them

2.2. We stay informed about our populations and their holistic care needs and proactively support people

2.3. We co-design and co-deliver proactive integrated care and support with our partners

3.1. Our care services have the appropriate conditions where high quality care can flourish

3.2. Our care services deliver equitable access, experience and outcomes

3.3. Our care services are clinically, financially and environmentally sustainable, supported by digital technology and estates

3.4. We have a sustainable, healthy and engaged workforce whose wellbeing is supported

We recognise that it is important to read this Care Services Strategic Plan alongside other strategic plans within the Trust, such as our *People Plan*, our *Quality Strategic Plan*, our *Strategic Estates Plan* and our *Digital Plan*.

Further details on these plans and how they link to the Care Services Strategic Plan can be found in section 4, the implementation plan. Further detail on the priorities, objectives, accompanying activities and outcomes can be found in section 3, our overall care services strategy.

We will take key steps to deliver on our priorities and objectives over the next five years

Our key activities

To deliver on our priorities we know that there are key activities we will need to undertake, and many of these will be sequential. The diagram below highlights the activities we will complete to deliver on each objective linked to our priorities.

	Year 1	Year 2	Year 3	Year 4	Year 5
1. We co-create and co-deliver care services with people who have lived experience	Employ people with experience of using our services (obj. 1.1)		Care services led by people who have experience using our services (obj. 1.1)		
	Training and skills for people who use our services (obj. 1.2)	Work experience offered to people with lived experience (obj. 1.2)	Employ people with experience of using our services in operational roles (obj. 1.2)		
	Design approach to co-production (obj. 1.3)	Embed co-production approach (obj. 1.3)	Develop and embed approach to evaluate and continuously improve approach (obj. 1.3)		
2. We collaborate with our partners to understand our populations and provide proactive integrated care	Provide ways for staff to connect with partner organisations (obj. 2.1)	Establish and strengthen relationships with our partners (obj. 2.1)			
	Agree and embed a population health management approach (obj. 2.2)	Identify unmet need in our population (obj. 2.2)			
	Work with our partners to address unmet need in our populations (obj. 2.3)	Establish new ways of working with partners (obj. 2.3)	Use shared community assets creatively with our partners to improve accessibility of our services (obj. 2.3)		
3. We provide high quality, equitable and sustainable care services	Embed research and development into service design and delivery (obj. 3.1)	Embed collective leadership and a culture of continuous improvement (obj. 3.1)			
	Develop a robust approach to measuring and monitoring equity in access, experience and outcomes (obj. 3.2)		Embed equity considerations and requirements into our approach to care service co-design (obj. 3.2)		
	Build capacity, capability and flexibility into our care services workforce (obj. 3.3)	Co-design care services that are environmentally sustainable (obj. 3.3)	Invest in proactive care and community-based support (obj. 3.3)		
	Develop a comprehensive training and skills offering to all staff (obj. 3.4)	Enhance resources to support staff wellbeing (obj. 3.4)			

Context and Case for Change

We are a provider of specialist mental health and learning disabilities services

Services we provide

We are the main provider of mental health and learning disabilities services in Leeds and a provider of specialist services for broader regional and national populations. We deliver a total of 39 services across nine service lines:

We provide services to	**781,000** people

We have	**2,929** care services staff

We currently operate accross	**66** sites

Service Line	Direct Budget £000s	Population Served
Acute	24,911	Leeds
Older People's	17,499	Leeds
Perinatal and Liaison	10,195	North and National
Regional Eating Disorders , Complex Rehabnilitation and Gender Identity	16,917	North East, Yorkshire, Leeds & National
Forensics	10,072	Leeds & York
Children and Young People	8,456	West Yorkshire, York, National
Learning Disabilities	6,615	Leeds
Community and Wellbeing	15,928	Leeds
Regional and Specialist	9,700	Leeds, Regional and National

A full list of our current services within each service line can be found in the Appendices A-I.

Our wider partnership context

We operate within a broader health and care system and we proudly work with partners to join up care pathways to improve outcomes for people who use our services. We provide many of our services in collaboration with our partners in our place and Integrated Care Systems (ICSs), as well as regionally and nationally:

- We are part of **two Integrated Care Systems**: West Yorkshire and Harrogate Health and Care Partnership, and Humber Coast and Vale Health and Care Partnership.

- We are part of **Provider Collaboratives** for some of our more specialist services as:

  - Lead Provider for Tier 4 Children and Young People's Mental Health Services (CYPMHS) in West Yorkshire and Lead Provider for Adult Eating Disorders in the North East and Yorkshire region.

  - Lead Provider for the Veterans' Mental Health Complex Treatment Service (VMH CTS) and the Veterans' Mental Health High Intensity Service in the North of England.

  - Lead Provider for the West Yorkshire CREST (Community Rehabilitation Enhanced Support Team) service.

  - Part of the West Yorkshire Adult Secure Provider Collaborative.

- We are part of the **West Yorkshire Assessment and Treatment Units (ATU) collaborative commissioning model**, led by Bradford District Care Foundation Trust.

Our partnership working is driven through established programme and delivery boards, such as the Place-based Partnership Mental Health Delivery Board and the West Yorkshire Specialised Programme Board.

In Leeds, where we provide most of our services, there are inequalities in access to care and health outcomes

Summary of current demographics and needs

Leeds has a total population of around **800,000** people. The population is ethnically diverse, with almost a third being Black, Asian or from a minority ethnic population (BAME) in 2020, an increase from **19%** recorded in the 2011 Census.

There are inequalities in health and social outcomes for people in the city. For example, there is a **11 and 12 year difference in life expectancy** between those living in the most and least affluent areas, for males and females respectively. Nationally, there are inequalities in access to healthcare: there is evidence, for example, that BAME people experience barriers to accessing care and also have poorer mental health. People from BAME ethnic backgrounds are more likely to be detained under the Mental Health Act than people of white backgrounds.

10% of people in Leeds under the age of 25 are likely to have a mental health problem or need support with their emotional wellbeing

The 2021 Leeds Joint Strategic Assessment (JSA) outlines that the children and young people population in Leeds is increasingly diverse with increasing deprivation levels. In 2021 the proportion of children in Leeds living in **poverty** was **24%**, above the UK average of **19%**.

Mental health conditions are more common in children who live in poverty, are new to the country, are excluded from school, are in the justice or care systems, have experienced trauma, or have special education needs.

Adults aged 18 and over reporting a clinically significant level of psychological distress increased from 21% in 2019 to 30% in 2020

The 2021 Leeds JSA identifies that the **pandemic** has had a significant impact on the mental health of the Leeds adult population and has exacerbated inequalities in mental health.

For example, Black, Asian and ethnic minority adults were more likely to report higher levels of depression and anxiety, with Bangladeshi and Pakistani men reporting the largest declines in mental health. **Suicide rates** between 2018 - 2020 were **higher in deprived areas** of the city.

People with mental health problems are more likely to be out of employment

The number of people in employment in Leeds is estimated at around **413,000**.

The pre-Covid unemployment rate in Leeds was lower than the national average.

In Leeds, the number of older people who work has increased in the last 20 years. Half of all unpaid carers (around **40,000**) in the city are over 50 years old. This is in keeping with the demographic shift in the city to a population with more older people.

Over 20% of older people (65+) are identified as having a common mental health illness (CMHI) in Leeds

The over 50 population has grown by an estimated almost **30,000** between 2001 and 2019, a **12% to 17%** increase in each of the 50 plus age groups.

16,323 older people in the city are estimated to have depression, of whom **85%** are expected not to be receiving treatment.

The proportion of (indices of multiple deprivation) people living with frailty within the most deprived decile according to IMD is almost three times higher (**22%**) than those who live in the least deprived decile (**8%**).

Health inequalities and poor mental health outcomes are also a challenge across our wider footprints

Challenges in West Yorkshire

The *West Yorkshire MHLDA Strategy* highlights mental health outcome and access issues that are a particular challenge across the system:

- Suicide rates in West Yorkshire are above the national average.

- The number of children and young people with neurodiversity being admitted to specialist mental health inpatient care has increased.

- There is an increasing number of children and young people with behavioural issues being excluded from school and requiring mental health services support.

- Employment levels for people with a mental health condition or a learning disability is lower than the national average.

- There are more adults with a learning disability receiving long term support from local authorities relative to other places in the country, however health-check uptake in this cohort is lower than elsewhere in England.

- The prevalence of problem gambling in West Yorkshire is higher than the national average of **0.9%**, with places such as Leeds having rates as high as **1.3%**.

National mental health outcome trends

Even before the pandemic, poor mental health outcomes and inequalities were recognised in the publication of the *Five Year Forward View, and NHS Long Term Plan*. For example, people with severe mental health problems and people with a learning disability often have poorer physical health and die younger than those who don't.

Mental health problems are more common in transgender people and around half of rough sleepers are thought to have mental health needs.

The pandemic has exacerbated mental health issues across England. National lockdowns and shielding have had an impact on the health and wellbeing of the population. The proportion of adults reporting a clinically significant level of psychological distress increased from **21%** in 2019 to **30%** in April 2020, coinciding with the periods of national lockdown. Data from the Office for National Statistics (ONS) in May 2021 found that depression rates in the UK have doubled since before the pandemic. Loneliness has increased in older people as a result of the pandemic and for young people, the disruption to education and social interaction is a concern for future mental health. We are yet to understand the long-term impact of the pandemic on our health and care services.

Our three areas of focus for tackling health inequalities include:

- **Access**
- **Experience**
- **Physical health**

NHS

West Yorkshire and Harrogate Health and Care Partnership
Mental Health, Learning Disability and Autism Strategy
2019/2024

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

NHS

FIVE YEAR FORWARD VIEW

October 2014

There are challenges in our care services that we must address to improve outcomes for our service users

Strengths and challenges of current service provision

Over two months, we looked at how we provide care, what is working well and where we could make it even better through speaking with our staff, and importantly, the people who use our services.

Through this assessment we have identified strengths in our care services. For example, we scored 'good' overall in the 2019 CQC inspection, with services being described as 'effective', 'caring', 'responsive' and 'well-led' and outstanding practice identified in some of our services. In addition, we lead in several innovative care services, such as our community eating disorders service, our expanded perinatal inpatient unit and our veterans mental health service. We have well established partnerships in many of our care services, such as our work with the third sector in Leeds OASIS. In some of our services, new and creative staff roles are being created to address skills gaps.

There are however multiple challenges in our care services that we must overcome. Some of these challenges are specific to service areas whereas others are relevant to all of our care services. These are outlined below:

Service user involvement	While service user involvement is well established in some of our care service areas, in others we must improve our approach to meaningfully working with people with lived experience. At present, co-production with service users and carers, and involvement of service users in care delivery, is not embedded in our care services.
Demand for services and long waiting times	Demand has increased, and continues to increase for some of our services, which has led to long waiting times. For example, there are **3157** people on our Gender Identity Service waiting list (Feb 2022 data) and for our Leeds Autism Diagnostic Service (LADS) service, only **54.3%** of assessments were started within **13 weeks** compared with our **95%** target (Dec 2021 data).
Acuity and complexity of care needs	Our clinical teams are finding that more and more people who use our services require support with multiple, complex and increasingly acute needs. Our services haven't been adapted to respond to this increasing acuity and complexity. In some cases this means that people are cared for in environments that aren't therapeutically optimal for them or others.
Care settings and clinical adjacencies	Many of our clinical settings are not therapeutically supportive or conducive to a person's recovery. Some of our inpatient areas lack access to outdoor space, are on first or second storeys, and some of our service adjacencies (e.g. at the Newsam Centre where Forensics is co-located with our eating disorders and gender identity services) are not clinically appropriate.
Physical health needs of our service users	We have a Healthy Living Service to support our service users with their physical health needs, however our clinical staff report that there are gaps in physical health care support. In our most recent quarterly data capture, **67.1%** of cardiometabolic assessments were completed for inpatients and only **39.9%** in our Early Intervention in Psychosis (EIP) Service, compared with our **90%** targets.
Staffing pressures and clinical capacity to meet demand	Many of our care services face staffing pressures. This has been particularly apparent during the pandemic where we have experienced several periods of business continuity due to staffing shortages, however recruitment and retention of clinical talent is a longer term challenge for us and a challenge to ongoing provision of safe and high quality care services.

The Covid-19 pandemic has presented challenges to our services and many of our services have adapted

Impact on service delivery

Many of our services have had to change how they work to limit the spread of the virus and be flexible to changes in staffing levels during the pandemic. A key change was moving many of our outpatient services from seeing people in person to holding most appointments remotely over video or phone call.

These changes have worked well for some people and less well for others. For some services, such as our Learning Disabilities services, remote appointments have been more challenging as it is often better for staff and service users to communicate face to face.

We also know that there are some people who don't have the technology to be able to access appointments remotely and that this can lead to unequal access to care and support for different people using services that provide care remotely over video call. This challenge of achieving 'digital inclusion', where everyone is able to use digital devices to access care, is important to us and to our partners in the city.

As a result of many services being paused to manage the immediate response to the pandemic, we have a backlog of planned care like the NHS is experiencing across the country. This significant national challenge will be a priority in our local systems and for our care services over the next **12-24 months**.

Accelerating innovation

Although the pandemic has presented these challenges, we have continued to deliver high quality care and have even accelerated innovation in some of our services through the changes we've made.

For example, our CONNECT service for Adult Eating Disorders received an NHS Parliamentary Award (The Excellence in Mental Health Care Award) for going above and beyond to put service users first and for innovative care delivery.

Most of our outpatient services successfully transitioned to be able to complete appointments virtually and remote access to appointments has been sustained in some of our services. Some service users have provided feedback that they prefer remote appointments. For example, from a service user survey completed by the LADS team, it has been identified that if given a choice over how to access appointments, approximately **40%** of service users would prefer remote consultations.

While we see opportunities to continue offering virtual appointments for our services, we recognise that not everyone is able to access these and in some cases it will be safer for people to be seen in person.
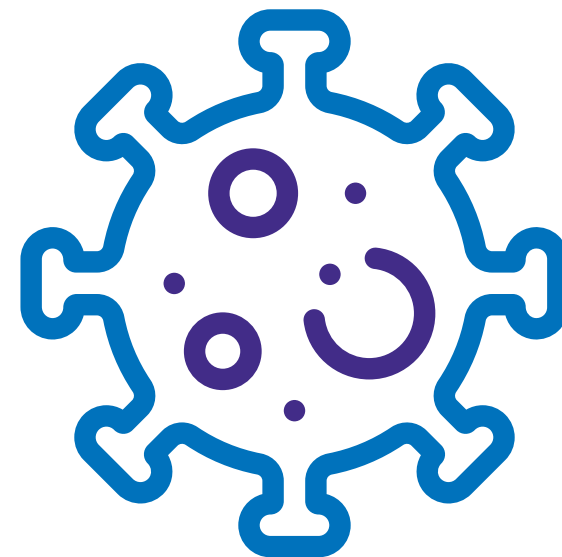
Learnings to take forwards

Some of the changes we have made to our services during the pandemic will be sustained over the long term. During the pandemic, our services had to adapt and we will aim to carry forward learnings around service agility and flexibility to support our services to be resilient and adaptable over the longer term.

We will use our lessons learnt from the pandemic to strategically transform into a resilient service that is able to withstand any future events. Now is the ideal time to begin this transformation.

We must also consider local and national strategic drivers for change to our care services

National and local mental health policies

As well as looking at how we provide care, we have reflected on what relevant national and local policies mean for the future our care services. Some of these are outlined below.

Policy	Overview	What this means for the future of our care services
NHS Long Term Plan (LTP)	A ten year plan for delivering sustainable health and care against the backdrop of opportunities for transformation and national challenges, such as the ageing population.	• The commitment to increase mental health care in the community for us means expanding our community and wellbeing services. • The LTP commitment to reduce the number of people with autism and/or a learning disability being admitted into inpatient mental health services means that we must expand our support to people in their own homes and in community settings to provide preventative and proactive support to avoid their care needs escalating.
The national strategy for autistic children, young people and adults: 2021 to 2026	A five year vision for improving the lives of people with autism, built around six themes from access to education and employment through to health inequalities and quality mental health care.	• The strategy aims to reduce waiting times and improve diagnostic pathways to improve access to timely diagnosis - the future of our LADS service should consider this. • The vision for improved community mental health and crisis support for people with autism means we should think about how our community services are accessible for people with autism. • Inpatient care for people who have autism must be provided with consideration of an individual's needs - for our future care services this means having inpatient settings with appropriate environments and care services staff with appropriate skills to support people with autism.
Reforming the Mental Health Act white paper	There has been a public consultation on the White Paper plans to reform the Mental Health Act. This will impact the law on when someone can be detained and receive treatment without consent.	• We should to account for the potential changes to the Act, with the key guiding principles of the reform being: - Choice and autonomy, respecting the service user's choices - Least restriction, powers are used in the least restrictive way - Therapeutic benefit, supporting the service user to get better so that they no longer fall within the Act - The person as an individual, treating everyone as different individuals • Examples of proposals include a requirement for care and treatment plans to be developed in partnership with service users in a timely manner for the first time.

Policy	Overview	What this means for the future of our care services
West Yorkshire and Harrogate Health and Care Partnership Mental Health and Learning Disabilities Strategy	A five year strategy for the ICS outlining the ambition to improve the mental health of the population.	• Our future services must align to and help to deliver the West Yorkshire and Harrogate MHLDA strategy. • Key areas in the strategy that our care services will be important to deliver on include: reducing requirements for out of area care, development of new ways of providing specialist mental health services, supporting more people to be able to live at home through more community support, and improving physical health for people with mental health problems.
Humber Coast and Vale Health and Care Partnership Long Term Plan 2019 - 2024	A five year strategy setting out the ambition for the ICS, following its establishment in 2016.	• Our future services must align to and help to deliver the Humber Coast and Vale Health and Care Partnership Long Term Plan and ambition for everyone living in the area to 'start well, live well and age well'. • Key priorities in the plan that are important for us to deliver on include: helping people to look after themselves and stay well, providing services that are joined up across all aspects of health and care, improving the care provided in key areas and making the most of all our resources.
Leeds Mental Health Strategy 2020-2025	The Leeds Mental Health Strategy 2020-2025 sets out eight priorities to improve mental health for people in the city.	• For the care and support we provide to people living in Leeds, our future services must align to and help to deliver on the eight priorities in the Leeds Mental Health Strategy. • For example, we must work with partners in our place to prevent poor mental health in our communities and improve access to employment and skills development for people with mental health problems. • In addition, our care services should 'recognise the impact that trauma or psychological and social adversity has on mental health' and include support to people with a serious mental illness to have better physical health.

Future in Mind: Leeds 2021 - 2026	A five year strategy for improving mental and emotional health and wellbeing for young people up to age 25 in Leeds.	• Our future care service should consider the key priority outcomes in the Future in Mind strategy, in particular those relating to:
		  - Transition between services
		  - Support being provided as close to home as possible
		  - Recognition of the impact of trauma on young people's mental health.

As we look to the future, we should consider the changing profile of the population we serve

In Leeds we can expect a growing elderly population, with fewer working age adults in the next 10 years

As shown in Figure 01 below, while the Leeds population is forecast to grow by c. 5.4% in total between 2020 and 2036, some age bands have significantly higher growth rates.

For example, the 90+, 80-89 and 70-79 age groups will see the greatest cumulative growth up to 2036, with a greater proportion of the population of an older age. These populations are typically more frequent users of health and care services, and their care needs can be more complex than other population cohorts, so we can anticipate a rise in demand for our older people's services.

This trend is consistent with national and global population demographic changes

While the data presented below is only for our local population in Leeds, we know that the demographic shift to an ageing population with fewer working age adults is a national and global trend.

We must plan our future care services to be resilient and sustainable so we can respond effectively to this projected increase in demand.

Figure 01
Forecast % growth
of Leeds Population,
by age band, per year

Legend:
- 0 - 9
- 10 - 19
- 20 - 29
- 30 - 39
- 40 - 49
- 50 - 59
- 60 - 69
- 70 - 79
- 80 - 89
- 90+
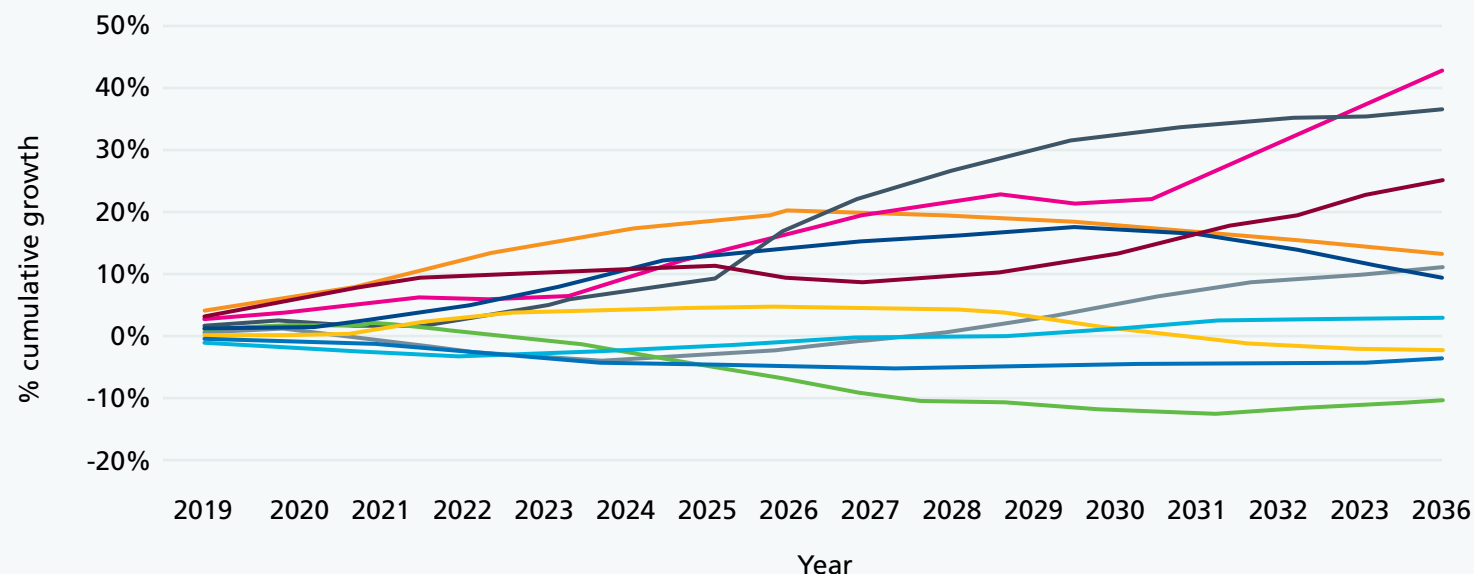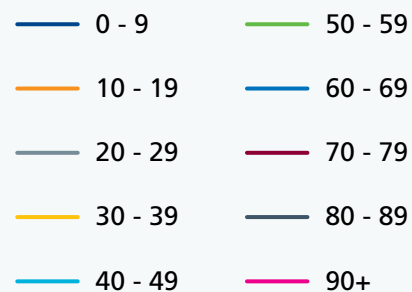
Without changing our care services, demand for inpatient care is projected to increase beyond our capacity

We have completed modelling to understand how demand for our care services is expected to change in future

The modelling outlined below ('do nothing' modelling) shows how demand for our inpatient services, measured through the number of beds required, is projected to grow over the next fifteen years if we make no changes to our current services.

The modelling has identified a need for more than 100 additional beds by 2036 if we make no changes to our care services. This would be a significant increase in our bed base that would likely require us to expand our estate. Doing this would not be in line with the national 'left shift' agenda around more care being provided in the community, nor would it support our ambitions around environmental sustainability. We must therefore 'do something' to change our services so that we are able to provide care that supports people to remain at home and provide services that are sustainable and future proof.

Details on the modelling approach, methodology and assumptions are included in the accompanying paper entitled *'Demand and Capacity Modelling Methodology and Outputs'*.

'Do nothing' bed requirement forecast

Service Line	Current bed base	'Do nothing' 2036 bed forecast
Adult acute services	132	197 - 204
Children and young people's services	34 (incl. 6 PICU)	26 -28
ED, R&R, and GI services	67	81 - 84
Forensic services	69	80 - 85
Learning disability services	9	8 - 9
Liaison and perinatal services	16	23
Older people's services	80	103
Total	**407**	**518 - 536**

We have a 'burning platform' for change and we must take this opportunity to set out our 10 year ambition

Changing demographics and forecasted demand

We know that there will be a higher demand for our mental health services in the future, due to our changing population and the impact of Covid-19, which has exacerbated mental health problems as well as had an impact on prevalence of mental health issues.

Based on the way we currently provide care services, demand for our inpatient services are projected to increase significantly over the next 10 - 15 years - this requirement would be difficult for us to achieve and would not be in line with national and local strategies to move more care out of hospital settings and closer to people's homes.

We therefore must look to deliver mental health care services differently and more efficiently to meet the projected increased demand for our services.

We also know that our Leeds population is becoming increasingly diverse, and that minority population groups often experience health inequalities in relation to access, experience and outcomes. While there are many factors that determine a person's health, we have a role to play in addressing health inequalities. This means we must provide services that are equitable, and accessible to anyone who needs mental health or learning disabilities care and support. Where we do not have direct influence on wider determinants of health and wellbeing, we must work with our partners on these complex whole system issues.

Challenges to our current service delivery

While we can't change everything, we can focus on changing those things within our gift. As part of this we should consider how best to use existing estates and investment in new estates, aligned to the developing estates strategy. We should also consider how to improve staff satisfaction and wellbeing to both retain and attract staff to the Trust. We should also continue to aim for high quality and innovation, increasing the scope of psychological and creative therapies that we provide and driving digitally-enabled care.

We should address how services will incorporate agile working and flexibility in their delivery to be able to adapt to unexpected external factors. We must take learnings from the pandemic to improve the resilience of our care services and our ability to respond to increased demand that we expect due to the impact of Covid-19 on mental health and wellbeing.

National and local policy drivers for change

Our future care services must be aligned to the national strategic direction for mental health and learning disabilities services to move more care into the community. They should also align with the plans of our place and system partners and promote delivery of integrated care.

