Step Up to Great Mental Health

Service improvement programme

Urgent and Emergency Care Mental Health services

Integrated Community Mental Health services

Decision Making Business Case

Version 12

06/12/2021

Decision Making Business Case Contents

Appendices

1. Summary

This Decision-Making Business Case (DMBC) sets out the case for change, engagement and consultation process on our plans to improve our Urgent and Emergency Mental Health Care pathway and to strengthen the integration of our Community Mental Health services in Leicester, Leicestershire and Ruland Integrated Care System (ICS).

The DMBC then sets out the consultation feedback and recommended decisions to enable us to move to implementing our investment and improvement plans.

Chapter two describes the population health need and the diversity of the communities in Leicester, Leicestershire and Rutland (LLR). This includes the JSNA mental health profile for each area.

Chapter three sets out the national and local case for change. These plans will help us to deliver a series of national best practice frameworks while responding to local need. The issues that drive the national improvement programmes are all present in LLR. We also have significant local challenges that we are seeking to address through this investment and improvement programme.

Chapter four describes the three year process to coproduce our plans through a programme of engagement workshops with service users, staff and wider stakeholders. The process of codesign will continue through the implementation planning and delivery phases.

Chapter five sets out the detail of the proposed future service models described in our Pre Consultation Business Case that formed the basis for the public consultation undertaken in summer 2021. This chapter also sets out the expected benefits of making the proposed changes and how the individual service changes fit together.

Chapter six summarises the consultation process that the ICS ran from May to August 2021. This chapter provides detail of the broad range of communication vehicles and the significant number of engagement events that have shaped our final plans.

Chapter seven describes the consultation feedback and our response to it. This chapter describes the level of support for each proposed service change, provides detail on the feedback comments and sets out our response to the feedback.

Chapter eight provides detail of our investment plans and the increased workforce that it will fund.

Chapter nine summarises the Equality Impact Assessment (EIA) undertaken following the consultation. This builds on the EIA process undertaken to inform the Pre Consultation Business Case and consultation process.

Chapter ten sets out how we plan to coproduce our implementation plans with local communities, service users, families, carers, partner organisations and staff.

Chapter eleven updates our response to the national reconfiguration tests and describes the governance of the Step Up to Great programme.

Chapter twelve sets out the recommended decisions to be considered by the CCG Board following the consultation process and Equality Impact Assessment.

We would like to thank everyone who has participated in the consultation process for sharing their experiences and what matters most to them. We would also like to acknowledge the fantastic support we received in promoting the consultation from local voluntary and community sector partners.

2. Population health need

Leicester, Leicestershire and Rutland

The LLR ICS covers Leicester, Leicestershire and Rutland. This is the same footprint as Leicestershire Partnership NHS Trust, the main provider of secondary mental health services. The service change plans in this DMBC relate to this geographic area. It has a population of circa 1.1 million people. The LLR geography is diverse in terms of ethnicity, deprivation and health need. We have divided the population health need chapter into three sections to profile each of the local authority areas. Our service change proposals put to public consultation were informed by this analysis in terms of the need for mental health support, expected volumes of activity and the appropriate vehicles of delivery.

Leicester

Leicester is the ninth largest city in England, has a population of 355,200 and is the most populous area in the East Midlands. The city is made up of 7,355 hectares and is surrounded by the district councils of Leicestershire. Leicester is a compact urban area made up of traditional terraced housing in its inner core and a number of interwar and post war housing estates on its outer core.

Leicester has all the features of a large city including retail, culture and sports venues. Leicester is a unitary authority. Leicester has had a long history of manufacturing including textiles, footwear, engineering and more recently retail and food. There are two large universities: De Montfort University and Leicester University with combined student numbers of circa 35,000. The city has one category B Adult Male prison with capacity for 408 prisoners.

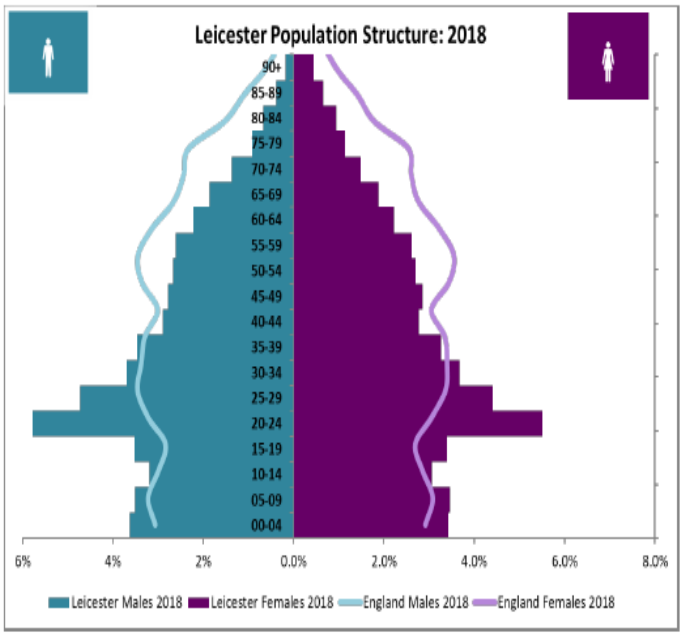
Since World War II, Leicester has experienced large scale immigration from across the world. Economic migrants from the Irish Republic and the West Indies arrived throughout the post war period; people from the Indian sub-continent began to arrive in the 1960's and Ugandan Asians in the 1970's; in the 1990's Somali's settled in the city; and since 2004 significant numbers of Eastern Europeans have made Leicester their home. This makes Leicester one of the most diverse places in England.