Our plan should consider a renewed focus shifting the balance of activity and capability, targeting spend on prevention initiatives and a focus on physical and mental health.

Our future care services should account for the potential changes to the Mental Health Act, particularly around there being patient-centric care which focuses on the autonomy of the individual where they have the capacity to consent or refuse medical treatment.

10 YEARS

The following section sets out our overarching care services strategy, detailing our ambition for the future and the key changes to achieve this.

Care Services Strategic Plan - 2023 - 2033   **P19**

Overall Care Services Strategy

We are a provider of specialist mental health and learning disabilities services

Our ambition statements for care services

We have worked with care services staff, service users and carers to develop ambition statements for care services. These bring to life where we want to be in 10-15 years. Our ambition statements for care services aligns to our Trust's vision to provide outstanding mental health and learning disability services as an employer of choice. They also align with our health inequalities ambitions to provide better access, experience and physical healthcare.

Our priorities for care services

Identifying priorities for our care services supports us to make decisions about our care services, particularly when we are deciding how to use limited resources. Our care service priorities form the core part of our strategic plan, are relevant for all of our care services and reflected in our service line aspirations for the future.

Our previous care service priorities

In our most recent care services Strategic Plan we focused on the following three priorities:

- Supporting people in their recovery;
- Supporting people to achieve their agreed goals and outcomes; and
- Supporting staff to promote and coordinate helpful and purposeful practice.

Over the past three years we have put our previous Care Services Strategic Plan into practice and have achieved many of the things we set out to do.
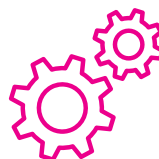
Throughout our work to develop this refreshed Strategic Plan, we identified **three priorities** that were consistently recognised as important by staff, service users and carers. These are outlined on the right.

Our refreshed priorities for care services are:

Priority 1:

We co-create and co-deliver care services with people who have lived experience

Priority 2:

We collaborate with our partners to understand our populations and provide proactive integrated care

Priority 3:

We provide high quality, equitable and sustainable care services

We will:

- Consider people who use our services and their carers holistically, valuing their skills, strengths and attributes as well as understanding their needs;
- Provide inclusive and accessible services for both people who use our services and their carers;
- Reduce inequalities for people with mental health conditions, addictions and neurodiversity, including ADHD, learning disabilities and/or autism;
- Provide care services that are resilient and sustainable;
- Empower people who use our services and carers to live fulfilling lives;
- Innovate and be creative to develop and deliver services that achieve the desired outcomes for people who use our services and carers;
- Take a preventative and proactive approach to care to promote emotional and mental wellbeing;
- Achieve the 3Cs of effective Communication, good Coordination, delivered with Compassion, by working closely with our partners; and
- Involve service users and carers in everything that we do, listening and valuing their views.

We have identified objectives for each of our three new priorities for care services

Our new priorities for our care services:

1.
We co-create and co-deliver care services with people who have lived experience

2.
We collaborate with our partners to understand our populations and provide proactive integrated care
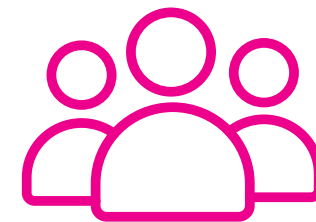
3.
We provide high quality, equitable and sustainable care services

Objectives for each priority

1.1. Our care services are led together with people who have experience of using our services, working in partnership

1.2. We contribute to our local economy through wider skills development and employment opportunities for people who use our services

1.3. We lead continuous co-production of care services with our communities and citizens

2.1. We understand who our partners are (both across the ICS and place) and create the right environments to work with them

2.2. We stay informed about our populations and their holistic care needs and proactively support people

2.3. We co-design and co-deliver proactive integrated care and support with our partners

3.1. Our care services have the appropriate conditions where high quality care can flourish

3.2. Our care services deliver equitable access, experience and outcomes

3.3. Our care services are clinically, financially and environmentally sustainable, supported by digital and estates

3.4. We have a sustainable, healthy and engaged workforce whose wellbeing is supported

The following pages describe these objectives in further detail and bring to life the impact achieving these will have on people in the future.

1. We co-create and co-deliver care services with people who have lived experience (1 of 2)

Why is this a priority?

People who have experience of using our services have valuable perspectives on the care and support that we provide. We want to consider these perspectives in all key decisions we make about the way we provide care to help us make changes that will have the most impact for people.

Therefore our strategic plan will focus on how we can develop meaningful service user and carer led services. This is based around three objectives:

Our objectives

1.1. Our care services are led together with people who have experience of using our services, working in partnership

Some of our care services already have people with lived experience working to provide support in peer support roles and this is working well. We will build on this and aim to work in true partnership with people who have experience of using our services to lead our care services collaboratively.

We will achieve this by employing people with lived experience in peer support roles to provide care and support together with our care services staff. We will also establish a leadership and governance structure with experts embedded who have lived experience.

1.2. We contribute to our local economy through wider skills development and employment opportunities for people who use our services

We will create opportunities for people with experience of using our services:

- We will offer work experience at the Trust, whether in a specific role or in multiple areas for breadth of experience;

- We will offer time limited or task-oriented roles for people who would like to work on a flexible basis e.g. supporting with interview panels;

- We will provide substantive employment opportunities.

By doing this we will truly involve people, giving people a platform to encourage others with lived experience to have confidence in sharing their views. Through this we will also contribute to our local economy as an anchor institution, and support social mobility through action on the wider determinants of health.

1.3. We lead continuous co-production of care services with our communities and citizens

All of our services will be co-produced with service users and carers. This means that we will have an embedded team of operational staff, clinical staff, service users and carers to have joint discussions from the outset when re-designing services. This will not be be a 'nice to have' - co-production will be a requirement going forwards.

Our service users and carers will be listened to and their views valued equally to those of our Trust staff. We will work with people to develop and refine our co-production approach that considers inclusivity and accessibility. We will also embed service users into our governance processes to develop sustainable solutions to achieve meaningful co-production.

1. We co-create and co-deliver care services with people who have lived experience (2 of 2)
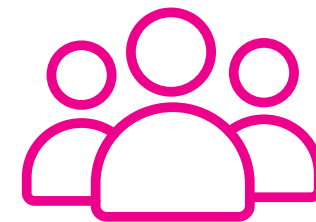
What will this mean for people in future?

Achieving our objectives for this priority will have an impact on people who use our services and on our staff. To bring to life what these objectives will mean for people, we have developed fictional 'personas' that describe what people's experiences could be like in future.

On this page we have also included quotes from people we worked with to develop this Care Services Strategic Plan about their ambition for this priority.

My name is Angela and I have just taken part in a six week work experience programme, working within the learning disabilities service involvement team. I also have lived experience and have previously used the Trust's services. The team supported me at first with my digital skills so that I could join Zoom meetings and I used this to lead service user involvement sessions and learning disabilities co-design sessions with clinical and operational staff. Through this I was able to contribute and give my opinion about the future estates for this service, challenging others to think about how to really deliver accessible services.

"We should aspire to be known for co-design and co-production with our local communities and partners. We should be known for being a fair employer and our integrity to deliver gold standard care to our service users."
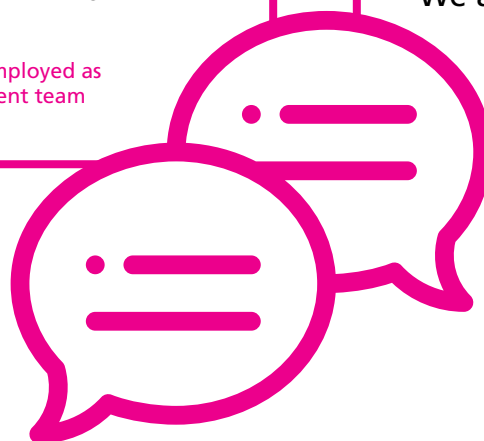
Quote from Trust care services survey

"I am so proud of myself doing this on my own. I love this job."

Quote from an interview with a Trust service user employed as a coordinator and support worker in the involvement team

We aspire to "effectively co-designing and co-producing services with staff, service users and carers."

Quote from Trust care services survey

2. We collaborate with our partners to understand our populations and provide proactive integrated care (1 of 2)
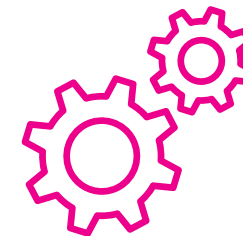
Why is this a priority?

We are working as a component in a system and contribute to our wider system strategy and place. We are already working as a partner in our system and have some well established provider collaborative programmes (e.g. in the Adult Secure provider collaborative and as the Lead Provider for Tier 4 CAMHS in the ICS).

People with mental health conditions rarely require mental health care services alone. People who use our services also need support from our partners. To improve service user and carer experience we have to work together with partners across the system. This will result in people not having to tell their story more than once, improving their experience of care services that support their holistic needs.

Our objectives

2.1. We understand who our partners are (both across the ICS and place) and create the right environments to work with them

Across our broad range of mental health services we work with a variety of partners across our place, systems, region and nationally. For us to be able to work together effectively to provide great care, it is important for people working in all of our services to know their colleagues in partner organisations and to have strong working relationships with them.

Creating the right environments to build these relationships and to work together will include measures such as:

- Identifying where we could work more closely and effectively with partners and acknowledging that we should invest time and effort to develop new ways of working;

- Aligning incentives with partner organisations;

- Co-locating our staff with their counterparts from partner organisations; and

- Demonstrating behaviours that promote and role model collaboration at all levels.

2.2. We stay informed about our populations and their holistic care needs and proactively support people

We understand the importance of population health management, which is about knowing the health needs of individuals and groups within our population and how these are likely to change in the future. This will help us to understand both the current and future demand for our services but also where there is unmet need in our population across our place. This will enable us to target our health and care support to promote equity of access to our services.

We know this isn't something we can do alone; we will work closely with our place partners to define our role in population health management in the city.

Working with our partners, we will also consider wider determinants of health, such as education and housing, and how these factors impact mental health care and support needs currently and in the future. This will consider where we can best support our place partners to prevent the development of mental health problems in our local populations.

2.3. We co-design and co-deliver proactive integrated care and support with our partners

We will work with our partners to co-design and provide integrated, tailored and holistic care to people, regardless of whether they 'meet' traditional service referral criteria.

We will not let anyone 'fall through the gaps' between different services. We will move away from disjointed ways of accessing care and services that have strict referral criteria as we know this can lead to people being referred to multiple different services and having to wait a long time for care. Instead, we will work with our partners to develop simple, coherent and consistent ways for people to access care and support when and where they need it.

2. We collaborate with our partners to understand our populations and provide proactive integrated care (2 of 2)
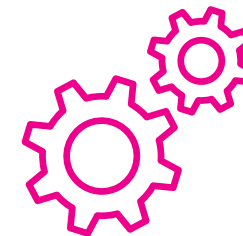
What will this mean for people in future?

Achieving our objectives for this priority will have an impact on people who use our services and on our staff. To bring to life what these objectives will mean for people, we have developed fictional 'personas' that describe what people's experiences could be like in future.

On this page we have also included quotes from people we worked with to develop this Care Services Strategic Plan about their ambition for this priority.

My name is Phil and I'm a mental health nurse within the Acute Liaison Psychiatry Service (ALPS) service in Leeds General Infirmary. Our team work 24/7 to assess and manage people who present in the emergency department or who have self-harmed. We're now able to see people in a dedicated mental health assessment area in the department, which really helps us to build therapeutic relationships as it feels more confidential and calm than being in an A&E cubicle. I'm now working more closely with colleagues in mental health charities and I can better signpost people I see in A&E to these services. Some of these services have even started to see people who I would previously see regularly in A&E, providing support to them out of hospital - I have been supporting the teams to develop the skills and experience to do this, which has been really rewarding.

We seek "good partnership working internally and externally providing long-term continuity of care and professionals."

Quote from Trust care services survey

We aspire to "increase the diversity of our workforce and professions so that we can deliver services to our local community in a more accessible way through partnership working."

Quote from Trust care services survey

We would like "the ability to deliver services where needed; working collaboratively to make best use of resources."

Quote from Trust care services survey

3. We provide high quality, equitable and sustainable care services (1 of 2)
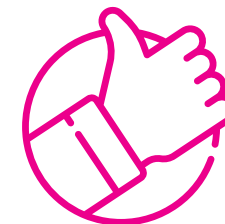
Why is this a priority?

The *NHS Long Term Plan* outlines the importance of further 'progressing on care quality and outcomes'. This is based on the recognition that central to care services there should be high quality service provision that meets the needs of all individuals who require care. This is regardless of complexity of need, geographic location and socio-economic factors, such as deprivation.

Our refresh of the Trust Quality Strategic Plan highlights the importance of driving compassionate, person centred, safe reliable and effective care to service users and carers.

Our objectives

3.1. Our care services have the appropriate conditions where high quality care can flourish

To achieve high quality services there are a number of dependent factors. This includes having the resources to invest in improving service delivery and a highly capable workforce with appropriate skills and training to deliver quality care. We will use research and development to provide best in class care services. This will include understanding how we can deliver accessible services.

We will invest in innovative care delivery methods, supported by accessible digital tools and technologies. We will enable staff to focus their time on training and development. We will upskill across our service lines, sharing our specialist knowledge with other care staff to deliver consistency across services and share good practice.

3.2. Our care services deliver equitable access, experience and outcomes

We will provide services that are equitable. This means that people will have equal access to care that we provide regardless of their income level, race, employment status, first language or gender. To achieve this, our services will be inclusive - involving a diverse range of people with experience of using our services in decisions about the care we provide will be key to achieve this.

We will monitor how equitable our services are in terms of access, experience and outcomes. This will involve measuring any differences in level of access to services, experiences of care and in mental health outcomes across different population groups. We will use this information to continually identify what we could do differently to achieve equity.

3.3. Our care services are clinically, financially and environmentally sustainable, supported by digital and estates

Not only is it important to design care services that are fit for today's population but it is also important for them to be fit for the future. Our future care services will support us to achieve our zero ambition - by providing more care closer to people's homes and remotely enabled by digital technology , we will reduce our carbon footprint.

We will continually seek to identify, learn from or lead on innovation in our clinical services to support clinical sustainability and provision of high quality care. This will be supported by our research and development activities.

We have identified areas in our service lines where financial sustainability is a challenge. Our future care services will be efficient as well as high quality, and provide value for money.

3.3. We have a sustainable, healthy and engaged workforce whose wellbeing is supported

We know that in order to deliver quality care services we require a capable workforce who have the necessary capacity to deliver care. In order to achieve this, we will consider how we develop an attractive workforce offering, such as supporting people to develop their skills through access to training events and courses.

We also recognise the importance of supporting the wellbeing of our people. This links very closely to our recent People Plan. Our Care Services Strategic Plan will support the delivery of our People Plan - for example, we aspire to enable more of our care services staff to meet together in person as we have heard how important this is to promote team wellbeing.

3. We provide high quality, equitable and sustainable care services (2 of 2)

What will this mean for people in future?

Achieving our objectives for this priority will have an impact on people who use our services and on our staff. To bring to life what these objectives will mean for people, we have developed fictional 'personas' that describe what people's experiences could be like in future.

On this page we have also included quotes from people we worked with to develop this Care Services Strategic Plan about their ambition for this priority.

My name is Harpreet and I work as a mental health nurse in the Deaf CAMHS service. I have profound hearing loss and BSL is my first language. When I was younger I didn't think it would be possible for me to work as a nurse, delivering care to children and young people, although this has always been a passion. The Trust has been supportive to me every step of the way, offering training and career development opportunities with reasonable adjustments. I work independently the majority of the time but I always know that if needed, there are friendly BSL/English interpreters who are flexible around my face-to-face appointments and Zoom group work. I also support other professionals in a formal consultancy role to educate them on how to effectively communicate with deaf children and how to improve accessibility of services.

"The Trust should be known in future for high quality and innovation."

Quote from Trust care services survey

We aspire to be "a Trust which provides high quality clinical care in fit for purpose estates, delivered by a well trained workforce dedicated to service delivery, teaching, research and innovation."

Quote from Trust care services survey

We will "strive to achieve positive outcomes for all service users, their families and communities based on sound clinical models and engagement."

Quote from Trust care services survey

We will also make changes within each of our service lines to support delivering our priorities

Our service line aspirations

We have worked with staff across our nine service lines to discuss the aspiration for all of our care services as well as the reasons we need to change. To develop these we have also used information from sources such as the *CQC, Royal College of Psychiatrists* and our performance data.

Our 'headline' service line changes have been developed organically and we recognise that this does not represent the full list the ambitions for all service lines (these are included in the relevant Appendices).

Over the next 10-15 years there are two types of changes that we will be making:

1) **Stabilisation / recovery**

   these are the changes to make over the next five years which will set us up for more ambitious changes in the future. We know that over the next few years we, like all of the NHS, will be focused on recovering our services that have been impacted by the pandemic. We also know that the future national and commissioning direction for mental health services may change. However, we can and should take steps forwards now to set us up for transformational activities in the longer term.

2) **Transformation**

   these are the aspirations that we will strive to achieve over the next 10-15 years which will fundamentally shift the way in which we deliver care services. These will be innovative and based on an evidence-base for change. This will take us to a position where we are leaders nationally in delivering on our three priorities, around co-production, collaboration and high quality care services.
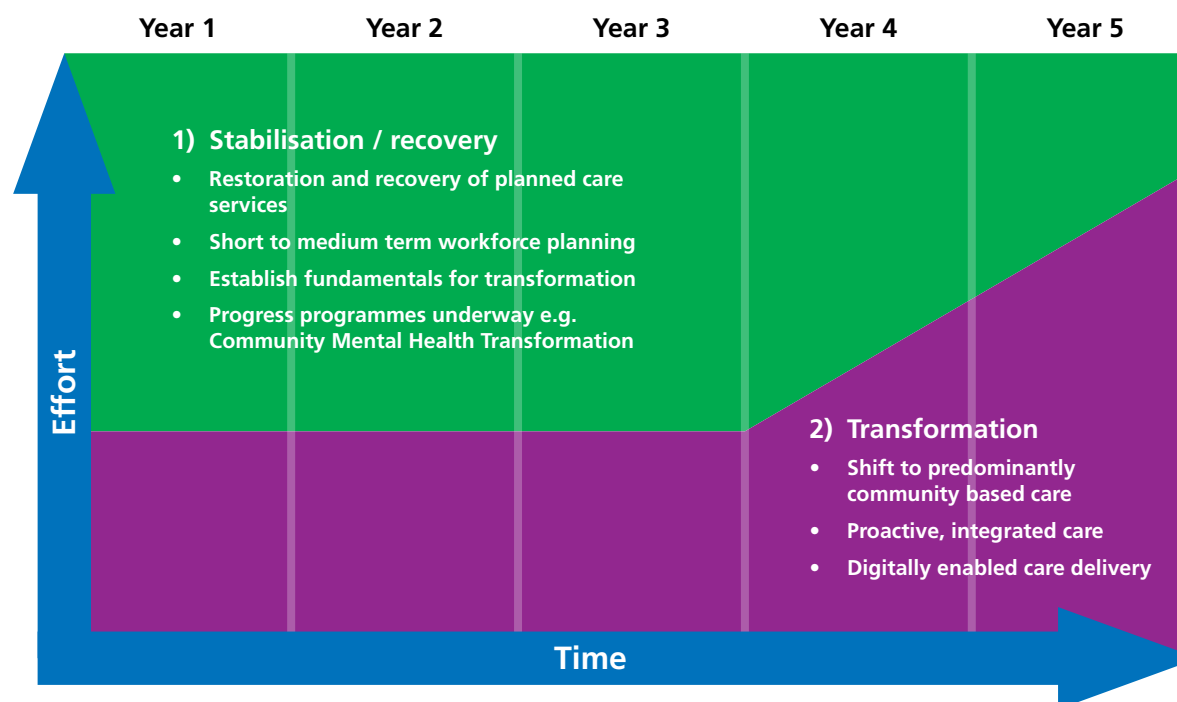
The next pages highlight what the key service line aspirations are, indicating which of these are about stabilisation / recovery and which relate to transformational activities.

Further detail on each of the service line broader aspirations and context behind this can be found in Appendices A-I.

Our headline service line aspirations

A full summary of service line ambitions can be found in Appendices A-I.

Key:
- **Stabilisation / recovery**
- **Transformation**

Service line	Why do we need to change?	Key changes
Acute	• We have a high number of out of area placements with several internal and external delayed transfers / discharges. This has an impact on quality of care and on the service user and carer / family experience. • Our buildings / clinical environments are not fit to provide modern mental health inpatient care. We have a higher than average number of beds on each ward. The service is located across two sites. We have a mixed gender Psychiatric Intensive Care Unit (PICU). • Our Crisis Service (CRISS / Police Pathway) struggle to meet the demand and needs of the people of Leeds due to the current configuration and pathway with Single Point of Access (SPA). There is a need to review all crisis services in line with community transformation. • The changing needs of the inpatient population combined with our recruitment and retention challenges require us to review the skills requirements of our workforce.	• Continue our ongoing initiatives on: introducing housing officers addressing clinical variation, formulation and early discharge. • Expand our Intensive Support Service and Crisis Resolution Service by 50%. • Work with Oasis and Crisis Assessment Unit (CAU) to enable people with more acute needs to be supported by Oasis. • Pathway improvement work to improve flow across adult acute, forensic and recovery / rehabilitation care pathway. • Stop providing District Control Room (street triage to continue). • Implement city-wide support helpline. • Reduce the number of S136 beds. • Introduce West Yorkshire ICS-wide PICU working arrangement. • Continue to embed a clear and progressive clinical career pathway to support the recruitment and retention of experienced clinical staff, focusing on where there are skills that we require, rather than where there are roles that we require.

Our headline service line aspirations

A full summary of service line ambitions can be found in Appendices A-I.

Key:
- **Stabilisation / recovery**
- **Transformation**

Service line	Why do we need to change?	Key changes
Community and Wellbeing	• We are working with place partners to transform community services - this is being driven through the Community Mental Health Transformation and is an important national directive driven by the NHS Long Term Plan. • Community services are currently five days a week - demand continues through the weekend, is reflected in referral patterns to acute services. • Many service users are referred multiple times to multiple services in the community; there is a risk that people who need support are 'falling through gaps' in service referral criteria.	• Transform into the new community mental health offer across the Leeds District, where Primary Care Mental Health, Adult Social Care, Third Sector services and Working Age Adult Community Mental Health Services (WAA CMHS) all become integrated into three community hubs. • Expand community services to 7 day provision.
Perinatal and Liaison	• We have an established perinatal community service - the NHS Long Term Plan aims to improve and increase access to perinatal mental health care for women and families. • Ensure we have equitable provision of liaison psychiatry outpatient services across the West Yorkshire footprint. • Ensure our liaison teams have access to sufficient space within acute Trust services • The waiting list for National Inpatient Centre for Psychological Medicine (NICPM) is long and staff capacity is a challenge due to staffing retention. CQC have stated that the premises were not suitable for the purpose they were being used for.	• Increase our perinatal community service provision and offer support to women, partners and families in alignment with the NHS Long Term Plan commitments. • Co-location of liaison psychiatry teams with acute trusts in line with Royal College standards. • Continue providing NICPM in an appropriate estate (acknowledgement that funding direction is likely to influence this) and recruit to address staffing gaps. • Consider our future estate options such as purpose built MBU with therapeutically beneficial environment and co-location with other inpatient services in line with Royal College standards.

Our headline service line aspirations

A full summary of service line ambitions can be found in Appendices A-I.

Key:
- **Stabilisation / recovery**
- **Transformation**

Service line	Why do we need to change?	Key changes
Learning Disabilities (LD)	• We are working with local authority commissioning partners to ensure the sustainability and future delivery of our Supported Living Services. • We recognise that an important principle of co-production is encouraging peer support, which currently is not delivered within our service. • We currently have some gaps in our preventive support offer, especially in our respite provision.	• Collaboratively redesign the delivery and leadership model of the Supported Living Service so that the service remains competitive, affordable and deliverable. • Employ people with lived experience in involvement co-worker posts. • Add three 'emergency admission' beds for LD respite services. • Establish more integrated working between respite, emergency and Intensive Support Team.
Forensics	• In Leeds, acuity of care needs is increasing and there is a perception that our services may be required to adapt to manage higher risk. • The male forensic pathway is constantly stretched; flow is a challenge between low and medium secure services and there are long waiting lists for beds. Recruitment and retention of staff is a challenge within the service. • Our current environment across both Newsam and Clifton House sites is impacting service user experience. We do not currently meet expected standards for our services as we do not have en-suite facilities and there are limited seclusion facilitates to manage challenging behaviour (e.g no female seclusion at Newsam).	• Expand our community forensics services. • Review / redesign inpatient pathways with aim to reduce delayed transfers of care and discharges. • Integrate and expand our Forensics Psychology service into the community when patients are discharged.

Our headline service line aspirations

A full summary of service line ambitions can be found in Appendices A-I.

Key:

- **Stabilisation / recovery**
- **Transformation**

Service line	Why do we need to change?	Key changes
Children and Young People (CYP)	• We have a new model of care as lead provider for inpatients in West Yorkshire - our links with community CAMHS vary across the West Yorkshire places and care is not fully integrated across care pathways. • We are aware of a current service gap for 18 - 25 year olds in National Deaf CAMHS and the NHS Long Term Plan outlines an expectation that *'by the end of 2023/24 no age-based thresholds are in operation (i.e. no patient should be asked to transition automatically at age 18) and that all services are adapted to better meet the needs of 18-25 year olds as part of a comprehensive offer for 0-25 year olds that reaches across mental health services for CYP and adults'*. • Demand for NG feeding services has increased and at present this is provided only in inpatient settings.	• Introduce a 'day care' facility in both Mill Lodge and Red Kite View to provide an nasogastric feeding service for children and young people with eating disorders who require this intervention and do not otherwise need to be in hospital. • As part of a national network of services to work with NHSE and Trusts nationally to identify the development process for expanding National Deaf CAMHS to include provision for 18 - 25 year olds (options appraisal process currently in progress with service network). • Further integrate inpatient services with community CAMHS to provide more joined up care across the pathway, strengthening working relationships.

Our headline service line aspirations

A full summary of service line ambitions can be found in Appendices A-I.

Key:
- **Stabilisation / recovery**
- **Transformation**

Service line	Why do we need to change?	Key changes
Regional Eating Disorders, Complex Rehabilitation and Gender Identity	• Demand for gender identity services is increasing (there were 3,358 people on our waiting list in Feb 22). We recognise that gender identity is not a mental health disorder and are moving away from this approach. There are current pilots in England of gender identity collaborative models. • Ward 5 - Locked Rehabilitation facility is considered a traditional and unsustainable model, and the environment is not conducive to recovery (e.g. lack of outdoor access). • The CONNECT service for adult eating disorders is relatively new - the care model has already shifted care into the community from inpatient. However we expect there are service gaps between CONNECT and community mental health services, and our ways of working with our system partners could be improved.	• Introduce a community eating disorders service to support people who do not meet referral criteria for CONNECT. • Replace our Recovery Centre with an enhanced community rehabilitation offer. • Establish a system-wide 'quality of life' complex care facility. • Enhance our Assertive Outreach offer. • Move to a 'two tier' gender identity service (with increased role of primary care and third sector partners to support with less complex cases with LYPFT providing support to people with more complex support needs).

Our headline service line aspirations

A full summary of service line ambitions can be found in Appendices A-I.

Key:
- **Stabilisation / recovery**
- **Transformation**

Service line	Why do we need to change?	Key changes
Older People's Services (OPS)	• Delayed transfers of care in OPS is a challenge (24.9% of transfers were delayed in 2022) - this is linked to the challenge in access to care home provision for patients to be discharged from the Mount. • Access to appropriate facilities to support older people with acute and intensive care needs isn't available. • The city-wide ambition is for people to receive care in their own homes as much as possible and for as long as possible. • Demand is increasing and is expected to increase further for our memory assessment service.	• Establish access to a specialist long-term facility for people with dementia with complex care needs (use of Dolphin Manor and Willows in short-term). • Potentially establish a dementia PICU for older people with acute and intensive care needs (this would be provided on a West Yorkshire footprint). • Aligned with the Leeds city ambition to support people in their own homes as much as possible, enhance the Intensive Home Treatment Team (IHTT) offer as part of the enhanced community response work that we are doing with the Leeds system (aim to operate at full capacity plus an additional 10% of current capacity). • Co-locate OPS beds with acute site. • Review structure of OPS community teams based on population need. • Evaluate clinical model of, and respond to increase in demand for, Memory Assessment Service.

Our headline service line aspirations

A full summary of service line ambitions can be found in Appendices A-I.

Key:
- **Stabilisation / recovery**
- **Transformation**

Service line	Why do we need to change?	Key changes
Regional and Specialist	• Demand for neurodevelopmental services is high and increasing, leading to long waiting lists, and sustainable clinical capacity to meet demand is a challenge (e.g. 54.3% of LADS assessments started within 13 weeks compared to 95% target). • The veterans service are the lead provider for two provider collaboratives, although there is a potential to expand this to be the lead provider across three service tiers. • For the ADHD service, the waiting list is currently 1,800 due to historic under funding of the service and general increase in referrals over the last few years. • Unmet need for addictions support has been identified in two populations: adults with a gaming addiction and children and young people with a gambling addiction. • Alcohol use has increased during the pandemic and fewer people have accessed care. The physical and mental health of people with substance misuse has reported to have worsened. • Within EMERGE and the Pathway Development Service (PDS) unmet need has been identified for people under the age of 18, neurodiverse people and those not meeting current referral/ diagnostic criteria.	• Introduce 'two tier' autism diagnostic service with increased role of primary care / third sector partners for less complex cases and ongoing role for LYPFT in more complex cases. • Introduce system-wide offer for ADHD, with increased role for primary care / other partners for less complex cases (ongoing role for LYPFT in more complex cases). • Expand our ADHD service to include treatment and management support, as well as diagnostics, and introduce service to support children and young people with ADHD in transition to adult services. • Expand our EMERGE and PDS services to include support to people under the age of 18 (14+) and people with neurodiversity. • Expand gambling addiction service provision and open new bases in North West and South Yorkshire. • Start providing a gaming addiction service for adults and a young person's gambling service. • Expand our veterans service in the region, potentially as lead provider across three service tiers (this is dependent on work around new care model development with partners) or through expanding referral criteria.

With these changes, we will be able to provide better care and meet future demand for our services

We have looked at how the changes we've identified will impact the projected demand for our services over the next fifteen years. This is set out on the following page.

The 'do something' modelling outlined below shows the forecast demand for our inpatient services based on the key strategic changes identified for our services and anticipating that Leeds will see a growing elderly population, with fewer working age adults over the next 10 years.

Making these changes will enable us to plan for our services in future without needing additional beds - for some services, we may even be able to reduce the number of inpatient beds. This position is much more closely aligned to the direction of travel of our system and national policy, such as the Long Term Plan, to move more care out of hospital settings and into the community to support people closer to home.
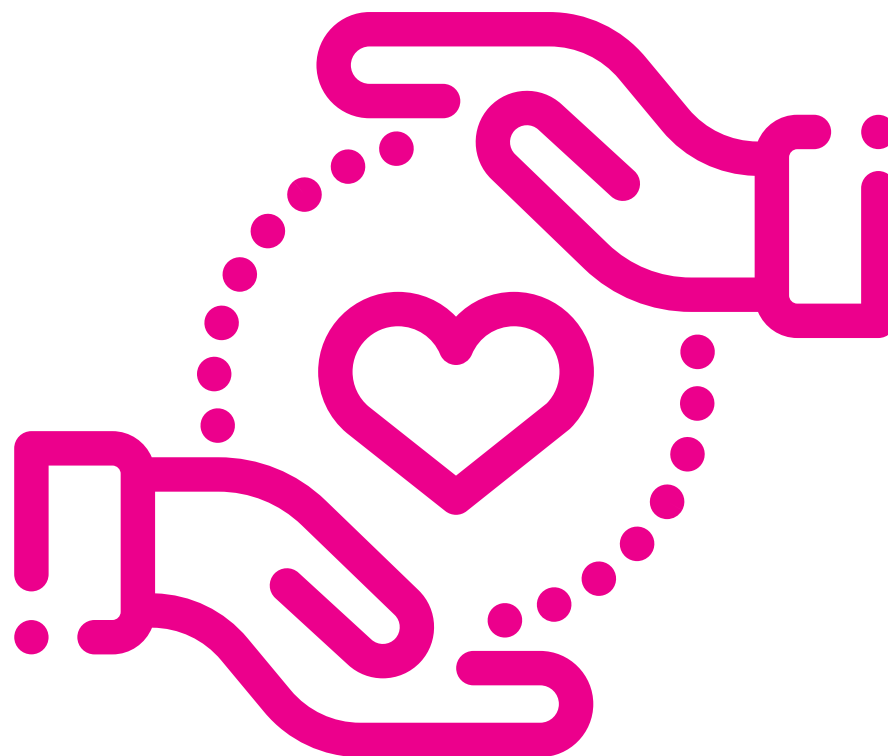
Details on the modelling approach, methodology and assumptions are included in the accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.

Further information on the modelling is also included in the service line appendices (Appendices A - I).

'Do something' bed requirement forecast

Service line	Current bed base	'Do nothing' 2036 bed forecast	Key 'do something' service changes impacting future bed requirements	'Do something' 2036 bed forecast
Adult acute services	132	197 - 204	Expansion of out of hospital acute services, as well as community mental health services, introduction of West Yorkshire PICU working arrangement, work with Oasis partnership.	121 - 126
Children and young people's services	34 (incl. 6 PICU)	26 - 28	'Day centre' NG feeding provision.	21 - 23
ED, R&R, and GI services	67	81 - 84	Expansion of community rehabilitation services and introduction of specialist community eating disorders service.	58
Forensic services	69	80 - 85	Enhancement of community forensics service and collaborative redesign of care pathways.	62 - 63
Learning disability services	9	8 - 9	Addition of emergency inpatient provision for LD services.	11 - 12
Liaison and perinatal services	16	23	Expansion of community perinatal services.	20
Older people's services	80	103	Introduction of complex care facility for people with complex dementia needs, potential co-location of care with acute trust sites, expansion of community-based services (e.g. IHTT) and review of community team structure with view to allocate resource in line with need to support addressing health inequalities.	82 - 84
Total	407	518 - 536		375 - 386

We have identified key enablers to achieve our aspirations for future care services (1 of 3)

Key enablers to achieve our care services aspirations

Digital technology, workforce, estates, finance and research and development are the enabling areas to achieve our service line aspirations and our care services priorities. We recognise that there are some dedicated plans within the Trust for a number of these areas, such as our *People Plan*, our *Quality Strategic Plan*, our *Strategic Estates Plan* and our *Digital Plan*. Further details on these plans and how they link to this Care Services Strategic Plan can be found in section 4, the implementation plan.

The table below outlines the how each enabler will help us to achieve our three care services priorities.

Enabler	1. We co-create and co-deliver care services with people who have lived experience	2. We collaborate with our partners to understand our populations and provide proactive integrated care	3. We provide high quality, equitable and sustainable care services
Digital technology	• Use of technology to support development of service user peer networks • Barriers to digital accessibility addressed and mitigated against, partly through improving staff, service users and carer's digital competency and regardless of digital confidence, context and capability to have worsened.	• Integrated digital systems with our partners regionally, supported by linking the Care Director system to the Yorkshire and Humber Care Record system, reducing the time spent for staff on administrative tasks	• Virtual reality (VR) interventions, such as for therapy (e.g. body image therapy) and service user education • Barriers to digital accessibility addressed and mitigated against • Digital tools, such as apps, developed, for all service users and carers which enable service users to receive care from home and self-manage both physical and mental health aspects of their care
Estates	• Working environments and care settings are inclusive and accessible • Locations of our care services are accessible and enable co-production and co-delivery of care with service users	• Our care services staff are able to meet with colleagues from partner organisations in shared space to collaborate, build relationships and share knowledge	• Care settings are safe, therapeutic environments are conducive to recovery to recovery and provision of high quality care • Care services are located with appropriate clinical adjacencies e.g. to facilitate safe and efficient transfers of care and/or flexible access to trained staff • Care settings are inclusive and accessible

We have identified key enablers to achieve our aspirations for future care services (2 of 3)

Enabler	1. We co-create and co-deliver care services with people who have lived experience	2. We collaborate with our partners to understand our populations and provide proactive integrated care	3. We provide high quality, equitable and sustainable care services
Workforce	• Career progression opportunities are available in the Trust for people with lived experience • Skills development support to care services staff e.g. in co-production	• Potential joint posts with partner organisations (e.g. Voluntary and Community Sector organisations, academic institutions) to promote collaboration • Culture change to support integrated ways of working with partners	• Development opportunities accessible for staff to improve staff satisfaction and support retention • Cultural change to embed non-traditional roles in care service teams • Quality improvement capability building for staff to embed quality improvement culture
Finance	• Funding for employment and skills development offer to people with experience of using our services • Potential investment in training to support care services staff to build skills in co-production	• Clarity on commissioning direction for care services and any new funding available • Potential jointly / collaboratively funded resources (e.g. roles, buildings, research activity) • Increased transparency with partners on investment priorities to work together to align on shared priorities and identify potential efficiencies	• Clarity on commissioning direction for care services and any new funding available • Investment in priority changes to care services to support development of resilient and sustainable services • Targeted investment to support underserved populations (e.g. improving inclusivity and accessibility of care services) to support provision of equitable care • Clarity on potential funding opportunities for research and development to enable research activity to be embedded in care services

We have identified key enablers to achieve our aspirations for future care services (3 of 3)

Enabler	1. We co-create and co-deliver care services with people who have lived experience	2. We collaborate with our partners to understand our populations and provide proactive integrated care	3. We provide high quality, equitable and sustainable care services
Research & Development (R&D)	• Potential opportunities to identify good practice in co-production and evidence-based for effective peer support models	• Clarity on R&D priorities for key partners and potential opportunities to collaborate on research programmes • Strengthened relationships with colleagues in other organisations through R&D to support integrated working and culture of collaboration	• Research and development embedded in all service lines to enable research to become an integral part of quality service provision and for service models to be evidence-led • New evidence, innovation and good practice communicated with front line teams to identify opportunities to implement

The outcomes we are aiming to achieve for each of our objectives (1 of 2)

Our outcomes

By achieving our three priorities for care services we will make an impact and affect real change across the communities we serve. We can articulate this impact and change by describing the outcomes that we are working towards, both as an organisation and for broader society. This page and the next describes what these outcomes are and what this means in practice.

Objectives	Outcomes for each objective
1.1. **Our care services are led together with people who have experience of using our services, working in partnership**	• People with lived experience have meaningful influence over decisions we make as a Trust • More people with mental health conditions, addictions and neurodiversity are employed • Service users benefit from peer support from people with lived experience
1.2. **We contribute to our local economy through wider skills development and employment opportunities for people who use our services**	• People with mental health conditions, addictions and neurodiversity have career opportunities and aspirations • More people with mental health conditions, addictions and neurodiversity are employed
1.3. **We lead continuous co-production of care services with our communities and citizens**	• All of our care services are co-produced with people with lived experience • Our care services are inclusive, accessible and equitable
2.1. **We understand who our partners are (both across the ICS and place) and create the right environments to work with them**	• All of our care services teams knows who their partners are • All of our care services teams create the right environments to work with their partners
2.2. **We stay informed about our populations and their holistic care needs and proactively support people**	• All of our care services teams and those of our partners where relevant know their populations • We have a holistic view of population need, including unmet need

The outcomes we are aiming to achieve for each of our objectives (2 of 2)

Objectives	Outcomes for each objective
2.3. **We co-design and co-deliver proactive integrated care and support with our partners**	• Our populations can access care services that are tailored to their holistic needs • People who use our services and those of our partners do not notice organisational boundaries in their experience of care and support • People who use our services receive care and support close to their homes or in their own homes
3.1. **Our care services have the appropriate conditions where high quality care can flourish**	• All of our care services staff work in environments where high quality care can flourish • Every care service measures their 'STEEEP' outcomes (Safe, Timely, Effective, Efficient, Equitable and People-centred care) • We know where our quality 'high spots and hot spots' are and we use this knowledge to celebrate, learn and continuously improve • People who use our services experience Safe, Timely, Effective, Efficient, Equitable and Person-centred care
3.2. **Our care services deliver equitable access, experience and outcomes**	• All of our care services our equitable • All people with mental health conditions, addictions and neurodiversity have access to care and support, have an improved experience of care and support and have improved outcomes
3.3. **Our care services are clinically, financially and environmentally sustainable, supported by digital and estates**	• Our care services are resilient and flexible to changes in demand • People with mental health conditions, addictions and neurodiversity have access to care and support in the community • Our care services are environmentally sustainable and support delivery of our Trust Green Plan
3.4. **We have a sustainable, healthy and engaged workforce whose wellbeing is supported**	• All of our workforce are happy and satisfied to work for our Trust • All of our workforce are equipped with the appropriate skills and capability to deliver quality care services • All of our workforce feel supported in their wellbeing

Implementation Plan

Our Care Services Strategic Plan will be delivered through a number of activities over the next five years

Our key activities

The visual below highlights the key activities for us to deliver on each of our three priorities over the next five years. The following pages detail the key milestones, start dates and owners for each activity in our implementation plan. Our implementation plan is to be refined further to include our delivery plans for achieving all our service line ambitions described in appendices A – I.

	Year 1	Year 2	Year 3	Year 4	Year 5
1. We co-create and co-deliver care services with people who have lived experience	Employ people with experience of using our services (obj. 1.1)		Care services led by people who have experience using our services (obj. 1.1)		
	Training and skills for people who use our services (obj. 1.2)	Work experience offered to people with lived experience (obj. 1.2)	Employ people with experience of using our services in operational roles (obj. 1.2)		
	Design approach to co-production (obj. 1.3)	Embed co-production approach (obj. 1.3)	Develop and embed approach to evaluate and continuously improve approach (obj. 1.3)		
2. We collaborate with our partners to understand our populations and provide proactive integrated care	Provide ways for staff to connect with partner organisations (obj. 2.1)	Establish and strengthen relationships with our partners (obj. 2.1)			
	Agree and embed a population health management approach (obj. 2.2)	Identify unmet need in our population (obj. 2.2)			
	Work with our partners to address unmet need in our populations (obj. 2.3)	Establish new ways of working with partners (obj. 2.3)	Use shared community assets creatively with our partners to improve accessibility of our services (obj. 2.3)		
3. We provide high quality, equitable and sustainable care services	Embed research and development into service design and delivery (obj. 3.1)	Embed collective leadership and a culture of continuous improvement (obj. 3.1)			
	Develop a robust approach to measuring and monitoring equity in access, experience and outcomes (obj. 3.2)		Embed equity considerations and requirements into our approach to care service co-design (obj. 3.2)		
	Build capacity, capability and flexibility into our care services workforce (obj. 3.3)	Co-design care services that are environmentally sustainable (obj. 3.3)	Invest in proactive care and community-based support (obj. 3.3)		
	Develop a comprehensive training and skills offering to all staff (obj. 3.4)	Enhance resources to support staff wellbeing (obj. 3.4)			

Implementation for priority one and key milestones for each activity (1 of 2)

Key activities and milestones

Below highlights the activities, key milestones, start date and activity owner for priority 1: *we co-create and co-deliver care services with people who have lived experience.*

Activity	Key milestones	Start date	Activity owner
1.1. Our care services are led together with people who have experience of using our services, working in partnership			
1.1.1. Establish a leadership and governance structure for experts by experience employed by the Trust	• Governance structure for experts by experience signed off by Executive Board	Year 2	Executive Board
1.1.2. Employ people with experience of using our services as a user or carer in care services peer support roles	• Terms of Reference for all peer support roles created • Training programme rolled out to peer support workers	Year 1	Service user involvement team
1.2. We contribute to our local economy through wider skills development and employment opportunities for people who use our services			
1.2.1. Provide training and skills development opportunities for people who use our services	• Training programme developed • Training programme rolled out	Year 1	Service user involvement team
1.2.2. Create work experience opportunities for people with lived experience	• Work experience opportunities identified by all service lines • Marketing campaign to advertise work experience roles	Year 1	Service user involvement / workforce teams

Implementation for priority one and key milestones for each activity (2 of 2)

Activity	Key milestones	Start date	Activity owner
1.2.3. Employ people with experience of using our services in roles in the Trust outwith care services (e.g. communications, admin)	• Roles identified • Terms of Reference developed with reasonable adjustments clearly outlined	Year 1	Operational team
1.3. We lead continuous co-production of care services with our communities and citizens			
1.3.1. Establish a robust approach to co-production with people who use our services, our local communities and citizens	• Current approach to co-production assessed • Approach to co-production agreed	Year 2	Service user involvement team / service lines
1.3.2. Embed this approach into all care service areas	• Approach to co-production implemented	Year 3	Service line leads
1.3.3. Develop an approach to evaluating and continuously improving our approach to co-production	• Approach to evaluation agreed and signed off by service user groups and Executive Board • Continuous monitoring approach agreed and implemented	Year 3	Service user involvement team

Implementation for priority two and key milestones for each activity (1 of 2)

Key activities and milestones

Below highlights the activities, key milestones, start dates and activity owners for priority 2: *we collaborate with our partners to understand our populations and provide proactive integrated care*

Activity	Key milestones	Start date	Activity owner
2.1. We understand who our partners are (both across the ICS and place) and create the right environments to work with them			
2.1.1. Provide mechanisms for our care services staff to connect with their peers in partner organisations	• Agreement with partner organisations on approach to connecting peers together • Implement agreed approach	Year 1	Service line leads
2.1.2. Establish and strengthen relationships with our partners	• Mapping process of all partners locally, regionally and nationally complete, identifying where relationships require to be developed	Year 2	Executive Board
2.2. We stay informed about our populations and their holistic care needs and proactively support people			
2.2.1. Work with our partners to use our collective skills and experience to identify and understand our populations, taking a population health management approach	• Data on latest population demographics and need profile obtained • Trust role in population health management agreed and implemented	Year 1	Health Informatics team
2.2.2. Identify unmet need in our populations	• Analysis of population data and insights from service line teams, system partners and service users and carers	Year 2	Health Informatics team

Implementation for priority two and key milestones for each activity (2 of 2)

Activity	Key milestones	Start date	Activity owner
2.3. We co-design and co-deliver proactive integrated care and support with our partners			
2.3.1. Work with our partners to address unmet need in our populations, co-designing solutions that make the most of our collective capabilities and capacity	• Scope for areas to redesign agreed with partners based on unmet need insights • Approach to co-design agreed with partners • Services developed to address unmet need	Year 1	Service line leads
2.3.2. Establish new ways of working with partners to minimise the impact of organisational boundaries on a person's experience of care	• Strengths and weaknesses of current ways of working identified • New ways of working agreed and implemented	Year 1	Service line leads
2.3.3. Use shared community assets creatively with our partners to improve accessibility of our services	• Engagement with service users / carers completed to identify accessibility issues • Opportunities for use of community assets identified	Year 2	Service line leads / estates team

Implementation for priority three and key milestones for each activity (1 of 2)

Key activities and milestones

Below highlights the activities, key milestones, start dates and activity owners for priority 3: *we provide high quality, equitable and sustainable care services.*

Activity	Key milestones	Start date	Activity owner
3.1. Our care services have the appropriate conditions where high quality care can flourish			
3.1.1. Embed collective leadership, learning and a culture of continuous improvement	• Educational campaign/ training on collective leadership launched	Year 2	Executive Board
3.1.2. Embed research and development into service design and delivery so we have the knowledge, tools and evidence to provide the best care anywhere	• Investment areas for research and development agreed	Year 1	Executive Board
3.2. Our care services deliver equitable access, experience and outcomes			
3.2.1. Develop a robust approach to measuring and monitoring equity in access, experience and outcomes for all of our care services	• Approach to measuring and monitoring access, experience and outcomes agreed and implemented	Year 1	Quality team
3.2.2. Embed equity considerations and requirements into our approach to care service co-design	• Equity considerations identified and agreed • Approach to incorporating equity considerations into service design agreed	Year 3	Service line leads

Implementation for priority three and key milestones for each activity (2 of 2)

Activity	Key milestones	Start date	Activity owner
3.3. Our care services are clinically, financially and environmentally sustainable, supported by digital and estates			
3.3.1. Build capacity, capability and flexibility into our care services workforce	• Plan to address key care services workforce gaps developed • Communications and engagement campaign on training and education offer for care services staff launched	Year 1	Workforce team
3.3.2. Invest in proactive care and community-based support to prevent escalation of care needs requiring more intensive support	• Targeted opportunities for community-first support identified and agreed	Year 3	Service line leads
3.3.3. Co-design new care services and ways of working that promote environmental sustainability	• Opportunities to enhance new and existing estates and working practices identified based on national policy and good practice	Year 2	Estates team
3.4. We have a sustainable, healthy and engaged workforce whose wellbeing is supported			
3.4.1. Develop a comprehensive training and skills offering to all staff	• Existing training and skills offerings to staff clarified • Gaps in skills and training identified and plan to address them agreed	Year 1	Workforce team
3.4.2. Enhance resources to support staff wellbeing	• Opportunities for collaboration spaces for teams to meet together in person identified • Additional skills requirements to support high quality skills delivery identified	Year 2	Workforce team

How this strategy links to wider plans across our Trust

Our plans across the Trust

Below describes other existing plans across the Trust and how they link to the Care Services Strategic Plan.

Corporate Trust strategy (2018-2023)	The 'Living our values to improve health and lives' Trust strategy highlights our purpose, vision, ambition and values as a Trust which all run as a 'golden thread' through this Care Services Strategic Plan. Any care services design in the future will be aligned to these core values, with us having integrity, keeping it simple and being caring.
Quality Strategic Plan (2018-2022)	Our care services priorities, particularly our third priority (we provide high quality, equitable and sustainable care services), align to the principles set out in the Quality Strategic Plan. The objectives for our third priority are closely aligned with the five core areas in our quality plan (creating the conditions, knowing where we can learn from high quality and support improvement where required, helping in a joined up way, developing ways to manage quality).
People Plan (2021-2024)	Our new People Plan sets out our ambitions of looking after our people, belonging in the NHS, new ways of working and delivering care and growing for the future. The plan also sets out how we build an inclusive culture and a workforce of the future, both which are imperative to delivering high quality care services.
Strategic Estates Plan (in development)	We are currently developing a refreshed estates strategy. This will be based on our aspirations for the future of our care services set out in this Care Services Strategic Plan. The estates strategy will consider the options for our future estate that support the delivery of high quality and sustainable care services.
Our Digital Plan (2021-2024)	We have recently launched a refreshed digital plan, that sets out our aim to use 'innovative technology and intelligence to enable safer, inclusive and more effective care'. This highlights key progress to date, our key projects and priority areas for digital in terms of using services, implementing digital, delivering services and partnership working. Our Care Services Strategic Plan is aligned to these project areas, with further detail on this found in Appendix J.
Green Plan (2021-2025)	This plan articulates how we will contribute to achieving the NHS 2040 and 2045 targets with key priorities relating to the delivery of care services being behaviour/ engagement, operational practice, and hybrid working. This is particularly relevant to our Care Services Strategic Plan objective 3:3: 'Our care services are clinically, financially and environmentally sustainable'.
Research & Development Plan (in development)	We have published a three-year Research and Development Strategy which highlights our ambition for embedding research activity into our care services. This aligns with one of our objectives in this Care Services Strategic Plan: 'Our care services have the conditions where high quality care can flourish'. As the research and development plan is developed it will be important that areas of focus for the future align with the strategic direction of our care services.

Appendix

Appendix

Summary of sections

Our appendix provides supporting and more detailed information on a number of themes, as outlined below.

- Who the service line provides services to;
- How the service line currently works;
- Why the service line should change;
- How the service line will change in the future;
- How the service line will achieve these changes;
- How these changes will make a difference.

Appendix A:
Acute Service Line Aspiration

Our acute services are core mental health services providing care and support to adults in Leeds

Our acute services teams support people living in Leeds with acute mental health problems.

People we care for may already have mental health conditions or they may be experiencing a mental health problem for the first time.

Many people who use our acute services also get support from other service areas, such as community mental health teams and specialist teams. Often this means that a period of acute care is one part of a person's care journey, with support provided by other teams before and after this period.

Our Acute Service Line is made up of the following services:

Crisis Resolution Intensive Support Service (CRISS):
Our CRISS team work with people who are experiencing a mental health crisis. The team provide short term intensive support to people in their own homes to help them through the period of crisis.

Crisis Assessment Unit (CAU):
Our CAU is an inpatient unit where people experiencing a complex mental health crisis are assessed and supported over a short period. People may go on to need support in our inpatient services, or may be able to go home with or without ongoing support.

Acute Inpatient Services:
Our acute inpatient teams care for people with acute mental health needs who need high levels of support that cannot be provided safely out of hospital. This service is available for people with a learning disability and mental health needs and people who are detained under the Mental Health Act.

Psychiatric Intensive Care Service (PICU):
Our PICU team supports people with highly acute or complex mental health needs, providing intensive specialist care.

We provide great care to our service users and are proud of the services we provide.

We are committed to providing high quality acute care. This is reflected in recent improvement work we have completed such as our gatekeeping work with CRISS, our work around safety huddles and improving working across service lines and community teams as part of developing pathways.

In our most recent CQC inspection in 2019, we were assessed as 'good', which we have maintained even throughout the challenges posed by the Covid-19 pandemic.

We know from recent work with our city partners that in Leeds we have more challenges with mental health compared to other places in England, and there are inequalities in mental health in our place:

- It is estimated that 106,000 people in Leeds experience a common mental health disorder.

- We know that one third of people in Leeds who get support from crisis services have not previously used mental health services (such as community services).

- More people are admitted to hospital as a result of self-harm in Leeds, compared with the national average.

- Suicide and self-harm admission rates are higher in poorer areas of Leeds, with the highest suicide rates being in middle aged men and highest rates of self-harm in young women.

- Leeds has a higher rate of people subject to the mental health act compared to the England average.

We are proud of the services we provide, however there are challenges to ongoing provision of quality acute care

Many of the challenges we have are consistent with those faced by other acute mental health services across the country.

Nationally, issues with recruitment and retention of clinical talent are linked to challenges with building a sustainable mental healthcare workforce.

The Covid-19 pandemic has had an impact on people's mental health, for example through increased social isolation, and the effects of this are expected to be long lasting.

Long waits for non-acute mental health care and support, which are expected to have worsened due to the pause on some non-urgent care during the pandemic, may lead to the development of more acute care needs.

In addition to these national trends, locally we have identified the core challenges we face within our Acute Service Line, which we must address to improve people's outcomes and experiences of care:

- We have a high number of **out of area placements** with several internal and external delayed transfers and discharges. This has an impact on quality of care and on the service user and carer experience.

- Our **buildings and clinical environments** are not fit to provide modern mental health inpatient care. We have a higher than average number of beds on each ward and the service is located across two sites (Newsam and Becklin centre), meaning our teams don't feel connected to each other and we are often required to use secure transport to transfer service users between sites. We have a **mixed gender PICU**, which can lead to out of area placements for people who require care in a gender specific PICU.

- CRISS, our crisis service, **struggle to meet the demand** and needs of the people of Leeds due to the current configuration and pathway with SPA. There is a need to review all crisis services in line with community transformation.

- The **changing needs of the inpatient population**, combined with our recruitment and retention challenges, require us to review the skills requirements of our workforce.

Without change, demand for acute mental health care in Leeds is set to increase beyond our capacity to respond

We have completed demand and capacity modelling to understand how demand for our services is expected to change in future.

The modelling outlined below ('do nothing' modelling) shows how demand for our inpatient services, measured through the number of beds required, is projected to grow over the next fifteen years if we make no changes to our current services.

It is clear from the data that if we 'do nothing', there is an upwards trajectory in bed requirements across all of our acute adult inpatient wards.

The extent of the additional bed requirement is dependent on the potential long-term recurrent impact of Covid-19. If we assume that the long-term recurrent impact of Covid-19 is 'low'[1], by 2028 we will need around 190 beds across adult acute services, and by 2036 we will need around 204. **This is 50 - 70% higher than the bed capacity we currently have.**

For our out of hospital acute services, demand (measured through activity/contact), is also set to increase by 2028 and 2036 if we do not make any changes.

'Do nothing' modelling for adult acute inpatient services and out of hospital services

Adult acute inpatient services	Required beds per year (incl. occupancy) 2019	Beds used in 2019 (occupancy)	Required beds per year (incl. occupancy) 2028[2]		Required beds per year (incl. occupancy) 2036[2]		Planned bed capacity
			Best case[1]	Intermediate 1[1]	Best case[1]	Intermediate 1[1]	
Becklin Ward 1	22	22 (101%)	33	34	35	37	22
Becklin Ward 3	22	22 (98%)	30	31	32	33	22
Becklin Ward 4	22	22 (100%)	30	31	32	33	22
Becklin Ward 5	22	22 (100%)	33	34	35	36	22
CAU	6	5 (90%)	7	7	9	8	6
Newsam Ward 1 - PICU	12	11 (93%)	19	19	20	21	12
Newsam Ward 4	21	21 (100%)	29	30	31	32	21
S136	6	3 (<50%)	4	4	4	4	5
Total	**133**	**128**	**185**	**190**	**197**	**204**	**132**

Acute out of hospital services	Extrapolated contacts 2019[3,4]	Forecast range of do nothing' contacts 2028[4,5]	Forecast range of 'do nothing' contacts 2036[4,5]
Crisis Resolution	2,828	3,110 - 3,239	3,405 - 3,525
Intensive Support Service	27,232	29,686 - 30,966	32,320 - 33,600
Street Triage	2,363	2,585 - 2,696	2,836 - 2,947
District Control Room	375	342 - 356	375 - 389
SPA Switchboard	5,910	6,604 - 6,882	7,339 - 7,617
Total	**38,645**	**42,326 - 44,138**	**46,275 - 48,087**

1 Based on estimation using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council, the 'Best case' scenario assumes no long-term recurrent impact of COVID and the 'Intermediate 1' / 'low' recurrent impact of COVID scenario applies some long-term recurrent impact of COVID. For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.

2 Assumes future occupancy rate of 85%-90% (90% used if 2019 value was >90%, 85% used if 2019 value was <85%). Bed numbers are rounded up to the nearest whole number.

3 Where a full year of data is not available for the calendar year, or where the data looks to contain anomalies, a shorter period has been taken and then extrapolated based on number of months.

4 Contacts include both attended and DNAs as both are relevant for forecasting future estate requirements.

5 Range based on 'best case' and 'intermediate 1' scenarios.

We will make strategic changes to our acute services to improve care and enable us to meet future demand

To address the challenges we are facing now and set our services up for the future, we must make changes so that we can continue to provide high quality and equitable care to people in Leeds. We have identified a set of key changes to our acute services, shown below.

In developing these, we have considered the overarching strategic priorities for care services, and how the changes we make within the Acute Service Line align and support the delivery of them. Our priorities for care services are:

- We co-create and co-deliver care services with people who have lived experience
- We collaborate with our partners to understand our populations and provide proactive integrated care
- We provide high quality, equitable and sustainable care services

The diagram below highlights how the changes we will make to acute services align with these priorities.

In identifying the key changes for acute care, we have also considered the strategic direction of our local system as well as relevant national policy - our future services must align to the 'left shift' agenda set out in the NHS Long Term Plan, moving more care into the community and focusing on early intervention and prevention.

In line with this national direction, our ultimate ambition for our acute mental health services is to support more people to be cared for in the community for as long as possible. We know that this cannot be achieved through changing LYPFT acute mental health services alone, and recognise how important it is for us to continue working closely with community mental health teams and our wider city partners.

Change	Rationale and benefits	Priority alignment
Expand our Intensive Support Service and Crisis Resolution Service by 50%	This will mean more people can receive acute care in the community, reducing admissions.	We co-create and co-deliver care services with people who have lived experience
Continue our ongoing initiatives on: • Introducing housing officers • Addressing clinical variation • Formulation • Early discharge	These initiatives aim to reduce average length of stay in acute adult inpatient wards, enabling people to get home as soon as safe and possible for them.	
Work with Oasis and CAU to enable people with more acute needs to be supported by Oasis	This will enable more people to be supported outwith acute mental health hospitals. In the long term (5+ years), this may lead to no requirement for a CAU.	We collaborate with our partners to understand our populations and provide proactive integrated care
Pathway improvement work to improve flow across adult acute, forensic and recovery / rehabilitation care pathway	This will reduce delayed transfers of care /discharges, reducing overall length of stay and enabling service users to be cared for in the most appropriate environment, improving quality and experience.	
Stop providing District Control Room (street triage to continue)	This is driven by commissioning changes. It may have an impact on street triage contacts.	
Implementation of city-wide support helpline	This will create a clear route for people to access support and avoid calls for support to SPA.	We provide high quality, equitable and sustainable care services
Reduce the number of S136 beds	Relative to elsewhere in the country our S136 capacity is high; our actual requirement is half of our capacity.	
Introduce West Yorkshire ICS-wide PICU working arrangement	This will reduce out of area placements and reduce average length of stay for PICU.	

With these changes, we will be able to provide better care and meet future demand for our services

We have looked at how the changes we've identified will impact the projected demand for our services over the next fifteen years. This is set out below.

Based on agreed assumptions, it is projected that expansion of out of hospital acute care (as set out in the previous page), enhanced community mental health services and pathway improvement work **could reduce length of stay in our acute adult wards to an average of 32 days with 85% occupancy. This means our current bed capacity would** be sufficient to meet future demand. However, there remains a gap between demand and capacity for PICU-beds, which is likely attributable to the significant number of repatriated patients.

As our service changes are focused on expanding out of hospital support, the 'do something' modelling for **our community-based services (Crisis Resolution, Intensive Support Service) are projected to increase**. This would be expected to increase in line with an increase in capacity as the services are expanded.

The introduction of a city-wide support helpline is projected to prevent around 343 calls to the SPA Switchboard per month (c. 4,000 per year), releasing capacity for the SPA team and redirecting service users to better routes for accessing immediate support.

'Do something' modelling for adult acute inpatient services and out of hospital services

Adult acute inpatient services	Beds available in 2019	Beds used in 2019 (occupancy)	Required beds per year (assuming 90% occupancy) 2028		Required beds per year (assuming 90% occupancy) 2036		Planned bed capacity
			Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact)[1]	Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact)[1]	
Becklin Ward 1	22	22 (101%)	21	22	23	24	22
Becklin Ward 3	22	22 (98%)	18	19	20	21	22
Becklin Ward 4	22	22 (100%)	20	21	22	23	22
Becklin Ward 5	22	22 (100%)	21	22	22	23	22
Newsam Ward 1 - PICU	12	11 (93%)	19	19	20	21	12
Newsam Ward 4	21	21 (100%)	17	17	18	19	21
Total	**121**	**120**	**116**	**120**	**125**	**131**	**121**
Non-PICU beds required			97	101	105	110	109
Female non-PICU beds required			42	44	45	47	44
Male non-PICU beds required			55	57	60	63	65

Acute out of hospital services	Extrapolated contacts 2019[2,3]	Forecast range of 'do nothing' contacts 2036[3,4]	Forecast range of 'do something' contacts 2028[3,4]	Forecast range of 'do nothing' contacts 2036[3,4]	Forecast range of 'do something' contacts 2036[3,4]
Crisis Resolution	2,828	3,110 - 3,239	4,229 - 4,405	3,405 - 3,535	4,631 - 4,807
Intensive Support Service	27,232	29,686 - 30,966	40,967 - 42,732	32,320 - 33,600	44,602 - 46,367
Street Triage	2,363	2,585 - 2,696	2,585 - 2,696	2,836 - 2,947	2,836 - 2,947
District Control Room	375	342 - 356	-	375 - 389	-

1 Based on estimation using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council, the 'Best case' scenario assumes no long-term recurrent impact of COVID and the 'Intermediate 1' scenario applies some long-term recurrent impact of COVID. For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.

2 Where a full year of data is not available for the calendar year, or where the data looks to contain anomalies, a shorter period has been taken and then extrapolated based on the number of months. E.g. if April - Dec was taken as the baseline period, this has been uplifted by 12/9. The appointments / contacts have then been calculated based on the displayed ratio against the extrapolated referrals.

3 contacts include both attended and DNAs as both are relevant for forecasting future estate requirements.

4 Range based on 'best case' and 'intermediate 1' scenarios.

These changes will have an impact on the experiences of staff and people who use our services

While we have identified the impact of the key changes to our service in terms of demand for and capacity of our services, ultimately this is about providing great care to people who need support.

We know that without changing how we provide acute mental health care, we will not be able to keep up with the demand and our services will not be sustainable - this will limit our ability to continue to provide safe, high quality and equitable care.

The ambition we have set out for the Acute Service Line aims to deliver on our wider care services strategic priorities. However we will also aim to impact on outcomes that are specific to our services - will know we are achieving the right outcomes if:

- Service users and their carers are able to access timely, high quality and equitable acute mental health care and support that meets their needs.
- We have zero out of area placements.
- We have an effective crisis pathway that enables smooth transitions between community, inpatient and specialist care.
- Our services are provided by a capable, supported and consistent workforce.
- Our inpatient settings are modern, accessible and inclusive, and our ward environments are conducive to recovery.
- Our staff have career progression opportunities, feel valued and staff retention improves.

To bring to life the impact we hope to have on outcomes for people, we have included below a service user 'persona' with a short story of what their care journey could look like in future, based on the ambition we have set out in this document.

> I recently got home from hospital after a few weeks of being quite unwell. I've had depression for a couple of years now and until recently had just been seeing my GP about it. About a month ago I saw my GP and they were quite worried about me - looking back, I really wasn't very well. My GP arranged for me to have some support from the home treatment team who saw me every day for a few days but I wasn't getting better so they decided it was safest for me to go into hospital. Luckily I started to feel better after a couple of days in hospital and I was able to get home again quickly. After I got home from hospital, the home treatment team visited me for about a week, which was really good to have that ongoing support.

Appendix B:
Community & Wellbeing Service Line Aspiration

Our community and wellbeing services provide care and support in the community to adults in Leeds

Together with our city partners, our community and wellbeing teams support people living in Leeds with serious or complex mental health problems.

We support people who are experiencing a mental health problem for the first time as well as people who have long term mental health conditions.

Some people we support may need more intensive or specialist care at times - this means that our service users may get care from different teams depending on their support needs and how these change.

Our Community and Wellbeing Service Line is made up of the following services:

Community Mental Health Teams:

We have six Community Mental Health Teams based across three locality hubs in Leeds (Aire Court Community Unit in South Leeds, St Mary's House in North East Leeds and St Mary's Hospital in North West Leeds). These teams work with people either to assess their care and support needs or to provide ongoing care coordination and support.

Healthy Living service:

Our Healthy Living Service is sits within our Community & Wellbeing Service Line. This team provide support with physical health and wellbeing to LYPFT service users, working alongside teams from other service lines. The Healthy Living service predominantly supports people while they are in hospital.

Our teams provide great care to our service users and we are proud of how we have innovated and adapted as a service.

A great example of innovation in our service is how we changed our approach to Clozapine titration during the pandemic and the introduction of our rough sleeper service. We also have strong partnerships in our city and benefit from working with organisations form the large and diverse third sector in Leeds. For example, our Early Intervention Psychosis service (EIP) is the only third sector-led EIP team in the country.

We know from recent work with our city partners that in Leeds we have more challenges with mental health compared to other places in England, and there are inequalities in mental health in our place:

- It is estimated that 106,000 people in Leeds experience a common mental health disorder.
- We know that one third of people in Leeds who get support from crisis services have not previously used mental health services, such as community mental health services.
- More people are admitted to hospital as a result of self-harm in Leeds, compared with the national average.
- Suicide and self-harm admission rates are higher in poorer areas of Leeds, with the highest suicide rates being in middle aged men and highest rates of self-harm in young women.
- Leeds has a higher rate of people subject to the mental health act compared to the England average.

We know there are challenges in our services that we must address to be able to sustainably provide great care

Like other community mental health services across the country, in Leeds we face a number of challenges within our services:

- Many people need to wait a long time to be seen after they are referred to community mental health services.

- Some people who seek support for their mental health and wellbeing are not able to access it due to referral criteria in many services; this often results in people 'falling through gaps' of different services.

- Staff retention, engagement and satisfaction is a challenge given capacity constraints in our workforce.

- We recognise that people who use our services have a range of needs, such as with their physical health, as well as their mental health and wellbeing needs. However at the moment, we aren't always able to meet people's holistic needs as our ways of working with our partners could improve to enable us to provide more integrated care.

- While we have done some work to improve service user involvement in our services (such as setting up a trauma informed service user reference group), we have more work to do to enable service users and carers to be meaningfully involved in co-production of community services.

- Our teams are often constrained by limited availability of clinical space, meaning that sometimes decisions around whether an appointment / clinical interactions is held remotely or in person are driven by estates constraints rather than clinical judgement.

- We expect demand for our community services to continue to grow, particularly in the aftermath of the Covid-19 pandemic.

We have an exciting opportunity to transform our services through Community Mental Health Transformation

While significant investment in community mental health services has historically been a challenge, the commitments set out in the NHS Long Term Plan (LTP) are an opportunity for us, and our partners, to transform community mental health care.

We are required to deliver on a number of Long Term Plan deliverables (see table below) and this work is being progressed through the Leeds Community Mental Health Transformation (CMHT) programme.

Our ambitions for CMHT in Leeds include:

- Fundamentally transforming the care offer for adults and older adults with a range of severe mental health /co-existing needs through new integrated models of care that enable timely access to high quality, evidence-based, joined-up care.

- Ensuring timely access and reduced waiting times to high quality, evidence-based treatment for adults & older adults with eating disorders, a diagnosis of 'personality disorder' or those in need of community-based mental health rehabilitation.

- The shared approach we are moving towards as a whole system in Leeds is shown in the diagram below (figure source: Leeds CMHT).
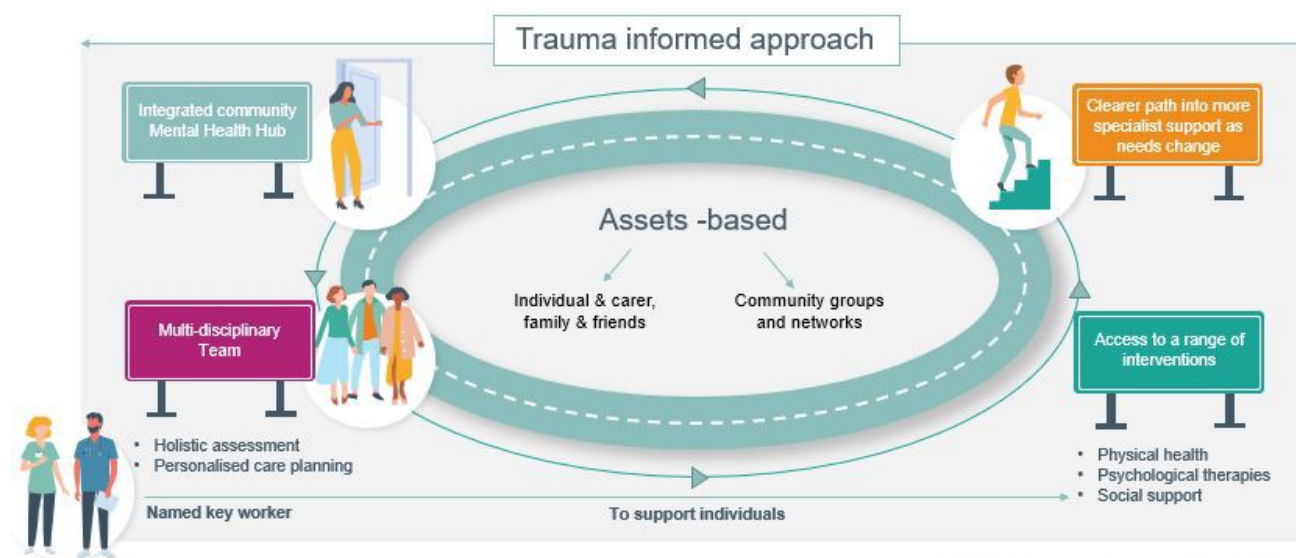
Transforming Community Mental Health in Leeds

Key deliverables in the NHS Long Term Plan by 2023/24				
Core community model	Transforming care for specific groups	Physical health	Individual Placement and Support	Early intervention in psychosis
A new multiagency community based offer, redesigning community mental health teams around Primary Care Networks through the establishment of integrated community mental health hubs.	Improving access and treatment for older adults and adults with: a diagnosis of personality disorder, in need of mental health rehabilitation, eating disorders.	Increasing the number of people with Serious mental illness (SMI) receiving a comprehensive physical health check.	Supporting more people to participate in the Individual Placement and Support Programme.	Maintaining the 60% Early Intervention in Psychosis access standard and ensuring 95% of services achieve Level 3 NICE concordance.

We have completed modelling to project the impact of this transformation on demand for our community services

The table on the next page outlines demand modelling for our community mental health services.

The data in the first six rows of the table show how demand for core community mental health services are expected to change following implementation of the Leeds CMHT ambitions. This data reflects our assumption that, in keeping the city-wide aspiration to move to an integrated model for community mental health care with primary care, third sector and local authority partners, LYPFT's community mental health expertise will support people in the community with the most complex and severe support needs. In line with the national and local strategic direction to move more care out of hospital settings, our aim is to be able to provide more intensive support to people in the community so that fewer people need to be admitted to hospital. Our assumption is that this investment in community care could reduce referrals to acute mental health services by around 40% and would provide a better experience and outcomes for service users and carers. We expect that our community mental health caseloads will remain broadly similar to our current caseloads, however the intensity of support we provide would increase.

The final row of the table, Community Eating Disorder Service, shows a new planned service, for which there is no historical or forecast data available. This change aims to address the challenge of unmet need for support with eating disorders in our local population. At present, around 500 referrals (annually) are not able to be accepted by our CONNECT service due to the referral criteria - this is a gap in provision. The introduction of a Community Eating Disorder Service aims to address this gap. If we assume that this community-based service would be able to take on 20% of the referrals that are not suitable for CONNECT, we can estimate that this service would have around 850 - 900 contacts per year (based on an average of 8 contacts per referral).

While this information gives us a view of the future demand for community services based on our strategic ambition and our current understanding of the potential impact of these, we recognise that over the next year, CMHT will be progressing detailed work to develop the approach and ways of working for our future integrated community mental health services.

We have completed modelling to project the impact of this transformation on demand for our community services

'Do nothing' and 'do something' modelling for adult community and wellbeing services

	Extrapolated contacts 2019[1,2]	Forecast range of 'do nothing' contacts 2028[2,3]	Forecast range of 'do something' contacts 2028[2,3]	Forecast range of 'do nothing' contacts 2036[2,3]	Forecast range of 'do something' contacts 2036[2,3]
CMHT Adult East	14,157	15,397 - 16,045	14,873 - 15,917	16,688 - 17,337	16,121 - 17,165
CMHT Adult North East	10,610	11,650 - 12,173	11,184 - 12,022	12,745 - 13,269	12,235 - 13,073
CMHT Adult North West	14,024	15,244 - 15,891	14,725 - 15,768	16,578 - 17,226	16,015 - 17,057
CMHT Adult South East	10,220	11,170 - 11,658	10,723 - 11,504	12,096 - 12,584	11,612 - 12,393
CMHT Adult South West	9,079	9,884 - 10,303	9,489 - 10,158	10,740 - 11,159	10,311 - 10,980
CMHT Adult West	10,449	11,362 - 11,836	10,976 - 11,739	12,385 - 12,859	11,964 - 12,727
ECT Service	849	991 - 1,010	991 - 1,010	1,123 - 1,142	1,123 - 1,142
Family Therapy	372	414 - 428	414 - 428	449 - 464	449 - 464
Healthy Living Team	4,789	5,444 - 5,574	5,444 - 5,574	6,135 - 6,266	6,135 - 6,266
Psychotherapy Medical	1,460	1,583 - 1,645	1,583 - 1,645	1,733 - 1,795	1,733 - 1,795
SALT	84 *(130 in 2021)*	146 - 151	146 - 151	169 - 174	169 - 174
Physical Health Mon + Imp	13,142	14,904 - 15,257	14,904 - 15,257	16,693 - 17,046	16,693 - 17,046
Community Eating Disorder Service					
Total	**89,235**	**98,187 - 101,971**	**95,451 - 101,172**	**107,536 - 111,320**	**104,561 - 110,282**

1   where a full year of data is not available for the calendar year, or where the data looks to contain anomalies, a shorter period has been taken and then extrapolated based on the number of months. E.g. if April - Dec was taken as the baseline period, this has been uplifted by 12/9. The appointments / contacts have then been calculated based on the displayed ratio against the extrapolated referrals

2   contacts include both attended and DNAs as both are relevant for forecasting future estate requirements.

3   Range based on no long-term recurrent impact of COVID ('best case') and 'intermediate 1' scenario which is based on some long-term recurrent impact of COVID (using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council). For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.

Transforming our community services will impact on the experiences of staff and people who use our services

While we have identified the impact of transforming community services in terms of demand for our services, ultimately this is about providing better, more joined up care to people who need support.

We know that we must change how community mental health services in our city work so that we are able to provide sustainable services that are safe, high quality, integrated and equitable.

The ambition we have set out for the Community and Wellbeing Service Line aims to deliver on our wider care services strategic priorities. However we will also aim to impact on outcomes that are specific to our services - will know we are achieving the right outcomes if:

- Service users and their carers are able to access timely, high quality and equitable mental health care and support in their local community.

- Staff working in our community mental health services feel valued, have opportunities to develop new skills and have career progression opportunities.

- People who use our services are meaningfully involved in decisions about their care and changes to community mental health services.

- People experience inclusive and accessible mental health care and support in Leeds.

- Everyone who needs mental health care and support in Leeds is able to access it.

- Fewer people experience acute mental health problems requiring crisis support or inpatient care in hospital.

- Inequalities in mental health outcomes in Leeds are reduced.

To bring to life the impact we hope to have on outcomes for people, we have included below a service user 'persona' with a short story of what their experience of community mental health support could look like in future, based on the ambition we have set out in this document.

> I had been feeling really stressed for a long time with lots going on at work and at home, and I didn't know who to talk to about it. I never wanted to bother my GP about these things. One day I went to my local leisure centre and noticed that a new wellbeing hub had opened right next door. At the reception area of the leisure centre I saw a poster with a QR code to a website about the wellbeing hub and saw that they run informal support groups for men. I was a bit skeptical as I'm not someone who's great at talking about their feelings but I tried it and have found it so helpful in understanding more about stress and how my body reacts to stress. I've recommended it to some friends and am now looking to get involved in running some of the group work myself.

Appendix C:
Children and Young People's Mental Health (CYPMH) Service Line Aspiration

We provide specialist mental health care and support to children and young people in Leeds, York and regionally

Our Children and Young People Mental Health Services (CYPMHS) teams provide specialist care and support children and young people with mental health problems.

Our CYPMH Service Line is made up of the following services:

CYPMHS inpatient for Humber, Coast and Vale (Mill Lodge):
Our team at Mill Lodge provide inpatient care to children and young people aged 13 -18 years old from Yorkshire and Humber.

CYPMHS inpatient for West Yorkshire (Red Kite View):
Our team at Red Kite View provide inpatient care to children and young people aged 13 - 18 years old living in West Yorkshire. We are the Lead Provider for inpatient CYPMHS in West Yorkshire and Red Kite View is a new unit. Our aim for Red Kite View is to provide inpatient care no more than 25 miles from people's home and we work closely with other CYPMHS teams across West Yorkshire to achieve this through delivering joined up care.

National Deaf CAMHS (NDCAMHS):
We support children and young people aged 0 -18 who have severe to profound hearing loss, have deaf parents, use BSL (British Sign Language) as their first language, experience emotional and/or behavioral issues with a rating of 50 or less on the Children's Global Assessment Scale [CGAS]. We are part of the northern arm of the National Deaf CAMHS service, commissioned by NHS England, with three teams based in York, Manchester and Newcastle.

As our CYPMH services are highly specialised, most of our service users will also receive care from our partner organisations, at different points in their care journey.

We know that in our region, there are challenges with mental health and wellbeing in the population of children and young people:

- 10% of the 250,000 people in Leeds who are under the age of 25 are likely to have a mental health problem or need support with their emotional wellbeing.

- Deaf children are 30 - 50% more likely to experience mental health problems than hearing children.

- 23% of deaf children are recorded as having an additional special educational need.

- The pandemic has had a major impact on children and young people, such as the disruption to education and lack of social interaction during the pandemic.

- Covid-19 restrictions have led to concerns regarding safeguarding and the disengagement of young people, particularly the most vulnerable.

- In 2021 almost 24% of children (under 16s) were estimated to live in poverty in Leeds, compared to 19% nationally.

- Although Leeds rates on indicators like child inpatient admissions for mental health conditions are below national averages, they have risen more sharply in the city in recent years.

We are proud of the great care we provide, however we recognise opportunities to make our services even better

We have identified areas where we face challenges in our CYPMH services and where we have opportunities to improve people's outcomes and experiences of care:

- We are facing significant demand pressures, particularly for our inpatient NG feeding service, in both Leeds and York. We are also seeing a consistent demand for inpatient beds.

- We are also aware of a current service gap for 18 - 25 year olds in both CYMPHS and Deaf CAMHS. The 'NHS Long Term Plan' commits to expanding services for 18 - 25 year olds and we recognise that we have a role to play in addressing this unmet demand.

- In January 2022 we opened Red Kite View, our new unit for inpatient children and young people mental health services. This is an opportunity for us to consider how we use space, such as activity rooms, creatively for therapeutic interventions.

- We have some challenges with the site at Mill Lodge - young people have fed back that some of the spaces are too small and there is a lack of outdoor space. There is no sensory room, which limits opportunities for therapeutic intervention.

- Our staff have shown great resilience through Covid-19 working under increased workloads and pressure and there are good examples of team working and a culture of support. However, we've heard our staff express a willingness for time and resources to be invested to enable them to attend training and skills development to support them in care delivery and their development.

- In our Deaf CAMHS service, currently there is an unequal balance of deaf and hearing staff in our service and we would like to address this balance and employ more people with lived experience.

Without change to our services, demand for CYPMH inpatient beds will increase in future

The 'do nothing' modelling outlined below shows how demand for our inpatient children and young people's services (measured through the number of beds required) and for National Deaf CAMHS (measured through the number of referrals and 'contacts') is projected to grow over the next fifteen years if we make no changes to our current services.

The data shows an upwards trajectory in bed requirements across all inpatient wards. The extent of the additional requirement is dependent on the potential long-term recurrent impact of Covid-19 (only 'best case' and 'intermediate 1' is shown here).

In interpreting the data it should be noted that Leeds CAMHS inpatient services have, until 2022, been provided in Little Woodhouse Hall, though these services have only been under LYPFT since 2021. Red Kite View opened in 2022 as a West Yorkshire ICS provision with 22 beds, although 6 of these are PICU beds.

Given that Red Kite View is an ICS offer, we are not comparing the current capacity with the forecast demand from Leeds inpatients alone, as there will be additional demand from elsewhere in the system and from service users who repatriated from out of area.

This modelling assumes, therefore, that the bed base identified to support the build and set-up of Red Kite View will be sufficient to meet demand going forward.

For Mill Lodge, however, the modelling shows a projected gap between demand for inpatient beds and current capacity to meet this demand.

For National Deaf CAMHS, the number of referrals to the service is forecasted to increase however the number of contacts are not.

Without change to our services, demand for CYPMH inpatient beds will increase in future

'Do something' modelling for adult acute inpatient services and out of hospital services

CYP inpatient services	Beds available in 2019	Beds used in 2019 (occupancy)[3]	Required beds per year (assuming 85% occupancy) 2028[1]		Required beds per year (assuming 85% occupancy) 2036[1]		Planned bed capacity
			Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact)[2]	Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact)[2]	
Leeds CAMHS Inpatients	6*	5* (81%)	10	11	10	11	16 (excl. 6 PICU beds)
CAMHS Inpatients York	15	11 (71%)	15	17	16	17	12
Total	**21**	**16**	**25**	**28**	**26**	**28**	**28 (excl. 6 PICU beds)**

National Deaf CAMHS	Assumed ratio of referrals to contacts	Extrapolated # referrals 2019[4]	Extrapolated # contacts 2019[4,5]	# forecast referrals 2028	# forecast contacts 2028[5]	# forecast referrals 2036	# forecast contacts 2036[5]
National Deaf CAMHS Service (best case)	15.4	101 (151 in 2021)	2,473 (2,325 in 2021)	154	2,378	148	2,275
National Deaf CAMHS Service ('intermediate 1' case)[2]	15.4	101 (151 in 2021)	2,473 (2,325 in 2021)	154	2,383	148	2,290

1 Assumes future occupancy rate of 85%-90% (90% used if 2019 value was >90%, 85% used if 2019 value was <85%). Bed numbers are rounded up to the nearest whole number.

2 Based on estimation using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council, the 'Best case' scenario assumes no long-term recurrent impact of COVID and the 'Intermediate 1' scenario applies some long-term recurrent impact of COVID. For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.

3 2021 value used for Leeds CAMHS inpatients.

4 where a full year of data is not available for the calendar year, or where the data looks to contain anomalies, a shorter period has been taken and then extrapolated based on the number of months. E.g. if April - Dec was taken as the baseline period, this has been uplifted by 12/9. The appointments / contacts have then been calculated based on the displayed ratio against the extrapolated referrals.

5 contacts include both attended and DNAs as both are relevant for forecasting future estate requirements.

We have identified service changes that will improve outcomes for service users and enable us to meet demand

The key strategic changes we will make to our CYPMH services are to:

Introduce a 'day care' facility in both Mill Lodge and Red Kite View to provide an NG feeding service for children and young people with eating disorders who require this intervention and do not otherwise need to be in hospital.

Expand our National Deaf CAMHS service to people aged 18 - 25 in order to provide continuity of care for young people as they transition to adulthood.

The modelling shown below outlines the projected impact of these changes on demand for inpatient care (in Mill Lodge and Red Kite View) and for NDCAMHS.

Based on evidence from an NG feeding day service model in Maudsley Hospital, in York there could be around 20 service users per year who would benefit from a 6-week NG feeding 'day care' intervention. This would reduce length of stay in Mill Lodge by about 30%.

The facility will aim to avoid inpatient admission and/or reduce length of stay, enabling people to remain at home for longer. Our team in Mill Lodge are already implementing this intervention, reducing the number of inpatient beds in the unit from 15 to 12 beds to introduce the service. The modelling projects that this initiative would mean that the existing bed base in Mill Lodge is sufficient until 2036. This scenario assumes an average length of stay of ~80 days (based on the 2018 and 2020 values) rather than ~95 days seen in 2019.

For Red Kite View, demand for an NG day service will be larger than it is for York, in proportion to the size of the population (c. 5-6x larger). We will aim to continue with our existing bed base, as shown in the table.

Expansion of our NDCAMHS service to 18 - 25 year olds is estimated to lead to a ~25% increase in referrals. It is assumed that expansion of the service will come with investment to enable provision for this increased demand.

We have identified service changes that will improve outcomes for service users and enable us to meet demand

'Do something' modelling for Children and Young People inpatient services and National Deaf CAMHS

CYP inpatient services	Beds available in 2019	Beds used in 2019 (occupancy)	Required beds per year (assuming 85% occupancy for Leeds, 90% for York) 2028[1]		Required beds per year (assuming 85% occupancy for Leeds, 90% for York) 2036[1]		Planned bed capacity
			Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact)[2]	Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact)[2]	
Leeds CAMHS Inpatients	6[3]	5[3] (81%)	10	11	10	11	16 (excl. 6 PICU beds)
CAMHS Inpatients York	15	11 (71%)	11	12	11	12	12
Total	**21**	**16**	**21**	**23**	**21**	**23**	**28 (excl. 6 PICU beds)**

National Deaf CAMHS	Assumed ratio of referrals to contacts	Extrapolated # referrals 2019[4]	Extrapolated # contacts 2019[4,5]	'Do something' ratio of referrals to contacts	Forecast 'do something' capacity required 2028	Forecast 'do something' capacity required 2036
National Deaf CAMHS Service (best case)	15.4	101 (151 in 2021)	2,473 (2,325 in 2021)	15.4	2,973 (+28%)	2,856 (+23%)
National Deaf CAMHS Service ('intermediate 1' case)[2]	15.4	101 (151 in 2021)	2,473 (2,325 in 2021)	15.4	2,978 (+28%)	2,861 (+23%)

1 Assumes future occupancy rate of 85%-90% (90% used if 2019 value was >90%, 85% used if 2019 value was <85%). Bed numbers are rounded up to the nearest whole number.

2 Based on estimation using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council, the 'Best case' scenario assumes no long-term recurrent impact of COVID and the 'Intermediate 1' scenario applies some long-term recurrent impact of COVID. For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.

3 2021 value used for Leeds CAMHS inpatients.

4 where a full year of data is not available for the calendar year, or where the data looks to contain anomalies, a shorter period has been taken and then extrapolated based on the number of months. E.g. if April - Dec was taken as the baseline period, this has been uplifted by 12/9. The appointments / contacts have then been calculated based on the displayed ratio against the extrapolated referrals.

5 contacts include both attended and DNAs as both are relevant for forecasting future estate requirements.

These changes will have an impact on the experiences of staff and children and young people who use our services

We are proud of the services we provide and are committed to continuing to provide safe, high quality and equitable care. In addition to the strategic changes we have already set out, we will seek to work with our partners to further integrate our services to provide more joined up care across CYPMH care pathways. We will also aim to support our staff in their development and their careers to support the sustainability of our workforce.

The ambition we have set out for our CYPMH services aims to deliver on our care services strategic priorities to:

- Co-create and co-deliver care services with people who have lived experience;
- Collaborate with our partners to understand our populations and provide proactive integrated care; and
- Provide high quality, equitable and sustainable care services.

However we will also aim to impact on outcomes that are specific to our services - will know we are achieving the right outcomes if:

- Children and young people who use our services experience truly joined up care and may not be aware of organisational boundaries when interacting with care services in our system.
- Children and young people who use our services are supported in locations close to their homes or in their own homes.
- We have no CYPMHS out of area placements.
- Children and young people who have experience of our services are meaningfully involved in co-designing our services.
- Our services are inclusive and accessible.
- Children and young people are able to regularly provide feedback on their experiences of our care services using simple, digitally-enabled and efficient methods.
- We influence prevention activity and investment to support young people in our place by working with partners on population health management.
- Young people have opportunities to take on peer support roles in our service.
- Our staff working in CYPMHS have career progression opportunities, feel valued and staff retention improves.

To bring to life the impact we hope to have on outcomes for people, we have included below a service user 'persona' with a short story of what their care journey could look like in future, based on the ambition we have set out in this document.

My name is Cecilia, I'm 14 and I've got an eating disorder. I recently got very ill and had to go into hospital for help with feeding and stabilising my weight. I had been in hospital before and found it quite difficult to go home and get back to school last time because I felt so far behind and I was worried about what people at school would think. This time, after a couple of days in hospital the team spoke to me and my mum about the option of coming into the hospital just during the daytime for the feeding support until I got better. I wasn't sure about it at first but decided to try it and I did get better. I was able to work with the psychologist, which helped, and they recommended some apps that I'm now using most days to try to monitor and manage my emotions.

Appendix D:
Eating Disorders, Rehabilitation and Gender Identity Service Line Aspiration

Our ED, Rehab and GI services provide specialist support to people in Leeds, West Yorkshire and in our region

Our eating disorders, rehabilitation and recovery, and gender identity services (ED, Rehab and GI) Service Line is made up of the following services:

CONNECT (West Yorkshire Adult Eating Disorders Service):
We are the Lead Provider for Adult Eating Disorders in the North East and Yorkshire region and our CONNECT service is made up of the community and outreach service and the Yorkshire centre for eating disorders inpatient service at the Newsam centre.

Rehabilitation and Recovery Inpatient Services:
Our two rehabilitation and recovery inpatient units (at Asket Croft and Asket House) provide assessment and individualised care packages to people with long-term mental health conditions to support them to live independently and confidently as possible.

CREST (Community Rehabilitation Enhanced support team):
Established in 2021, CREST is our new community mental health service supporting people to transition from out of area locked rehabilitation back into the community.

Locked Rehabilitation Service:
Our locked rehabilitation service provides inpatient care and support to people, aiming to work with people to reduce risk to themselves or others and support them to increase their independence.

Gender Identity Service:
Our gender identity service offers assessment, support and a prescribing service to people aged 17 and over with Gender Dysphoria.

Our ED, Rehab and GI Service Line is made up of different specialist services that respond to different service user needs and support people from different geographies. People who use our ED, Rehab and GI may also get support from other (LYPFT or partner) services, depending on their care and support needs.

Sometimes this means that our services can be one part of a person's overall care journey - this is particularly important for some of our rehabilitation and recovery services, which support people with transitioning from acute care and support people moving from inpatient care to living more independently in the community.

It is important to us to work closely with partners in our place, Integrated Care System (ICS) and region to make any transitions of care and support as smooth as possible for service users.

We are proud of the services we provide, however we recognise some challenges and areas for improvement

We provide great care and support to our service users and are proud of the services we provide, some of which have been recognised and celebrated nationally:

- Our CONNECT service for adult eating disorders received an NHS Parliamentary Award for innovative care delivery. CONNECT is a relatively new care model and has already shifted more care from inpatient settings into the community, enabling more people to be able to receive care closer to their homes.
- Our rehabilitation services teams provide great care and have recently been involved with a research project on improving service user experience.
- People who use our gender identity services report positive experiences with the service.

However we know that in all of our services within the ED, Rehab and GI Service Line, there are some challenges that we must overcome to provide even better care and support:

- There are around 500 referrals to our CONNECT service that we are not able to accept - we think this reflects a current gap in community-based support for people with eating disorders that should be addressed.
- Some of our CONNECT service users find it difficult to access some of our community-based services due to the location of them (e.g. they may be required to travel across West Yorkshire to Halifax to access the service).
- Our inpatient eating disorder beds (Yorkshire Centre for Eating Disorders, YCED), our locked rehabilitation unit and our gender identity service team are based in the Newsam Centre. Newsam is used for multiple services and the current mix of services based at the centre isn't clinically preferable and has an impact on service user experience. This is particularly important for our gender identity service as we recognise that gender identity is not a mental health disorder and are moving away from this approach.
- Our locked rehabilitation service is a traditional and unsustainable model of care and the environment is not conducive to recovery. Some of our rehab services (Asket Croft, Asket House and Assertive Outreach) are currently under review.
- Demand for our gender identity services is increasing - in February 2022 we had 3,358 people on our waiting list. This increase in demand for gender identity services is a national trend and there are pilots of new gender identity collaborative models currently underway across the country.

Without change, demand for our inpatient ED and Rehab services is set to increase beyond our current capacity

We have completed modelling to understand how demand for our ED, Rehab and GI services is expected to change in future.

The modelling outlined below ('do nothing' modelling) shows how demand for inpatient services within our ED, Rehab and GI Service Line, measured through the number of beds required, is projected to grow over the next fifteen years if we make no changes to these services.

It is clear from the data that if we 'do nothing', there is an upwards trajectory in bed requirements across all of our inpatient rehabilitation wards and our YCED.

The extent of the additional requirement is dependent on the potential long-term recurrent impact of COVID (only 'best case' and 'intermediate 1' shown here).

With an assumption of 85 - 90% occupancy as an operational target, **by 2028 in the 'best case' we would have a deficit of 8 beds**, rising to 14 beds in 2036. In the 'intermediate 1' scenario, our deficit would be 11 beds, rising to 17 in 2036.

For our community based and outpatient services, demand (measured through activity/contact), is also set to increase across all areas by 2028 and 2036.

'Do nothing' modelling for our eating disorders, rehabilitation and gender identity services

Inpatient services	Beds available in 2019	Beds used in 2019 (occupancy)	Required beds per year (assuming 85-90% occupancy) 2028[1]		Required beds per year (assuming 85-90% occupancy) 2036[1]		Planned bed capacity
			Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact)[2]	Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact)[2]	
Asket Croft	20	19 (96%)	24	25	26	27	20
Asket House	16	14 (89%)	17	18	19	19	15
Newsam Ward 5	17	15 (85%)	19	20	20	21	18
YCED	19	11 (59%)	15	15	16	17	14
Total	**72**	**60**	**75**	**78**	**81**	**84**	**67**

Community / outpatient	Extrapolated contacts 2019[3,4]	Forecast range of 'do nothing' contacts 2036[4,5]	Forecast range of 'do nothing' contacts 2036[4,5]
CONNECT	2,391 (8,143 in 2021)	8,729 - 8,997	9,536 - 9,804
Assertive Outreach	11,898	12,996 - 13,446	14,087 - 14,537
CREST	0 (722 in 2021)	793 - 819	845 - 872
Gender Identity	10,984	11,181	11,268
Recovery Centre	3,609	3,927 - 4,077	4,263 - 4,413
Total	**28,822**	**37,625 - 38,519**	**39,999 - 40,893**

1 Assumes future occupancy rate of 85%-90% (90% used if 2019 value was >90%, 85% used if 2019 value was <85%). Bed numbers are rounded up to the nearest whole number.

2 Based on estimation using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council, the 'Best case' scenario assumes no long-term recurrent impact of COVID and the 'Intermediate 1' scenario applies some long-term recurrent impact of COVID. For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.

3 where a full year of data is not available for the calendar year, or where the data looks to contain anomalies, a shorter period has been taken and then extrapolated based on the number of months. E.g. if April - Dec was taken as the baseline period, this has been uplifted by 12/9. The appointments / contacts have then been calculated based on the displayed ratio against the extrapolated referrals.

4 contacts include both attended and DNAs as both are relevant for forecasting future estate requirements.

5 Range based on 'best case' and 'intermediate 1' scenarios.

We will make strategic changes to our services to improve care and enable us to meet future demand

To address the challenges we are facing now and set our services up for the future, we must make changes. We have identified a set of key changes to our eating disorders, rehabilitation and gender identity services, shown below.

In developing these, we have considered the overarching strategic priorities for care services:

- We co-create and co-deliver care services with people who have lived experience
- We collaborate with our partners to understand our populations and provide proactive integrated care
- We provide high quality, equitable and sustainable care services

The diagram below highlights how the changes we will make to our eating disorders, rehabilitation and gender identity services align with these priorities.

In identifying the key changes for acute care, we have also considered the strategic direction of our local Integrated Care Systems as well as relevant national policy - our future services must align to the 'left shift' agenda set out in the *NHS Long Term Plan*, moving more care into the community and focusing on early intervention and prevention.

In line with this national direction, our ambition for eating disorders and rehabilitation services are to support more people to be cared for in the community for as long as possible. We recognise that gender identity is not a mental health disorder and are moving away from this approach in line with the direction for gender identity services nationally.

Change	Rationale and benefits	Priority alignment
Introduce a community eating disorders service to support people who do not meet referral criteria for CONNECT	This will address currently unmet need by providing a service that is suitable for some of the 500 annual referrals to CONNECT that are not able to be accepted. As this is a community-based service, this will lead to more community contacts and it is also likely to lead to reduced inpatient admissions and average length of stay (ALoS) for our inpatient eating disorders service.	We co-create and co-deliver care services with people who have lived experience
Replace our Recovery Centre with an enhanced community rehabilitation offer Establish a system-wide 'quality of life' complex care facility and women's Personality Disorder (PD) safe house facility Enhance our Assertive Outreach offer	The changes to our rehabilitation services will aim to shift to a social recovery model, with more care in the community, active rehab services and rehab as early intervention. We expect this will have an impact on: • Admissions to Asket Croft / House, which will likely reduce • ALoS at Asket Croft / House, which will likely decrease • Community referrals / contacts, which will increase • ALoS at Newsam Ward 5, which will decrease • Potentially acute inpatient admissions, which would decrease	We collaborate with our partners to understand our populations and provide proactive integrated care
Move to a 'two tier' gender identity service (with increased role of primary care and third sector partners to support with less complex cases with LYPFT providing support to people with more complex support needs)	Moving to a 'two tier' model for gender identity services will aim to increase overall capacity to respond to increasing waiting lists and referrals. This is unlikely to have a significant impact on LYPFT's activity however it may reduce our waiting list in future as more people waiting for support are able to be supported by primary care. We will also continue to embed peer support workers in our service.	We provide high quality, equitable and sustainable care services

This will enable us to provide better care to our service users and meet future demand for our inpatient services

We have looked at how the changes we have identified may impact the projected demand for our services over the next fifteen years and what this means for our capacity.

Significant work has been undertaken through the rehabilitation and recovery service review to identify the 'optimum' service model going forward in order to align with recommended national guidelines, improve service user experience and optimise use of space and resource. The review has identified the need for an integrated community rehabilitation team that provides extensive support to divert and prevent admissions, and also to facilitate early discharge. Through this provision and associated reduced admissions and length of stay, we expect that we can significantly reduce our bed base across Asket Croft and Asket House to a total of 24.

However, should we do this, we will need to undertake work at Asket House and Asket Croft to ensure we have sufficient therapeutic space, consideration given to trauma-informed design, availability of appropriate gender separation of inpatient beds, and availability of clinical space for psychologists / psychiatrists.

We are also considering setting up a 'quality of life' complex care facility, a residence for service users who may otherwise remain in Asket Croft, Asket House or Newsam Ward 5 over the very long-term. We expect that this initiative could lead to a reduced length of stay in these wards. This could give us capacity to use Newsam Ward 5 as a regional centre for locked rehabilitation beds in future.

For the Yorkshire Centre for Eating Disorders (inpatient ward), based on the historical underuse of beds and financial modelling, it is not anticipated that the current bed base of 14 would be expected to justify an increase. Though the forecast future demand could push the bed requirements to c.16 beds, it is hoped that, via the implementation of the community eating disorder team and its impact on reducing admissions and length of stay, the current bed base is sufficient going forward.

Based on this modelling, we expect to plan our bed capacity in line with the data in the 'Planned bed capacity' column in the table below.

'Do something' modelling for our inpatient eating disorders and rehabilitation services

	Beds available in 2019	Beds used in 2019 (occupancy)	Required beds per year (assuming 85-90% occupancy) 2028[1]		Required beds per year (assuming 85-90% occupancy) 2036[1]		Planned bed capacity
			Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact)[2]	Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact)[2]	
Asket Croft	20	19 (96%)					20
Asket House	16	14 (89%)					4
Newsam Ward 5	17	15 (85%)					18
YCED (assuming 90% occupancy)	19	11 (59%)	14	15	16	16	14
Total	**72**	**60**	**55**	**57**	**60**	**63**	**56**

1 Assumes future occupancy rate of 85%-90% (90% used if 2019 value was >90%, 85% used if 2019 value was <85%). Bed numbers are rounded up to the nearest whole number.

2 Based on estimation using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council, the 'Best case' scenario assumes no long-term recurrent impact of COVID and the 'Intermediate 1' scenario applies some long-term recurrent impact of COVID. For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.

These changes will lead to an increase in activity in some of our community-based services

Given that most of the changes to our services are in line with the national 'left shift' agenda to move more care out of hospital settings, we can expect an increase in many of our community-based services and this is reflected in the 'do something' modelling.

The rows in the table below highlighted in blue (Assertive Outreach, Gender Identity and Recovery Centre) show the areas where changes we will make impact the 'do something' forecasts.

For Assertive Outreach (AO), our ambition to enhance the skill mix in our workforce (e.g. to include psychology, peer support, OT and nurse leadership, physical health, substance misuse, housing) should provide more intensive and targeted support for service

users. It is difficult to predict whether this would increase the number of contacts within Assertive Outreach, however it is possible that this would lead to a reduced length of stay for AO service users who need inpatient care as part of their care pathway.

For Gender Identity Services - it is unlikely that the current gender identity secondary care provision will grow. However, the waiting list currently stands at >3,000 people with c.100-120 referrals per week vs. c. 45 new appointments - hence the current capacity is insufficient by c. 50%-60%. As such, primary care and the third sector are expected to need to support the set-up of a two-tier service, supporting provision for this currently unmet demand.

The row in the table highlighted in purple (Community Rehab) shows where we have a new planned service - historical or forecast data is not available as this will be a new service. The introduction of a Community Rehab Team will aim to replace our existing Recovery Centre with dedicated community rehabilitation services in line with NICE and commissioner guidance, as well as national specifications for rehabilitation and recovery. Our ambition is for this service to be staffed with around 28 FTE and with this workforce we expect to have capacity for around 500 - 600 contacts per week.

'Do something' modelling for our community / outpatient ED, Rehab and GI services

Community / outpatient services	Extrapolated contacts 2019[1,2]	Forecast range of 'do nothing' contacts 2028[2,3]	Forecast range of 'do something' contacts 2028[2,3]	Forecast range of 'do nothing' contacts 2036[2,3]	Forecast range of 'do something' contacts 2036[2,3]
CONNECT	2,391 (8,143 in 2021)	8,729 - 8,997	8,729 - 8,997	9,536 - 9,804	9,536 - 9,804
Assertive Outreach	11,898	12,996 - 13,446	12,996 - 13,446	14,087 - 14,537	14,087 - 14,537
CREST	0 (722 in 2021)	793 - 819	793 - 819	845 - 872	845 - 872
Gender Identity	10,984	11,181	11,181	11,268	11,268
Recovery Centre	3,609	3,927 - 4,077	-	4,263 - 4,413	-
Community Rehab					
Total	28,822	37,625 - 38,519	33,699 - 34,442	39,999 - 40,893	35,736 - 36,480

1 where a full year of data is not available for the calendar year, or where the data looks to contain anomalies, a shorter period has been taken and then extrapolated based on the number of months. E.g. if April - Dec was taken as the baseline period, this has been uplifted by 12/9. The appointments / contacts have then been calculated based on the displayed ratio against the extrapolated referrals.

2 contacts include both attended and DNAs as both are relevant for forecasting future estate requirements.

3 Range based on no long-term recurrent impact of COVID ('best case') and 'intermediate 1' scenario which is based on some long-term recurrent impact of COVID (using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council).

The changes we make will have an impact on the experiences of our staff and people who use our services

We are committed to continuing to provide safe, high quality and equitable care. The strategic changes we have set out in this document will help us to continue providing great care and support to our service users.

We know that without making these changes, there is a risk that we will not be able to meet future demand for inpatient care and these services will not be sustainable.

The ambition we have set out for our ED, Rehab and GI Service Line aims to deliver on our wider care services strategic priorities. However we will also aim to impact on outcomes that are more specific to our services - will know we are achieving the right outcomes if:

- Service users and their carers are able to access timely, high quality and equitable care and support that meets their needs.
- Service users are empowered to live independent and fulfilling lives as close to home as possible.
- The waiting list for our gender identity service improves.
- Our services are provided by a capable, supported and diverse multidisciplinary workforce.
- We have zero out of area placements for complex rehab.
- Our staff have career progression opportunities, feel valued and staff retention improves.

To bring to life the impact we hope to have on outcomes for people, we have included below a service user 'persona' with a short story of what their care journey could look like in future, based on the ambition we have set out in this document.

My name is Alex and I'm a carer for my brother, Jo, who has schizophrenia. Jo has had some ups and downs in the past year, and has needed to go into hospital a few times. While this has been hard at times, what has been positive is how proactive and flexible the rehab team have been in terms of Jo's care and support. It's been great that Jo has a consistent key contact for support in the rehab team who is able to see him at home or in the recovery centre. They have been able to talk us through options for Jo's care including ways for us to get more support at home when Jo hasn't been so well to avoid another hospital admission.

Appendix E:
Forensic Service Line Aspiration

We provide low secure forensic services in Leeds and York alongside our Integrated Care System partners

Our forensic services teams provide care and support to people with mental health problems who require treatment in a secure setting.

Our Forensic Service Line is made up of the following services:

Low Secure Forensics Service in Leeds:

Our forensic team based in Leeds work with service users on pathways from medium secure, adult mental health services and transfer from prison. Our inpatient services in Leeds are at the Newsam Centre. We also have a community outreach support service in Leeds. Our Leeds forensic services are part of the West Yorkshire Adult Secure Provider Collaborative, led by South West Yorkshire Partnership Foundation Trust. This is a relatively new partnership made up of the five organisations providing secure care within the West Yorkshire footprint.

Low Secure Forensics Service in York:

We also provide low secure adult inpatient mental health services in York at Clifton House, as well as community forensic services and a court assessment and probation liaison service. Our York-based forensic services are part of the Humber Coast and Vale Provider Collaborative.

We know from recent work with the West Yorkshire Provider Collaborative that in West Yorkshire:

- There are inequalities in the length of stay for females, with there being a greater variation in length of stay for females than males.

- There is a variation across providers in the length of stay for males in low secure units.

- There is a greater proportion of people from ethnic minority backgrounds in secure services across West Yorkshire than the national average. Overrepresentation is seen particularly with men of black or asian ethnicity.

- Females between the ages of 30 to 39 are the most overrepresented when it comes to admission age.

Sources: West Yorkshire and Harrogate (WY&H) Adult Secure Services Business and Clinical Case for the Lead Provider model.

Care Services Strategic Plan - 2023 - 2033   **P86**

We provide great care to our service users however we recognise challenges in our services that we must address

We have identified areas where we face challenges in our forensic services and where we have opportunities to improve people's outcomes and experiences of care:

- Across the service we are seeing increasing acuity with challenging behaviours which with our current resources, is difficult to respond to and placing a pressure on staff and the environment. Rising acuity alongside rising demand is partially leading to out of area placements. It is important for us now work together across the Provider Collaborative to take a long term view and transform our services so we are set up to respond to future demand while continuing to provide high quality care.

- Delays in transfer or discharge are often a challenge for our services. This means that people sometimes end up in hospital, or other settings, longer than they need to be. One of the reasons behind this is the complexity of forensic care pathways - there are often multiple transition or transfer points for people between different services, and the flow across these isn't well joined up at present. We also often do complex discharge planning that requires work and coordination by multiple professionals, which often takes time. Timely access to support on discharge (e.g. supported housing, community forensic mental health support) also leads to longer admissions.

- There are challenges in the environments of both of our low secure sites, which limits our ability to deliver high quality services. In Clifton House, except for seclusion, our estates are fit for purpose and have a good environment. The Newsam centre has multiple mental health services in addition to forensics. There is a lack of outdoor green space, limited access to quality seclusion facilities and not enough therapeutic space or shared space for group therapy work.

Without change, demand for our low secure inpatient units is set to increase beyond our capacity to respond

We have completed modelling to understand how demand for our services is expected to change in future.

The 'do nothing' modelling outlined in the table shows how demand for our inpatient services (measured through the number of beds required) and for our community services (measured through number of contacts) is projected to grow over the next fifteen years if we make no changes to our current services.

It is clear from the data that if we 'do nothing', there is an upwards trajectory in bed requirements across all of our forensic inpatient wards.

The extent of the additional bed requirement is dependent on the potential long-term recurrent impact of COVID (only 'best case' and 'intermediate 1' shown here)(1). With an assumption of 85 - 90% occupancy as an operational target, **by 2028 in the 'best case' we would have a deficit of 9 beds**, rising to 11 beds in 2036 - this includes a **significant deficit for Newsam Ward 2 (6 beds)** in 2036. In the 'intermediate 1' scenario[1], our deficit would be 10 beds, rising to 16 in 2036 - this includes a significant deficit for Newsam Ward 2 (7 beds) in 2036.

For our community based forensic services, demand is also set to increase by 2028 and 2036.

'Do nothing' modelling for forensic inpatient and community services

Inpatient services	Beds available in 2019	Beds used in 2019 (occupancy)	Required beds per year (assuming 85-90% occupancy) 2028[2]		Required beds per year (assuming 85-90% occupancy) 2036[2]		Planned bed capacity
			Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact)[1]	Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact)[1]	
Newsam Ward 2	12	12 (99%)	17	18	18	19	12
Newsam Ward 2 - Women's	11	10 (86%)	13	13	13	14	11
Newsam Ward 3	14	14 (100%)	16	16	17	18	14
Bluebell Ward	10	7 (71%)	8	8	8	9	10
Riverfields	10	6 (61%)	11	11	11	11	10
Westerdale	12	10 (81%)	13	13	13	14	12
Total	**69**	**58**	**78**	**79**	**80**	**85**	**69**

Community services	Extrapolated contacts 2019[3,4]	Forecast range of 'do nothing' contacts 2028[4,5]	Forecast range of 'do nothing' contacts 2036[4,5]
Community Forensics Team Leeds	2,901	3,224 - 3,367	3,481 - 3,623
Community Forensics Team York	1,047	1,107 - 1,152	1,159 - 1,205
Court & Approved Premises	589	615 - 640	647 - 671
Forensic AHP	1	1	1
Forensic Psychology	2,848	3,143 - 3,283	3,370 - 3,510
Total	**7,386**	**8,090 - 8,443**	**8,658 - 9,011**

1 Based on estimation using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council, the 'Best case' scenario assumes no long-term recurrent impact of COVID and the 'Intermediate 1' scenario applies some long-term recurrent impact of COVID. For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.

2 Assumes future occupancy rate of 85%-90% (90% used if 2019 value was >90%, 85% used if 2019 value was <85%). Bed numbers are rounded up to the nearest whole number.

3 Where a full year of data is not available for the calendar year, or where the data looks to contain anomalies, a shorter period has been taken and then extrapolated based on the number of months. E.g. if April - Dec was taken as the baseline period, this has been uplifted by 12/9. The appointments / contacts have then been calculated based on the displayed ratio against the extrapolated referrals.

4 Contacts include both attended and DNAs as both are relevant for forecasting future estate requirements.

5 Range based on 'best case' and 'intermediate 1' scenarios.

We will make strategic changes to our forensic services to improve care and enable us to meet future demand

To address the challenges we are facing now and set our services up for the future, we must make changes so that we can provide better care to people who use our services. We have identified a set of key changes to our forensic services, shown in the table below.

In developing these, we have considered the overarching strategic priorities for LYPFT care services, however we have also recognised that there are limits on the decisions we can make about our services without working through the provider collaboratives.

In identifying the key changes for our low secure services, we have also considered the strategic direction of our local Integrated Care Systems as well as relevant national policy - our future services must align to the 'left shift' agenda set out in the NHS Long Term Plan, moving more care into the community and focusing on early intervention and prevention.

Our priorities for care services are:

- We co-create and co-deliver care services with people who have lived experience
- We collaborate with our partners to understand our populations and provide proactive integrated care
- We provide high quality, equitable and sustainable care services

The diagram below shows the changes we will make to our forensic services and they align with these priorities.

Change	Rationale and benefits	Priority alignment
Expand our community forensics services	This change aims to improve flow out of inpatient based care and enable people to be able to continue their recovery at home with support from community teams. We expect this could reduce average length of stay (ALoS) on inpatient forensic wards.	We co-create and co-deliver care services with people who have lived experience
Review / redesign inpatient pathways with aim to reduce delayed transfers of care and discharges	This change aims to improve ways of working between providers across pathways of care to reduce delayed transfers of care. This will mean that more people are supported in the right environment for their care needs.	We collaborate with our partners to understand our populations and provide proactive integrated care
Integrate and expand our Forensics Psychology service into the community when patients are discharged	We will aim to make our Forensic Psychology service more integrated so that rather than focusing solely on in-reach provision to service users in inpatient facilities, we will expand this service out into the community to support service users upon their reintegration into wider society and provide the continuity of care.	We provide high quality, equitable and sustainable care services

We have looked at how the changes we've identified will impact the projected demand for our services in future

'Do something' modelling for forensic inpatient and community services

Inpatient services	Beds available in 2019	Beds used in 2019 (occupancy)	Required beds per year (assuming 85-90% occupancy) 2028[1]		Required beds per year (assuming 85-90% occupancy) 2036[1]		Planned bed capacity
			Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact)[2]	Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact)[2]	
Newsam Ward 2	12	12 (99%)	11	12	12	12	12
Newsam Ward 2 - Women's	11	10 (88%)	8	9	9	9	11
Newsam Ward 3	14	14 (100%)	10	11	11	12	14
Bluebell Ward	10	7 (71%)	5 (7)	6 (8)	6 (8)	6 (8)	10
Riverfields	10	6 (61%)	7 (10)	7 (10)	6 (8)	8 (10)	10
Westerdale	12	10 (81%)	8 (11)	9 (12)	9 (12)	9 (12)	12
Total	**69**	**58**	**49 (57)**	**54 (62)**	**54 (62)**	**56 (63)**	**69**

Community services	Extrapolated contacts 2019[3,4]	Forecast range of 'do nothing' contacts 2028[4,5]	Forecast range of 'do something' contacts 2028[4,5]	Forecast range of 'do nothing' contacts 2036[4,5]	Forecast range of 'do something' contacts 2036[4,5]
Community Forensics Team Leeds	2,901	3,224 - 3,367	3,869 - 4,040	3,481 - 3,623	4,177 - 4,348
Community Forensics Team York	1,047	1,107 - 1,152	1,328 - 1,383	1,159 - 1,205	1,391 - 1,446
Court & Approved Premises	589	615 - 640	615 - 640	647 - 671	647 - 671
Forensic AHP	1	1	1	1	1
Forensic Psychology	2,848	3,143 - 3,283	3,263 - 3,408	3,370 - 3,510	3,498 - 3,643
Total	**7,386**	**8,090 - 8,443**	**9,076 - 9,471**	**8,658 - 9,011**	**9,714 - 10,110**

The 'Inpatient services' table below shows the bed requirement forecast for forensic services in a 'do something' scenario, whereby we assume a minimum reduction in average length of stay (ALoS) of around 35% enabled by the following changes: review and redesign of the inpatient pathway, enhanced community forensic service provision and more timely transfers of care between low and medium secure through pathway development work with the provider collaboratives.

If we are able to achieve this, we expect that we will be able to meet the future demand with our current bed base. In fact, the modelling has found that for Clifton House, the current bed base would be sufficient with an improvement of ALoS of just 10%.

The rows in the 'Community services' table below highlighted in blue (Community Forensics Team Leeds, Community Forensics Team York and Forensic Psychology) show the areas where changes we will make impact the 'do something' forecasts. Our ambition is to provide more forensic care and support in the community, likely through a more intensive service. The 'do something' view of the future reflects this with an increase in the number of contacts per service user - this is assumed to be around 20% over and above the forecast service growth by 2028. Our ambition to integrate and expand our Forensic Psychology service assumes an increase in service activity in line with an average of two contacts per service user.

1 Assumes future occupancy rate of 85%-90% (90% used if 2019 value was >90%, 85% used if 2019 value was <85%). Bed numbers are rounded up to the nearest whole number.

2 Based on estimation using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council, the 'Best case' scenario assumes no long-term recurrent impact of COVID and the 'Intermediate 1' scenario applies some long-term recurrent impact of COVID. For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.

3 Where a full year of data is not available for the calendar year, or where the data looks to contain anomalies, a shorter period has been taken and then extrapolated based on the number of months. E.g. if April - Dec was taken as the baseline period, this has been uplifted by 12/9. The appointments / contacts have then been calculated based on the displayed ratio against the extrapolated referrals.

4 Contacts include both attended and DNAs as both are relevant for forecasting future estate requirements.

5 Range based on 'best case' and 'intermediate 1' scenarios.

These changes will have an impact on the experiences of staff and people who use our services

We know that without changing how we provide our forensic services, we will not be able to keep up with the demand for our low secure inpatient beds and our services will not be sustainable - this will limit our ability to continue to provide safe, high quality and equitable care.

The ambition we have set out for our Forensic Service Line aims to deliver on our wider care services strategic priorities. However we will also aim to impact on outcomes that are specific to our services - will know we are achieving the right outcomes if:

- Service users and their carers are able to access timely, high quality and equitable forensic mental health care and support that meets their needs.
- We have fewer inpatient admissions to forensic services and provide much more support in the community.
- Service users are cared for in the least restrictive environment as possible, supported by timely transfers and discharge.

To bring to life the impact we hope to have on outcomes for people, we have included below a service user 'persona' with a short story of what their care journey could look like in future, based on the ambition we have set out in this document.

> My name is Angela. I was recently in hospital for several months and was really unwell at the beginning of my admission. I have bipolar, and had previously been in hospital but had never been involved with police. This time the police were involved and I was admitted to a forensic unit. Fortunately my mood stabilised quickly with restarting my medication, working with the psychologists and getting outside into the hospital garden with the physiotherapists. I met a social worker on the ward as soon as I started to feel better - it was motivating to talk about getting home this early on in my admission and when it came to the time when the team felt I could go home, everything was ready to go.

Appendix F:
Learning Disabilities
Service Line Aspiration

We provide care and support to people with learning disabilities mainly in Leeds

We provide care to support people with learning disabilities (LD) living in West Yorkshire. Most people who use our LD services live in Leeds.

Our Learning Disabilities Service Line is made up of the following services:

Community Learning Disability Teams (CLDT):
We have several teams working in the community to support people with learning disabilities (a West North-West team, and East North-East team and a South South-East team). Our Health Facilitation Team provides a range of services including supporting people to get an annual health check.

Learning Disability Inpatient Services:
Our inpatient services offer respite for people with profound and multiple learning disabilities and for people with challenging behaviour. These services are based in Woodland Square at St. Mary's Hospital.

Learning Disability Specialist Health Planned Care Service (Respite):
Our planned respite service, based at 2 and 3 Woodland Square at St. Mary's Hospital, provides intermittent specialist care to adults with challenging behaviour and complex health needs. People who use our services have a learning disability and at least one of: a mental disorder, autism, dementia, multiple physical disabilities, and sensory impairment.

Specialised Supported Living Service (SSLS):
Our SSLS supports adults with learning disabilities, physical disabilities and complex needs to live independently. The service is based in Woodland Square at St. Mary's Hospital, however care is provided in service users' housing. The SSLS is our largest LD service with around 250 full time equivalent (FTE) staff working in the service and around 90 service users being supported at any one time.

Many people who use our services have complex care needs and other conditions, such as a mental health issue or physical disability, in addition to having a learning disability. It is thought that around 20-30% of people with a learning disability have autism.

People with learning disabilities can find it more challenging to communicate their care needs and to access care, particularly through digital routes as access to technology for people with learning disabilities is limited, compared with the general population.

As set out in the West Yorkshire Health and Care Partnership Mental Health, Learning Disability and Autism Strategy (2019 - 2024), we know that there are more people living with a learning disability who have long term support from Local Authorities in WY&H than in other places in England.

National research, such as the Learning Disability Mortality Review Programme (LeDer), has identified significant health inequalities in the adult learning disability population. The LeDer found that average life expectancy for adults with a learning disability is 16 years lower than the general population. People with learning disabilities also experience income inequalities, with a higher rate of deprivation and poverty than the general population.

Sources: Public Health England: Learning disability in Yorkshire and the Humber, our regional Learning Disabilities profile, NHS Long Term Plan.

Care Services Strategic Plan - 2023 - 2033   **P93**

We are proud of the great care and support we provide, however we have identified challenges in our LD services

Our teams provide great care and support to people with learning disabilities.

We are particularly proud of how we involve people with lived experience in the design and delivery of our services, such as through involvement co-worker posts, and we have ambitions to do more of this in future. In 2018, the CQC identified outstanding person-centred care in our Specialised Supported Living Service and rated the service as 'good' overall.

We have, however, identified some key challenges we face within our LD Service Line, which we must address to improve people's outcomes and experiences of care and support:

- Our teams working with people with learning disabilities are finding that more and more people need support with multiple and complex needs. Staff are also finding that more people are accessing services when their care needs are more urgent, meaning staff are usually required to respond more quickly and with more intensive interventions. Our services should adapt to the changing needs of service users to be better set up to support them.

- We know from our most recent CQC inspections that there are improvements to make to our services, such as greater compliance with Trust processes to support care that is safe and high quality, and improving access to therapeutic interventions.

- We also know from feedback from our service users that it is critical for our services to be accessible for everyone, including easy to read labels and reasonable adjustments in both the environment and communication style of staff.

- We have many passionate and committed staff working in our learning disabilities services. However, we have identified sustainability of our learning disabilities workforce as a threat to future service delivery, particularly as demand for care, and complexity of care needs, is increasing. For our community teams in particular, demand often seems to outweigh staff capacity and many staff are working under pressure.

We have completed modelling to understand how demand for our LD services is expected to change in future

The 'do nothing' modelling outlined shows how demand for our inpatient (measured through the number of beds required) and community (measured through the number of contacts) is projected to grow over the next fifteen years if we make no changes to our current services.

As outlined in the first table below, the current bed base for our inpatient services are forecast to be sufficient to meet demand, irrespective of the long-term impact of Covid-19.

For our community LD services, the number of contacts is projected to increase by 2028 and 2036 if we don't make any changes.

'Do nothing' modelling for our learning disabilities services

Inpatient services	Beds available in 2019	Beds used in 2019 (occupancy)	Required beds per year (assuming 85% occupancy) 2028[2]		Required beds per year (assuming 85% occupancy) 2036[2]		Planned bed capacity
			Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact)[1]	Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact)[1]	
2 Woodland Square	5	3 (65%)	4	4	4	5	5
3 Woodland Square	4	3 (74%)	4	4	4	4	4
Total	**9**	**6**	**8**	**8**	**8**	**9**	**9**

Community services	Extrapolated contacts 2019[3,4]	Forecast range of do nothing' contacts 2028[4,5]	Forecast range of 'do nothing' contacts 2036[4,5]
CLDT East North East	6,993	7,627 - 7,871	8,407 - 8,651
CLDT West and South	12,161	13,598 - 14,058	14,760 - 15,220
LD - ART	537	595	650
LD Intensive Support Team	1,764 (3,038 in 2021)	3,297 - 3,394	3,665 - 3,762
LD Orthotics	570	626 - 647	687 - 707
Total	**22,025**	**25,743 - 26,565**	**28,169 - 28,990**

1 Based on estimation using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council, the 'Best case' scenario assumes no long-term recurrent impact of COVID and the 'Intermediate 1' scenario applies some long-term recurrent impact of COVID. For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.

2 Assumes future occupancy rate of 85%-90% (90% used if 2019 value was >90%, 85% used if 2019 value was <85%). Bed numbers are rounded up to the nearest whole number.

3 Where a full year of data is not available for the calendar year, or where the data looks to contain anomalies, a shorter period has been taken and then extrapolated based on the number of months. E.g. if April - Dec was taken as the baseline period, this has been uplifted by 12/9. The appointments / contacts have then been calculated based on the displayed ratio against the extrapolated referrals.

4 Contacts include both attended and DNAs as both are relevant for forecasting future estate requirements.

5 Range based on 'best case' and 'intermediate 1' scenarios.

We will make changes to our LD services to enable us to provide better care and support to our service users

To address the challenges we are facing now and set our services up for the future, we must make changes so that we can provide better care to people who use our services. We have identified a set of key changes to our learning disabilities services, shown in the table below.

In developing these changes, we have considered the overarching strategic priorities for LYPFT care services and have also considered the strategic direction of our local system (our Leeds Place and our West Yorkshire Integrated Care System) as well as relevant national policy - our future services must align to the 'left shift' agenda set out in the NHS Long Term Plan, moving more care into the community, focusing on early intervention and prevention, and addressing health inequalities.

Our priorities for care services are:

- We co-create and co-deliver care services with people who have lived experience
- We collaborate with our partners to understand our populations and provide proactive integrated care
- We provide high quality, equitable and sustainable care services

The diagram below shows the changes we will make to our learning disabilities services and they align with these priorities.

Change	Rationale and benefits	Priority alignment
Collaborative redesign of the delivery and leadership model of the Supported Living Service so that the service remains competitive, affordable and deliverable	We are working with local authority commissioning partners to ensure the sustainability and future delivery of our supported living services.	We co-create and co-deliver care services with people who have lived experience
Addition of three 'emergency admission' beds for LD respite services	This change intends to address a system-wide challenge relating to our system Assessment and Treatment Unit (ATU). The addition of emergency respite beds intends to reduce avoidable admissions to the ATU and therefore reduce admissions/length of stay to the ATU.	We collaborate with our partners to understand our populations and provide proactive integrated care
Employment of people with lived experience in involvement co-worker posts	We recognise that an important principle of co-production is encouraging peer support, which currently is not delivered within our service.	
More integrated working between respite, emergency and Intensive Support Team	We currently have some gaps in our preventive support offer and recognise that more integrated working across teams working to provide different levels of support could improve pathways.	We provide high quality, equitable and sustainable care services

We have looked at how these changes will impact the projected demand for our services in future

The impact of the changes on our inpatient services are set out in the first table below if we 'do something' and make changes to our services.

The 'do something' modelling for 2 and 3 Woodland Square assumes that the number of beds in these wards will remain the same.

At present, any 'emergency' mental health needs for service users with a learning disability would be directed towards the Assessment and Treatment Unit in Bradford, which is not the intended use of this facility. To alleviate pressure on the ATU, and to enhance quality of experience for our service users requiring urgent care and support, we are proposing an 'emergency LD facility' of three beds is established, based upon an assumption of 30 admissions per year with ALoS of 30 days and occupancy of around 90%.

The row in the 'Community services' table below highlighted in blue (LD Intensive Support Team) shows the impact of the changes we will make on the 'do something' forecasts. As our ambition is to develop a more integrated service between our LD inpatient offer and the community, we hope to expand our LD Intensive Support Team by around an additional 10% (above expected growth). This is reflected in the modelling with the increase in number of contacts projected for 2028 and 2036.

This would enable us to provide a more intensive support offer to service users in the community and support a more seamless pathway between inpatient and community services.

'Do something' modelling for our learning disabilities services

Inpatient services	Beds available in 2019	Beds used in 2019 (occupancy)	Required beds per year (assuming 85% occupancy) 2028[1]		Required beds per year (assuming 85% occupancy) 2036[1]		Planned bed capacity
			Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact)[2]	Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact)[2]	
2 Woodland Square	5	3 (65%)	4	4	4	5	5
3 Woodland Square	4	3 (74%)	4	4	4	4	4
Emergency LD facility (90% occupancy)	-	-	3	3	3	3	3
Total	**9**	**6**	**11**	**11**	**11**	**12**	**12**

Community services	Extrapolated contacts 2019[3,4]	Forecast range of 'do nothing' contacts 2028[4,5]	Forecast range of 'do nothing' contacts 2036[4,5]	Forecast range of 'do nothing' contacts 2036[4,5]	Forecast range of 'do something' contacts 2036[4,5]
CLDT East North East	6,993	7,627 - 7,871	7,627 - 7,871	8,407 - 8,651	8,407 - 8,651
CLDT West and South	12,161	13,598 - 14,058	13,598 - 14,058	14,760 - 15,220	14,760 - 15,220
LD - ART	537	595	595	650	650
LD Intensive Support Team	1,764 (3,038 in 2021)	3,627 - 3,733	3,297 - 3,394	3,665 - 3,762	4,032 - 4,138
LD Orthotics	570	626 - 647	626 - 647	687 - 707	687 - 707
Total	**22,025**	**25,743 - 26,565**	**26,073 - 26,904**	**28,169 - 28,990**	**28,536 - 29,367**

1 Assumes future occupancy rate of 85%-90% (90% used if 2019 value was >90%, 85% used if 2019 value was <85%). Bed numbers are rounded up to the nearest whole number.

2 Based on estimation using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council, the 'Best case' scenario assumes no long-term recurrent impact of COVID and the 'Intermediate 1' scenario applies some long-term recurrent impact of COVID. For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.

3 Where a full year of data is not available for the calendar year, or where the data looks to contain anomalies, a shorter period has been taken and then extrapolated based on the number of months. E.g. if April - Dec was taken as the baseline period, this has been uplifted by 12/9. The appointments / contacts have then been calculated based on the displayed ratio against the extrapolated referrals.

4 Contacts include both attended and DNAs as both are relevant for forecasting future estate requirements.

5 Range based on 'best case' and 'intermediate 1' scenarios.

These changes will have an impact on the experiences of people who use our services and our staff

We are ambitious about continually improving the services we provide to continue to provide safe, high quality and equitable care.

The ambition we have set out for our Learning Disabilities Service Line aims to deliver on our wider care services strategic priorities. However we will also aim to impact on outcomes that are specific to our services - will know we are achieving the right outcomes if:

- Service users and their carers are able to access inclusive, timely, high quality and equitable care and support that meets their holistic needs.
- Service users can access information about care and support, including digital access to information.
- We have effective and flexible pathways of care and support that enable smooth transitions between community and inpatient care, when required.
- Service users and carers are meaningfully involved in the design of future services.
- People with lived experience are involved with providing care and support as part of our LD services team.
- Our staff have career progression opportunities, feel valued and staff retention improves.

To bring to life the impact we hope to have on outcomes for people, we have included below a service user 'persona' with a short story of what their care journey could look like in future, based on the ambition we have set out in this document.

> I'm Mark and I live in supported living. I really like having my own home and having help from the staff here. The staff helped me to set up a laptop so I can go online and join group classes and meet other people, which I really enjoy. I also go to community groups in person to meet people. Sometimes the community learning disabilities team come to see me at home so I don't have to go to hospital. This is really good for me because I prefer to be in my own home.
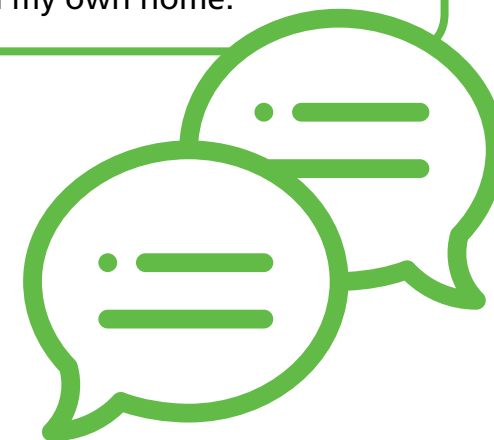
Appendix G:
Older People's Service Line Aspiration

Our older people's services are core mental health services providing care and support to people in Leeds

Our older people's services (OPS) teams support older people (people aged 65 and over) living in Leeds with acute and long term mental health problems.

Our Older People's Service Line is made up of the following services:

Older People's Inpatient service:
We provide inpatient support to older people with acute mental health needs. We do holistic assessments and provide treatment and rehabilitation across our four wards based at The Mount.

Older People's Community Mental Health services:
We deliver home-based care in Leeds across three teams (based at Aire Court, St Mary's House and St Mary's Hospital) and provide interventions and treatments, such as a review of prescriptions and medicines. We also host the Memory Assessment Service which delivers assessment, diagnosis and treatment to people with dementia or mild cognitive impairment.

Intensive Home Treatment Team for Older People (IHTT):
We assess and care for older people with complex and acute conditions, supporting people to avoid hospital admission where possible. We support with assessment, formulation, intervention, evaluation and discharge, usually in a person's home. We aim to see referrals to IHTT within 24 hours.

Younger People with Dementia service:
We provide assessment, diagnosis and treatment to adults up to the age of 65 with dementia, alongside support for their families and carers. This may include care home, outpatient clinic and hospital consultation.

Care Homes Team:
We support people who live in care homes who have mental health conditions and where the person, care home staff or families are at risk. We have two teams, one which delivers care with people with longer term mental health needs, such as dementia, and one team that delivers short-term intensive care home treatment.

Many older people who have mental health problems also have other care and support needs, such as physical health problems, and this means that many of our service users also get care from other organisations in Leeds. We are working with our partners in Leeds to improve care and support for older people.

We know from recent work with our city partners that:

- The number of older people in Leeds estimated to have depression is 16,323.

- Around 85% of older people in Leeds have depression but do not receive treatment.

- There are around 8,700 people living with dementia in Leeds.

- Older people with mental health problems are less likely to access Improving Access to Psychological Therapies (IAPT) services than working age adults.

One of our city priorities outlined in the *Leeds Mental Health Strategy 2020 - 2025* recognises the importance of supporting older people to access mental health services: *'ensure older people are able to access information, support and appropriate treatment that meet their needs'.*

We are proud of the great care we provide, however there are challenges to the sustainability of our current services

As more and more people are living longer, we are seeing increasing demand for health and care services to support older people. This is a global trend and is seen nationally across health and care systems in England as well as in our local place in Leeds.

Locally we have identified some of the core challenges we face within our Older People's Service Line, which we must address to be able to sustainably provide care and support to older people, and to improve people's outcomes and experiences of care:

- Delayed transfers of care in older people's services is a challenge, with 24.9% of transfers being delayed in 2022. This means some people are spending longer in hospital than they need to. This is often linked to challenges in accessing care home provision for people to be discharged from our inpatient wards. Our city-wide ambition is for older people to receive care in their own homes as much as possible and for as long as possible. We must work with our city partners to support more people in their own homes and to enable timely discharge for those who do need inpatient care.

- Our inpatient environment is not optimum to support older people with acute and intensive support needs - there is no dedicated unit for supporting older people with particularly acute and complex needs at present. The Mount, where our inpatient wards are based, is not purpose-built for older people's services. Our care settings for older people would be informed by dementia design and should be therapeutically supportive with access to sufficient therapeutic and clinical space.

- We expect demand for our services, particularly our Memory Assessment Service, to increase as more people in Leeds live longer. At the same time we know that we have workforce challenges to meet this increasing demand. For example, from an Allied Health Professionals (AHP) perspective we have some specific gaps in speech and language therapy for older people, with no commissioned post at present. In addition, we also have gaps in our psychology workforce. The British Psychological Society recommends approximately one psychologist per ward for older people and we do not meet this standard at present.

Without change, demand for our older people's inpatient services is set to increase beyond our capacity to respond

We have completed modelling to understand how demand for our services is expected to change in future.

The 'do nothing' modelling outlined shows how demand for our inpatient services (measured through the number of beds required) and our community services (measured through number of contacts) is projected to grow over the next fifteen years if we make no changes to our current services. It is clear from the data that if we 'do nothing', we will need more inpatient beds to be able to meet future demand.

The extent of the additional requirement is dependent on the potential long-term recurrent impact of Covid-19. With an assumption of 85 - 90% occupancy as an operational target, by 2028 in the 'best case' we would have a deficit of 8 beds, rising to 23 beds in 2036. In the 'intermediate 1' scenario[1], our deficit would be 12 beds, rising to 23 in 2036. These scenarios include provision for an average of one additional service user per year in Wards 1 and 3, and three per year in Ward 4, based on the assumption that inappropriately placed 'out of area' patients will be repatriated going forwards^.

'Do nothing' modelling for our older people's services

Inpatient services	Beds available in 2019	Beds used in 2019 (occupancy)	Required beds per year (assuming 85-90% occupancy) 2028[2]		Required beds per year (assuming 85-90% occupancy) 2036[2]		Planned bed capacity
			Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact)[1]	Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact)[1]	
Mount W1 Male Dementia *Assuming 90% occupancy*	17	15 (90%)	19	20	22	22	17
Mount W2 Fem Dementia *Assuming 90% occupancy*	15	14 (91%)	15	16	17	17	15
Mount Ward 3 *Assuming 85% occupancy*	24	18 (73%)	23	24	27	27	24
Mount Ward 4 *Assuming 90% occupancy*	24	24 (99%)	31	32	32	37	24
Total	**80**	**70**	**88**	**92**	**103**	**103**	**80**

Community services	Extrapolated contacts 2019[3,4]	Forecast range of do nothing' contacts 2028[4,5]	Forecast range of 'do nothing' contacts 2036[4,5]
Care Homes Team	3,756	4,652 - 4,780	5,621 - 5,748
CMHT OPS ENE	7,577	9,256 - 9,452	10,989 - 11,185
CMHT OPS SSE	4,124	5,019 - 5,126	5,945 - 6,053
CMHT OPS WNW	8,136	9,940 - 10,155	11,726 - 11,941
Complex Dementia Wrap Ar	0 (2,051 in 2021)	2,354 - 2,425	2,679 - 2,749
Dementia MH Liaison	734	838 - 865	936 - 963
IHTT OPS	8,490	10,229 - 10,460	11,949 - 12,181
Intensive Care Homes Team	3,592	4,402 - 4,493	5,291 - 5,382
YPDT	1,333	1,397 - 1,464	1,396 - 1,463
Memory Assessment Teams	10,255	11,927 - 12,279	13,634 - 13,986
Total	**38,645**	**42,326 - 44,138**	**46,275 - 48,087**

1 Based on estimation using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council, the 'Best case' scenario assumes no long-term recurrent impact of COVID and the 'Intermediate 1' scenario applies some long-term recurrent impact of COVID. For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.

2 Assumes future occupancy rate of 85%-90% (90% used if 2019 value was >90%, 85% used if 2019 value was <85%). Bed numbers are rounded up to the nearest whole number.

3 Where a full year of data is not available for the calendar year, or where the data looks to contain anomalies, a shorter period has been taken and then extrapolated based on the number of months. E.g. if April - Dec was taken as the baseline period, this has been uplifted by 12/9. The appointments / contacts have then been calculated based on the displayed ratio against the extrapolated referrals.

4 Contacts include both attended and DNAs as both are relevant for forecasting future estate requirements.

5 Range based on 'best case' and 'intermediate 1' scenarios.

We will make changes to our older people's services to improve care and support us to meet future demand

To address the challenges we are facing now and set our services up for the future, we must make changes so that we can provide better care to people who use our services. We have identified a set of key changes to our older people's services, shown in the table below.

In developing these changes, we have considered the overarching strategic priorities for LYPFT care services and have also considered the ambition of our local system in Leeds, as well as relevant national policy - our future services must align to the 'left shift' agenda set out in the NHS Long Term Plan, moving more care into the community, focusing on early intervention and prevention, and addressing health inequalities.

Our priorities for care services are:

- We co-create and co-deliver care services with people who have lived experience
- We collaborate with our partners to understand our populations and provide proactive integrated care
- We provide high quality, equitable and sustainable care services

The diagram below shows the changes we will make to our older people's services and they align with these priorities.

Change	Rationale and benefits	Priority alignment
Establish access to a specialist long-term facility for people with dementia with complex care needs (use of Dolphin Manor and Willows in short-term)	Delayed transfers of care in OPS is a challenge (24.9% of transfers were delayed in February) - this is linked to the challenge in access to care home provision for patients to be discharged from the Mount.	We co-create and co-deliver care services with people who have lived experience
Potentially establish a dementia PICU for older people with acute and intensive care needs (this would be provided on an ICS footprint)	Access to appropriate facilities to support older people with acute and intensive care needs isn't available. This would also likely reduce delayed transfers of care.	
Aligned with the Leeds city ambition to support people in their own homes as much as possible, enhance the IHTT offer as part of the enhanced community response work that we are doing with the Leeds system (aim to operate at full capacity plus an additional 10% of current capacity)	The city-wide ambition is for people to receive care in their own homes as much as possible and for as long as possible. This change would enable more people to be supported at home - this could lead to fewer inpatient admissions and could facilitate early discharge from hospital with support from IHTT on discharge.	We collaborate with our partners to understand our populations and provide proactive integrated care
Co-locate OPS beds with acute site	This will enable closer working between mental health and physical health teams with potential benefits of more timely access to physical health support older people in hospital for mental health support.	
Review structure of OPS community teams based on population need	This will aim to align our OPS community team resource to population need to support reduction in health inequalities in line with our city ambition.	We provide high quality, equitable and sustainable care services
Evaluate clinical model of, and respond to increase in demand for, Memory Assessment Service	Demand is increasing and is expected to increase further for our memory assessment service. This will enable us to review the service and plan for future demand.	

We have looked at how the changes we have identified may impact the projected demand for our services over the next fifteen years and our capacity to respond.

The table below shows the 'best case' scenario around the long-term impact of Covid-19[1].

It outlines the impact on our forecast bed requirements if we remove delayed transfers of care (DTOCs) from both our functional and organic average length of stay (ALoS). This could be achieved through access to a specialist long-term facility for dementia (in the short-term, this means use of Dolphin Manor to support the Willows) and through an enhanced IHTT provision facilitate earlier discharge.

These scenarios include provision for an average of one additional service user per year in Wards 1 and 3, and three per year in Ward 4 based on the assumption that inappropriately placed 'out of area' patients will be repatriated going forwards.

Based on this, and assuming the wards will operate at 85-90% occupancy going forward, there would be scope to remove nine of our organic (dementia) beds based on the 2028 projection, although three would need to be reinstated by 2036 to meet demand.

Assuming we are able to have zero delayed transfers of care, the following would be feasible:

- If Mount Wards 1 and 2 continue to operate at around 90% occupancy, we could reasonably reduce our bed base by six beds across the two wards until at least 2036.

- Assuming that Mount Wards 3 and 4 continue to operate at around a 90% level of occupancy, the current bed base of 48 beds could stay the same until 2028.

  - However, unless proposed additional initiatives (e.g. enhanced IHTT, more 'equitable' community provision, co-location on an acute site) provide some additional admission and ALoS reductions beyond the elimination of DTOCs, we would likely need to increase our bed base thereafter.

'Do something' modelling for our older people's inpatient services - 'best case' scenario

Best case scenario	Beds available in 2019	Required beds per year 2028[2] 90% occupancy (85% for Ward 3)		Required beds per year 2036[2] 90% occupancy (85% for Ward 3)		Planned bed capacity
		Incl DTOC	Excl DTOC	Incl DTOC	Excl DTOC	
Mount W1 Male Dementia	17	19	12	22	14	17
Mount W2 Fem Dementia	15	15	11	17	12	15
Mount Ward 3	24	23	19	27	22	24
Mount Ward 4	24	31	29	37	374	24
Total	80	88	71	103	82	80

1 Based on estimation using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council, the 'Best case' scenario assumes no long-term recurrent impact of COVID. For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.

2 Assumes future occupancy rate of 85%-90% (90% used if 2019 value was >90%, 85% used if 2019 value was <85%). Bed numbers are rounded up to the nearest whole number.

We have looked at how these changes are forecast to impact projected demand for our inpatient services (2 of 2)

We have also looked at the impact of these changes on forecast demand based on an 'intermediate case' scenario around the long-term impact of Covid-19[1].

This adds to the information set out in the previous page, giving us a view of what we can expect our 'do something' bed requirements to look like if there is a long-term impact of the pandemic on older people's mental health.

The table below outlines the impact on our forecast bed requirements if we remove delayed transfers of care (DTOCs) from both our functional and organic average length of stay (ALoS). This could be achieved through access to a specialist long-term facility for dementia (in the short-term, this means use of Dolphin Manor to support the Willows) and through an enhanced IHTT provision facilitate earlier discharge.

These scenarios include provision for an average of one additional service user per year in Wards 1 and 3, and three per year in Ward 4 based on the assumption that inappropriately placed 'out of area' patients will be repatriated going forwards.

It is clear that the long-term impact of Covid-19 does not have a significant impact on our forecast bed requirements, with an increase in the 2036 bed requirement for Ward 3 and 4 by just one compared with the 'best case' scenario shown on the previous page (the 'best case' scenario assumes no long-term impact of Covid-19).

As with the 'best case' scenario, assuming we are able to have zero delayed transfers of care, the following would be feasible:

- If Mount Wards 1 and 2 continue to operate at around 90% occupancy, we could reasonably reduce our bed base by six beds across the two wards until at least 2036.

- Assuming that Mount Wards 3 and 4 continue to operate at around a 90+% level of occupancy, the current bed base of 48 beds could stay the same until 2028.

  - However, unless proposed additional initiatives (e.g. enhanced IHTT, more 'equitable' community provision, co-location on an acute site) provide some additional admission and ALoS reductions beyond the elimination of DTOCs, we would likely need to increase our bed base thereafter.

Based on this modelling, we expect to be able to plan for 26 organic beds and 48 functional beds provided we plan to significantly enhance our community and IHTT older people's services. Organic means dementia. Functional means mental illness or a non dementia mental illness such as bipolar, depression etc.

'Do something' modelling for our older people's inpatient services - 'intermediate case' scenario

Intermediate case scenario	Beds available in 2019	Required beds per year 2028[2] 90% occupancy (85% for Ward 3)		Required beds per year 2036[2] 90% occupancy (85% for Ward 3)		Planned bed capacity
		Incl DTOC	Excl DTOC	Incl DTOC	Excl DTOC	
Mount W1 Male Dementia	17	20	13	22	14	17 -> 14
Mount W2 Fem Dementia	15	16	11	17	12	15 -> 12
Mount Ward 3	24	24	20	27	23	24
Mount Ward 4	24	32	30	37	35	24
Total	80	92	74	103	84	80

1 Based on estimation using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council, the 'Best case' scenario assumes no long-term recurrent impact of COVID and the 'Intermediate 1' scenario applies some long-term recurrent impact of COVID. For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.

2 Assumes future occupancy rate of 85%-90% (90% used if 2019 value was >90%, 85% used if 2019 value was <85%). Bed numbers are rounded up to the nearest whole number.

Our community provision is forecast to increase in line with our ambition to increase support in the community

We have also looked at how the changes we've identified will impact activity within our community older people's services in future. This is based on the 'intermediate 1'[1] scenario for the long-term recurrent impact of Covid-19 (i.e. there is some long-term impact of Covid on demand for mental health services).

The row in the table below highlighted in blue (IHTT) shows the impact of the changes we will make on the 'do something' forecast for service activity.

Our OPS IHTT is currently working at around two thirds of capacity given the services hours of operation due to how resource is currently allocated. With additional investment into the service, our ambition would be to operate at 100% capacity and increase the service by an additional 10% of current capacity in order to more intensive support in the community. This would have benefits in terms of outcomes for people, with more people able to be supported in their own homes, as well as support the reduction in future inpatient bed requirements for older people's services.

The rows in the table highlighted in pink (CMHT OPS ENE, CMHT OPS SSE, CMHT OPS WNW) are areas where we have a planned service change without formally quantified service impacts.

CMHT has recently been split into four teams (WNW has become West and North West), though this is not shown in the table. Though not yet implemented, we expect that the geographies in Leeds supported by each of these four teams will be reviewed to enable us to increase and more equitably distribute our workforce in line with the needs of our local population (e.g. considering ethnicity and deprivation level) to support our work to reduce health inequalities. Our intention with this is to enable people at most risk of becoming unwell, or those most in need of support, to be able to access the right support support earlier with the aim of better outcomes for people.

'Do something' modelling for our older people's inpatient services - 'intermediate case' scenario

Community services	Extrapolated contacts 2019[1,2]	Forecast range of 'do nothing' contacts 2028[2,3]	Forecast range of 'do something' contacts 2028[2,3]	Forecast range of 'do nothing' contacts 2036[2,3]	Forecast range of 'do something' contacts 2036[2,3]
Care Homes Team	3,756	4,652 - 4,780	4,652 - 4,780	5,621 - 5,748	5,621 - 5,748
CMHT OPS ENE	7,577	9,256 - 9,452	9,256 - 9,452	10,989 - 11,185	10,989 - 11,185
CMHT OPS SSE	4,124	5,019 - 5,126	5,019 - 5,126	5,945 - 6,053	5,945 - 6,053
CMHT OPS WNW	8,136	9,940 - 10,155	9,940 - 10,155	11,726 - 11,941	11,726 - 11,941
Complex Dementia Wrap Ar	0 (2,051 in 2021)	2,354 - 2,425	2,354 - 2,425	2,679 - 2,749	2,679 - 2,749
Dementia MH Liaison	734	838 - 865	838 - 865	936 - 963	936 - 963
IHTT OPS	8,490	10,229 - 10,460	13,911 - 14,226	11,949 - 12,181	16,251 - 16,566
Intensive Care Homes Team	3,592	4,402 - 4,493	4,402 - 4,493	5,291 - 5,382	5,291 - 5,382
YPDT	1,333	1,397 - 1,464	1,397 - 1,464	1,396 - 1,463	1,396 - 1,463
Memory Assessment Teams	10,255	11,927 - 12,279	11,927 - 12,279	13,634 - 13,986	13,634 - 13,986
Total	**38,645**	**42,326 - 44,138**	**63,695 - 65,266**	**46,275 - 48,087**	**74,466 - 76,037**

1 Where a full year of data is not available for the calendar year, or where the data looks to contain anomalies, a shorter period has been taken and then extrapolated based on the number of months. E.g. if April - Dec was taken as the baseline period, this has been uplifted by 12/9. The appointments / contacts have then been calculated based on the displayed ratio against the extrapolated referrals.

2 Contacts include both attended and DNAs as both are relevant for forecasting future estate requirements.

3 Range based on estimation using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council, the 'Best case' scenario assumes no long-term recurrent impact of COVID and the 'Intermediate 1' scenario applies some long-term recurrent impact of COVID. For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.

These changes will have aim to make care better for service users and improve staff experience

We know that without changing how we provide our older people's services, we will not be able to keep up with the demand for our inpatient beds in future and our services will not be sustainable - this will limit our ability to continue to provide safe, high quality and equitable care.

The ambition we have set out for our Older People's Service Line aims to deliver on our wider care services strategic priorities and align to the ambition of our city partners and the national direction for future mental health services.

However we will also aim to impact on outcomes that are specific to our services - will know we are achieving the right outcomes if:

- Our service users and their carers are able to access timely, high quality and equitable mental health care and support that meets their needs.
- We have no delayed transfers of care and no out of area placements.
- We have a supported and resilient multidisciplinary workforce.
- Our staff have career progression opportunities, feel valued and staff retention improves.

To bring to life the impact we hope to have on outcomes for people, we have included below a service user 'persona' with a short story of what their care journey could look like in future, based on the ambition we have set out in this document.

> I'm Jenny, I'm 70 years old and I am currently getting support for my mood. I've always enjoyed being active and other than my diagnosis of diabetes a few years ago, I am physically well. My mum had dementia and because I know it's in my family, as I get older I often think about it and it's a worry for me. I recently found myself feeling forgetful on occasions and it made me feel really on edge. I started to feel irritable and wasn't sleeping well and felt really low in mood. My GP referred me to the memory assessment service and also suggested I got assessed for talking therapies. It turns out that my memory is fine at the moment, and I'm now getting CBT for my mood, which I'm already finding helpful.

Appendix H:
Perinatal & Liaison Service Line Aspiration

We provide perinatal and liaison services across West Yorkshire, regionally and nationally

Our Perinatal and Liaison Service Line is made up of the following services:

Perinatal Mental Health Service:

We support women in Leeds during pregnancy and the first year following their child's birth. This is through an initial assessment. We offer a variety of support options, including pre-conception counselling, group work, care planning, referral to the Yorkshire and Humber Mother and Baby Unit for inpatient care and an outreach service.

Liaison Psychiatry:

We support people with physical health problems who also have mental health support needs. We offer the following:

- Outpatient services: Leeds and West Yorkshire Chronic Fatigue Syndrome/ ME Service and Leeds Psychosexual Medicine Service.

- Acute services: In-reach Liaison Psychiatry Team for adults receiving treatment at Leeds Teaching Hospitals NHS Trust (LTHT) and Acute Liaison Psychiatry Service (ALPS) for people who harm themselves or require acute care.

- Inpatient care: National Inpatient Centre for Psychological Medicine (NICPM), offering eight beds (approximately half of our beds are commissioned for Leeds residents and half for people nationally).

We are based in three locations: The Becklin Centre, Rose Garden Suite at Leeds General Infirmary, St James Hospital and The Newsam Centre.

We know that:

- In Leeds, 1500 women a year have a mental health problem during pregnancy or in the following year.

- The annual cost to the NHS and social care for not being able to access high quality perinatal mental health care is £1.2 billion.

- 30% with a long-term physical health condition are estimated to also have a mental health condition, with depression / anxiety being most common.

We are proud of the great care we provide, however we know there are some challenges with our services

We have identified some of the core challenges we face within our Perinatal and Liaison Service Line, which we must address to be able to improve people's outcomes and experiences of care and make our services sustainable:

- We have specialist expertise and strong research links in liaison psychiatry. However, there are some challenges in recruitment and retention, particularly for nurses, with the pandemic heightening pressures on the workforce. Recruitment and retention is also a challenge for NICPM, particularly with band 5 nursing staff and consultant posts. These workforce challenges may impact on clinical and financial sustainability of our perinatal and liaison services in future. They can also impact on staff experience and service user experience due to the potential impact on consistency and continuity of clinical teams.

- There is a lack of clarity around the pathway of care for people with medically unexplained symptoms and long term conditions. This means that many people can be referred to multiple different services before they are able to access the right care, and this can lead to delays in people getting the care and support they need. To address this, we should work with our partners, particularly primary care and IAPT, to develop a coherent and consistent pathway for people who are referred from primary care with these issues.

- Estates is a driver for change in several of our services. The NICPM estate was considered by CQC as *'requires improvement... because the premises were not suitable for the purpose they were being used'* and it is expected that this site will be closed in future. At present, our liaison inreach teams do not have sufficient access to clinical or office space and the current locations of these teams do not support collaborative working with partners in the acute trust.

Without change, demand for our inpatient perinatal and liaison services is set to increase beyond current capacity

We have completed modelling to understand how demand for our services is expected to change in future.

The 'do nothing' modelling outlined shows how demand for our inpatient services (measured through the number of beds required) and our community services (measured through number of contacts) is projected to grow over the next fifteen years if we make no changes to our current services.

It is evident that there is an upwards trajectory in bed requirements across both inpatient wards.

If we assume 85 - 90% occupancy as our operational target, both wards will have a bed deficit by 2028 and beyond in the 'do nothing' scenario.

'Do nothing' modelling for our perinatal and liaison services

Inpatient services	Beds available in 2019	Beds used in 2019 (occupancy)	Required beds per year (assuming 85-90% occupancy) 2028[1]		Required beds per year (assuming 85-90% occupancy) 2036[1]		Planned bed capacity
			Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact)[2]	Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact)[2]	
NICPM	8	7 (89%)	10	10	11	11	8
Perinatal inpatients	8	8 (98%)	11	11	12	12	8
Total	**16**	**15**	**21**	**21**	**23**	**23**	**16**

Community services	Extrapolated contacts 2019[3,4]	Forecast range of 'do nothing' contacts 2028[4,5]	Forecast range of 'do nothing' contacts 2036[4,5]
ALPS	5,091	5,610 - 5,869	6,154 - 6,413
Chronic Fatigue Service	2,258	2,487 - 2,648	2,704 - 2,864
HMHT	6,892	8,100 - 8,425	9,118 - 9,442
Liaison Out Patients	1,320 (2,018 in 2021)	2,183 - 2,265	2,406 - 2,487
Perinatal Community	5,520	6,103 - 6,371	6,895 - 7,161
Perinatal Outreach	150	166 - 173	187 - 194
Psychosexual Medicine	939	1,025	1,130
Weight Management	163	180	198
Total	**22,315**	**25,856 - 26,955**	**28,792 - 29,890**

1 Assumes future occupancy rate of 85%-90% (90% used if 2019 value was >90%, 85% used if 2019 value was <85%). Bed numbers are rounded up to the nearest whole number.

2 Based on estimation using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council, the 'Best case' scenario assumes no long-term recurrent impact of COVID and the 'Intermediate 1' scenario applies some long-term recurrent impact of COVID. For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.

3 Where a full year of data is not available for the calendar year, or where the data looks to contain anomalies, a shorter period has been taken and then extrapolated based on the number of months. E.g. if April - Dec was taken as the baseline period, this has been uplifted by 12/9. The appointments / contacts have then been calculated based on the displayed ratio against the extrapolated referrals.

4 Contacts include both attended and DNAs as both are relevant for forecasting future estate requirements.

5 Range based on 'best case' and 'intermediate 1' scenarios.

We will make changes to our perinatal and liaison services to improve care and support us to meet future demand

To address the challenges we are facing now and set our services up for the future, we must make changes so that we can provide better care to people who use our services. We have identified a set of key changes to our perinatal and liaison services, shown in the table below.

In developing these changes, we have considered the overarching strategic priorities for LYPFT care services and have also considered the ambition of our local system in Leeds, as well as relevant national policy.

Our future services must align to the 'left shift' agenda set out in the NHS Long Term Plan, moving more care into the community, focusing on early intervention and prevention, and addressing health inequalities.

Our priorities for care services are:

- We co-create and co-deliver care services with people who have lived experience
- We collaborate with our partners to understand our populations and provide proactive integrated care
- We provide high quality, equitable and sustainable care services

The diagram below shows the changes we will make to our perinatal and liaison services and they align with these priorities.

Change	Rationale and benefits	Priority alignment
Increase our perinatal community service provision and offer support to women, partners and families in alignment with the NHS Long Term Plan commitments	We have an established perinatal community service - the NHS Long Term plan aims to improve and increase access to perinatal mental health care for women and families. More support in the community will aim to support people closer to home. We expect this will reduce average length of stay (ALoS) and admissions for perinatal inpatient beds.	We co-create and co-deliver care services with people who have lived experience
Increase community provision (e.g. crisis cafes to support reduction in ALPS)	We expect that work to develop crisis care pathways and wider work to increase community support could have an impact on reducing ALPS activity in future.	
Co-location of liaison psychiatry teams with acute trusts (in both LGI and St James LTHT sites) in line with Royal College standards	Our liaison teams do not have access to sufficient space in acute trusts to be co-located with acute services. We also intend to increase equitable provision of liaison outpatient services across the ICS footprint.	We collaborate with our partners to understand our populations and provide proactive integrated care
Continue providing NICPM in an appropriate estate (acknowledgement that funding direction is likely to influence this) and recruit to address staffing gaps	The waiting list for NICPM is long and staff capacity is a challenge due to staffing retention. CQC have stated that the premises were not suitable for the purpose they were being used for.	
Consider our future estate options such as purpose built MBU with therapeutically beneficial environment and co-location with other inpatient services in line with Royal College standards	The Mount is a PFI asset and the future direction of this estate is currently unclear.	We provide high quality, equitable and sustainable care services

We have looked at how these changes are forecast to impact projected demand for our inpatient services

We have looked at how the changes we've identified will impact the projected demand for our services over the next fifteen years and our capacity to respond. The table below shows the modelling for our inpatient services.

There is a growth in bed requirement for NICPM beds in the 'do nothing' scenario. Because we don't expect significant changes to NICPM commissioning (e.g. commissioning for additional beds), the 'do something' forecast shown in the table below shows a deficit in planned capacity relative to forecast bed requirements in line with the 'do nothing scenario.

'Do something' modelling for our perinatal and liaison inpatient services

	Beds available in 2019	Beds used in 2019 (occupancy)	Required beds per year (assuming 85-90% occupancy) 2028[1]		Required beds per year (assuming 85-90% occupancy) 2036[1]		Planned bed capacity
			Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact)[2]	Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact)[2]	
NICPM	8	7 (89%)	10	10	11	11	8
Perinatal inpatients	8	8 (98%)	8	8	9	9	8
Total	**16**	**15**	**18**	**18**	**20**	**20**	**16**

For perinatal inpatients, our ambition is to enhance provision of community-based support in line with the NHS Long Term Plan commitments. We hope this will enable us to to provide care for more service users and also a more intensive service, potentially for longer (e.g. up to two years after birth).

We are expecting our perinatal community team to almost double in size by 2023 (compared to the size of the team in 2019). Though difficult to quantify the impact of expanding our community team, we have made the following assumptions for the 'do something' modelling based on research:

- Expanding our perinatal community team could lead to a reduction in average length of stay (ALoS) from 64 days (our average in 2019) to 56 days - a bed day saving of around 13%. There is some evidence from other facilities that suggests that ALoS could be even lower, in the range of 28 - 35 days, with expansion of community services. However, people who are seen in the community and those requiring inpatient services are distinct, with evidence to demonstrate that where people need admission must be admitted and not cared for in the community.

- There is also evidence that specialised perinatal CMHTs that are closely integrated with a mother and baby unit (MBU) can reduce the number of mother and baby beds required for a large population - one report cites a potential reduction from 0.4 beds for 1,000 births to 0.25 per 1,000 births, a reduction of c. 37%. Given the near doubling of our perinatal community team by 2023, we have assumed that there will be a 20% reduction in our bed requirement.

Based on these assumptions, we believe that the current size of our perinatal inpatient bed base should be sufficient in 2028 though we may have a deficit of 1 bed in 2036. If however we were to sometimes operate at a >90% occupancy, or aim for a further reduction in ALoS, our current bed base would be sufficient.

In 2023 we were given approval by NHS England to build a six bed Mother and Baby Unit serving the whole of Yorkshire and the Humber.

Based on this modelling, we expect to plan our bed capacity in line with the data in the 'Planned bed capacity' column in the table below.

1 Assumes future occupancy rate of 85%-90% (90% used if 2019 value was >90%, 85% used if 2019 value was <85%). Bed numbers are rounded up to the nearest whole number.

2 Based on estimation using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council, the 'Best case' scenario assumes no long-term recurrent impact of COVID and the 'Intermediate 1' scenario applies some long-term recurrent impact of COVID. For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.

Our community provision is forecast to increase in line with our ambition to increase support in the community

We have also looked at how the changes we've identified will impact activity within our community perinatal and liaison services in future.

The rows in the table below highlighted in blue (ALPS, Perinatal Community) shows the impact of the changes we will make on the 'do something' forecast for service activity.

Our hope is that the changes we are making to our acute (crisis) and community mental health services together with our system partners to move more care into the community and provide support to people earlier, will reduce the number of people experiencing a mental health crisis and harming themselves. This would have an impact on activity in our ALPS service, with a reduction in demand for the service.

The NHS Long Term Plan outlines an ambition to expand community perinatal mental health capacity to provide for 10% of mothers in the perinatal phase (up to 2 years following birth). We have modelled our 'do something' scenario, modelling through the impact of our proposed services changes to our perinatal mental health service in line with this.

In 2023, this would equate to around 1,000 referrals, which is almost twice the number of referrals we had in 2019. We hope this would enable more service users to be supported in the community and expect that this more intensive community offer could prevent admissions and/or reduce length of stay in MBU.

'Do something' modelling for our community perinatal and liaison services

Community services	Extrapolated contacts 2019[1,2]	Forecast range of 'do nothing' contacts 2028[2,3]	Forecast range of 'do something' contacts 2028[2,3]	Forecast range of 'do nothing' contacts 2036[2,3]	Forecast range of 'do something' contacts 2036[2,3]
ALPS	5,091	5,610 - 5,869	5,027 - 5,285	6,154 - 6,413	5,514 - 5,773
Chronic Fatigue Service	2,258	2,487 - 2,648	2,487 - 2,648	2,704 - 2,864	2,704 - 2,864
HMHT	6,892	8,100 - 8,425	8,100 - 8,425	9,118 - 9,442	9,118 - 9,442
Liaison Out Patients	1,320 (2,018 in 2021)	2,183 - 2,265	2,183 - 2,265	2,406 - 2,487	2,406 - 2,487
Perinatal Community	5,520	6,103 - 6,371	10,288 - 10,553	6,895 - 7,161	11,617 - 11,883
Perinatal Outreach	150	166 - 173	166 - 173	187 - 194	187 - 194
Psychosexual Medicine	939	1,025	1,025	1,130	1,130
Weight Management	163	180	180	198	198
Total	**22,315**	**25,856 - 26,955**	**29,455 - 30,553**	**28,792 - 29,890**	**32,874 - 33,973**

1 Where a full year of data is not available for the calendar year, or where the data looks to contain anomalies, a shorter period has been taken and then extrapolated based on the number of months. E.g. if April - Dec was taken as the baseline period, this has been uplifted by 12/9. The appointments / contacts have then been calculated based on the displayed ratio against the extrapolated referrals.

2 Contacts include both attended and DNAs as both are relevant for forecasting future estate requirements.

3 Range based on no long-term recurrent impact of COVID ('best case') and 'intermediate 1' scenario which is based on some long-term recurrent impact of COVID (using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council). For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.

These changes will have aim to make care better for our service users and improve staff experience

We know that without changing how we provide our perinatal and liaison services, there is a risk we will not be able to keep up with the demand for our inpatient beds in future and our services will not be sustainable - this will limit our ability to continue to provide safe, high quality and equitable care.

The ambition we have set out for our Perinatal and Liaison Service Line aims to deliver on our wider care services strategic priorities and align to the ambition of our system partners and the national direction for future mental health services.

However we will also aim to impact on outcomes that are specific to our services - will know we are achieving the right outcomes if:

- Service users and their carers are able to access timely, high quality and equitable mental health care and support that meets their needs.
- People are able to access more support in the community, in their own homes or close to their home.
- We have clear, integrated and efficient pathways of care.
- We have a supported and resilient multidisciplinary workforce.

To bring to life the impact we hope to have on outcomes for people, we have included below a service user 'persona' with a short story of what their care journey could look like in future, based on the ambition we have set out in this document.

My name is Andrea. I had my first baby 12 months ago now and am really pleased with how I'm doing. I've got bipolar disorder and was doing well on Lithium before I got pregnant - when I was thinking about having a baby I spoke to my consultant about the risks and my options for medication and support, and we agreed on a plan that felt right for me. During my pregnancy, I had more frequent visits from my CPN and I got support from the perinatal outreach team. I had a planned c-section and when I went home from hospital I had more regular visits from health visitors, the perinatal mental health team and my regular CPN. I had a bit of a wobble in the few weeks after I gave birth so the team worked with me to tweak my meds. I'm now part of a community group of new mums who have experienced mental health issues and really valuing the support we are able to give each other.

Appendix I:
Regional & Specialist Service Line Aspiration

We provide specialist mental health and neurodiversity services to people in Leeds, regionally and nationally

Our Regional and Specialist Service Line is made up of the following services:

Northern Gambling Service (Northern Gambling Clinic):
We provide specialist addiction therapy and recovery support to people with gambling addictions and mental health conditions in the North of England and North Midlands.

Adult Attention Deficit Hyperactivity Disorder (ADHD) Service:
We provide specialist assessment, monitoring and management to adults and young people in transition with ADHD in Leeds.

Autistic Diagnostic Service (LADS):
We assess and diagnose adults who may have autism in Leeds and offer a one off consultancy appointment post-diagnosis.

Alcohol and Drug Services: Forward Leeds:
LYPFT is part of Forward Leeds, delivering assessment, treatment and aftercare to people with drug and alcohol issues.

EMERGE Leeds: Complex Emotional Needs:
We work with people experiencing complex emotional needs and interpersonal difficulties, offering care coordination, group work programmes and support for professionals.

Pathway Development Service (PDS) - Yorkshire and Humberside:
We support people with personality disorders providing an independent review of care, supporting entry to and during secure unit stays and skills development for community teams.

Veterans' Mental Health Complex Treatment (VMH CTS) and High Intensity - North of England:
We are lead providers for two veterans services, supporting people with complex mental health conditions who have worked in the military. This includes care navigation and support during an inpatient stay.

While some of our services are provided to a wider population, from recent work with our city partners we have important insights about our local population in Leeds that are relevant to our specialist services:

- In Leeds, the rate of problem gambling is estimated to be double the national average. We also know that men are four times more likely to have a gambling disorder than women, and people from a BAME background are seven times more likely to have a gambling addition.

- Alcohol related hospital admissions are higher in Leeds than regional and national averages, and are higher in males than in females.

- More men access drug and alcohol services than women in Leeds, although women are more likely to have a mental health and substance use diagnosis.

- 30% of adults aged 18 and over reported a clinical significant level of psychological distress in Leeds in 2020, an increase from 21% in 2019.

We are based in three locations: The Becklin Centre, Rose Garden Suite at Leeds General Infirmary, St James Hospital and The Newsam Centre.

We know that:

- 50% of people who have autism also have a diagnosis of anxiety and/ or depression.

- Between 2020 and 2021, there was a 16.2% increase in the most severe gambling addiction referrals to NHS gambling clinics.

- It is estimated that at any one time, around 8000 out of the estimated 30,000 people who gamble pathologically are receiving treatment for a gambling addiction (excludes people treated in the private sector).

We are proud of the great care we provide, however there are challenges to the sustainability of our current services

We have identified challenges within our Regional and Specialist Service Line, which we must address to be able to sustainably provide specialist care and support to people in future, and to improve people's outcomes and experiences of care:

- We are experiencing **increasing demand** for many of our specialist services. For example in our LADS service, demand is rising and sustainable clinical capacity to meet increasing demand is a challenge for the future - from our most recent performance data, 54.3% of LADS assessments started within 13 weeks compared to our 95% target. We also have a long waiting list for our ADHD service.

- We have identified **unmet need** that our services could address: children and young people with a gambling addiction and adults with a gaming addiction. In addition, we know that alcohol use has increased during the pandemic while fewer people have accessed alcohol use support.

- Our service line includes teams who are experts in their field and some who are recognised nationally for their work. While this capability is strong within the specialist services, we know that professionals working in general mental health services sometimes don't have the **skills**, **experience** or confidence to support people in their services who also have a specialist need (e.g. an addiction or neurodiversity). There is an opportunity to explore ways to use the expertise in our service to support other professionals to develop their skills in supporting people with specialist care needs.

- Teams working in our services, both in Leeds and in other regional sites, often find it challenging to access **suitable therapeutic space** for consultations with service users, and office space for staff meetings. Sometimes this means that appointments are held remotely through video call, rather than in person, due to estates constraints rather than clinical decision making. For some of our services, such as addictions, it is preferable from a clinical safety perspective, to see service users in person so it is important to have access to appropriate space to enable this.

Activity across all of our regional and specialist services are projected to increase in future

The table below shows the current and forecast demand for regional and specialist services if we make no changes to our services (the 'do nothing' scenario). Demand for our services is measured by 'contacts'.

We have used baseline figures from 2019 except for services that have had significant changes in activity in 2020 or 2021 (this is shown in the table).

The table below shows a range of forecast contacts in 2028 and 2036 - this range reflects the 'best case'[3] and 'intermediate case'[3] scenarios for the long-term recurrent impact of Covid-19 on demand for mental health and neurodiversity support.

'Do nothing' modelling for our regional and specialist services

	Extrapolated contacts 2019[1,2]	Forecast range of 'do nothing' contacts 2028[2,3]	Forecast range of 'do nothing' contacts 2036[2,3]
ADHD	2,842 (5,772 in 2021)	7,471 - 7,651	10,211 - 10,391
Emerge Leeds	3,806	5,643 - 5,885	6,932 - 7,174
Gambling Services	1,446	1,732 - 1,780	2,063 - 2,111
Gambling Services NHSE	42 (1,903 in 2021)	2,186 - 2,246	2,577 - 2,637
LADS	1,726	2,391 - 2,450	3,239 - 3,298
Pathway Development Service	218	276	325
Veterans HIS Team NE	0 (2,070 in 2021)	2,610 - 2,681	3,060 - 3,131
Veterans MH CTS	3,335	4,036 - 4,146	4,678 - 4,789
Total	**13,415**	**26,345 - 27,115**	**33,084 - 33,853**

1 Where a full year of data is not available for the calendar year, or where the data looks to contain anomalies, a shorter period has been taken and then extrapolated based on the number of months. E.g. if April - Dec was taken as the baseline period, this has been uplifted by 12/9. The appointments / contacts have then been calculated based on the displayed ratio against the extrapolated referrals.

2 Contacts include both attended and DNAs as both are relevant for forecasting future estate requirements.

3 Range based on no long-term recurrent impact of COVID ('best case') and 'intermediate 1' scenario which is based on some long-term recurrent impact of COVID (using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council). For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.

We will make changes to our regional and specialist services to improve care and future proof our services

To address the challenges we are facing now and set our services up for the future, we must make changes so that we can provide better care to people who use our services. We have identified a set of key changes to our regional and specialist services, shown in the table below.

In developing these changes, we have considered the overarching strategic priorities for LYPFT care services and have also considered the ambition of our local system, region and relevant national policy.

Our future services must align to the 'left shift' agenda set out in the NHS Long Term Plan, moving more care into the community, focusing on early intervention and prevention, and addressing health inequalities.

Our priorities for care services are:

- We co-create and co-deliver care services with people who have lived experience
- We collaborate with our partners to understand our populations and provide proactive integrated care
- We provide high quality, equitable and sustainable care services

The diagram below shows the changes we will make to our regional and specialist services and they align with these priorities.

Change	Rationale and benefits	Priority alignment
Introduce 'two tier' autism diagnostic service with increased role of primary care / third sector partners for less complex cases and ongoing role for LYPFT in more complex cases	This change aims to better meet demand for autism diagnostic assessments. We expect that this will lead to fewer referrals to our LADS service.	We co-create and co-deliver care services with people who have lived experience
Introduce system-wide offer for ADHD, with increased role for primary care / other partners for less complex cases (ongoing role for LYPFT in more complex cases)	This change aims to better meet demand for ADHD services. We expect that this will lead to fewer referrals to our ADHD service.	
Expand our ADHD service to include treatment and management support, as well as diagnostics, and introduce service to support children and young people with ADHD in transition to adult services	These changes aim to address a current service gap. We expect this will lead to increased referrals due to the expansion of the scope of the service. These changes will require recurrent investment in the service.	We collaborate with our partners to understand our populations and provide proactive integrated care
Expand our EMERGE and PDS services to include support to people under the age of 18 (14+) and people with neurodiversity	These changes aim to address a current gap in service and meet currently unmet need. This would lead to increased referrals in line with the expansion of the service.	
Expand gambling addiction service provision and open new bases in North West and South Yorkshire.	These changes aim to address gaps in services and unmet need. We expect these will lead to increased referrals to our services.	We provide high quality, equitable and sustainable care services
The new Op Courage service launched in April 2023. LYPFT is committed to working with existing partners under the lead provider Cumbria, Northumberland, Tyne and Weir NHS Trust, and will reconfigure its service and embed the revised clinical model across our areas of responsibility.	The model of care for veterans services in the region is currently being redeveloped with our partners. We expect these changes would lead to reduced referrals for CTS due to the smaller geography but likely more for TILS.	

We have looked at how these changes are forecast to impact projected demand for our services

The table below outlines the 'do something' modelling for our regional and specialist services based on the changes we have identified.

The rows in the table highlighted in blue show the services impacted by the changes outlined on the previous page.

We expect that the shift to a system-wide offer for ADHD services, with more cases managed by primary care in future (potentially with pre and post diagnostic support as well as diagnostic assessments), could lead to around 25% fewer referrals to the service by 2028. An assumption of 25% fewer referrals to LYPFT services by 2028 has also been assumed for the future 'two tier' LADS service.

The 'do something' scenario for Emerge and PDS assumes an expansion to support people aged 14 and over and people with neurodiversity.

The 'do something' forecast for NHSE commissioned Gambling Services shows more contacts in future relative to the 'do nothing' scenario, reflecting the expansion of this service.

The future contacts for our CTS Veterans Services are significantly higher than the 'do nothing' view based on the assumption that we could expand our provision to all three tiers of Veterans services across the North.

'Do something' modelling for our regional and specialist services

	Extrapolated contacts 2019[1,2]	Forecast range of 'do nothing' contacts 2028[2,3]	Forecast range of 'do something' contacts 2028[2,3]	Forecast range of 'do nothing' contacts 2036[2,3]	Forecast range of 'do something' contacts 2036[2,3]
ADHD	2,842 (5,772 in 2021)	7,471 - 7,651	5,603 - 5,783	10,211 - 10,391	7,658 - 7,838
Emerge Leeds	3,806	5,643 - 5,885	5,643 - 5,885	6,932 - 7,174	6,932 - 7,174
Gambling Services	1,446	1,732 - 1,780	2,165 - 2,212	2,063 - 2,111	2,579 - 2,626
Gambling Services NHSE	42 (1,903 in 2021)	2,186 - 2,246	2,732 - 2,793	2,577 - 2,637	3,221 - 3,281
LADS	1,726	2,391 - 2,450	1,793 - 1,852	3,239 - 3,298	2,429 - 2,488
Pathway Development Service	218	276	276	325	325
Veterans HIS Team NE	0 (2,070 in 2021)	2,610 - 2,681	2,610 - 2,681	3,060 - 3,131	3,060 - 3,131
Veterans MH CTS	3,335	4,036 - 4,146	13,453 - 13,563	4,678 - 4,789	15,594 - 15,704
Total	**13,415**	**26,345 - 27,115**	**34,276 - 35,046**	**33,084 - 33,853**	**41,797 - 42,567**

1 Where a full year of data is not available for the calendar year, or where the data looks to contain anomalies, a shorter period has been taken and then extrapolated based on the number of months. E.g. if April - Dec was taken as the baseline period, this has been uplifted by 12/9. The appointments / contacts have then been calculated based on the displayed ratio against the extrapolated referrals.

2 Contacts include both attended and DNAs as both are relevant for forecasting future estate requirements.

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These changes will have aim to make care better for service users and improve staff experience

We know that without changing how we provide our regional and specialist services, there is a risk that our services will not be sustainable and this will limit our ability to continue to provide safe, high quality and equitable care.

The ambition we have set out for our Regional and Specialist Service Line aims to deliver on our wider care services strategic priorities and align to the ambition of our partners and the national direction for future mental health services.

We will know we are achieving the right outcomes if:

- Our service users and their carers are able to access timely, high quality and equitable mental health and neurodiversity care and support that meets their needs.
- Our waiting lists improve, meaning people get access to care more quickly.
- We have a supported and resilient multidisciplinary workforce.
- Our staff have career progression opportunities, feel valued and staff retention improves.
- Our services are considered leading and we are able to use our expertise to influence local and national policy and to promote innovation and collaboration with our partners.

To bring to life the impact we hope to have on outcomes for people, we have included below a service user 'persona' with a short story of what their care journey could look like in future, based on the ambition we have set out in this document.

My name is Leo and I've recently been diagnosed with autism. I referred myself to LADS after speaking to my GP a few months ago. I was initially worried about having to wait a long time to be seen based on what I've heard about waiting lists for autism assessments, but once my referral was received I was contacted by a support worker who offered to speak to me about their experience of being diagnosed with and living with autism. I was able to meet them over a video call and found it helpful to talk through some of my worries. This really helped while waiting for my diagnostic assessment from the LADS team.

integrity

simplicity

caring

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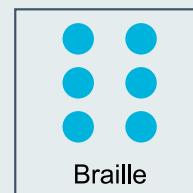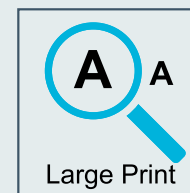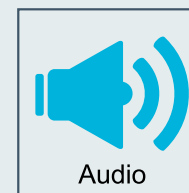
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