Leicester - Population profile

Leicester had a total population of 355,218 in 2018 with equal numbers of males and females. The population of Leicester is relatively young compared to the England average. One fifth of the population (20%) is aged 20 to 29 years old compared to 13% across England. A third of households include dependent children. The population aged over 65 makes up 12% of the total compared to 18% across England.

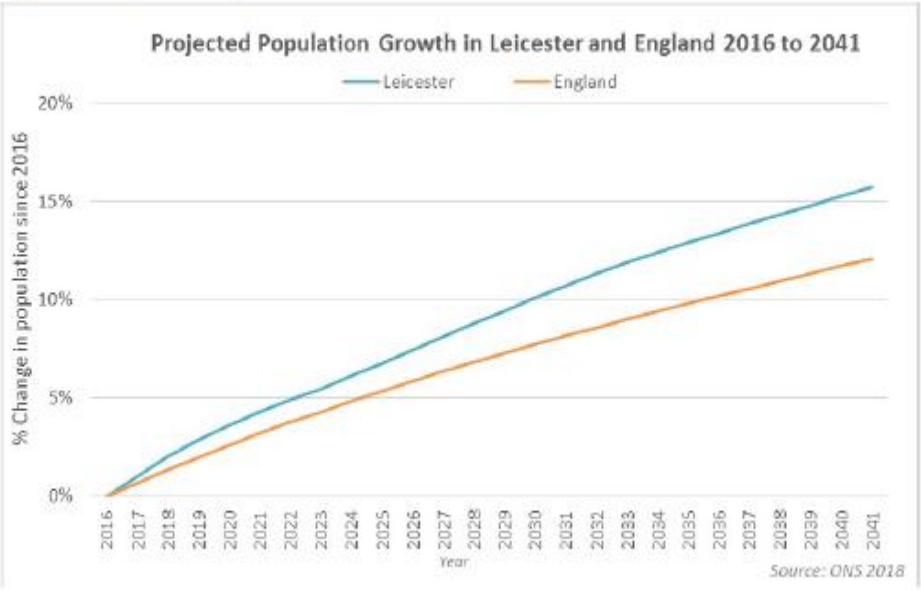
The population is due to grow by 7.5% between 2016 and 2026 and by 16% by 2041. This is a higher rate of growth than is expected for England at 12%. The over 65s are expected to make up 15.8% of the population by 2041 compared to 11.9% in 2018.

Figure 1: Population structure in Leicester and England by age and sex – 2018



Source: ONS mid-2018 population estimates

Figure 2: Projected Population Growth 2016 to 2041



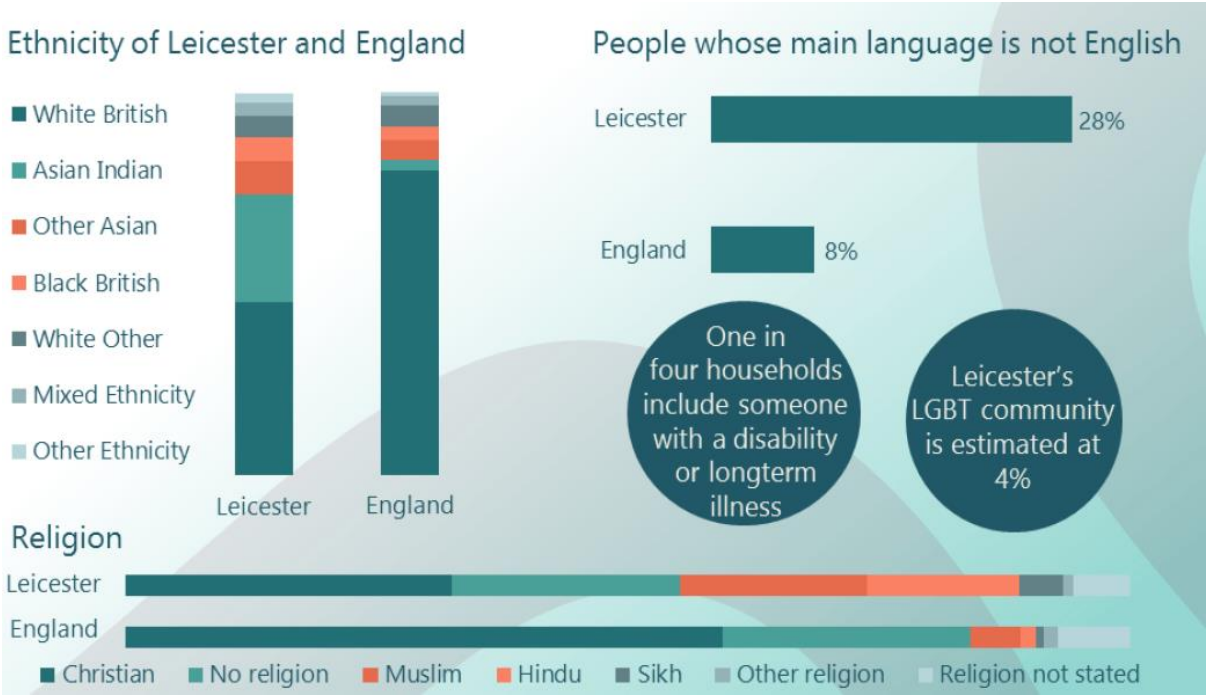
Source: ONS, 2016-based population projections

Leicester – Ethnicity

Leicester is the most ethnically diverse area in the LLR ICS. As the chart below demonstrates, Leicester has a lower proportion of White British people than the England average, with a higher proportion of Asian Indians, Other Asian and Black British citizens.

The proportion of people in Leicester whose main language is not English is more than three times higher than the national average at 28%.

The same level of diversity is seen in terms of the stated religion of the Leicester population. There are a lower proportion of Christians, with a higher proportion of Muslims, Sikhs and Hindus.

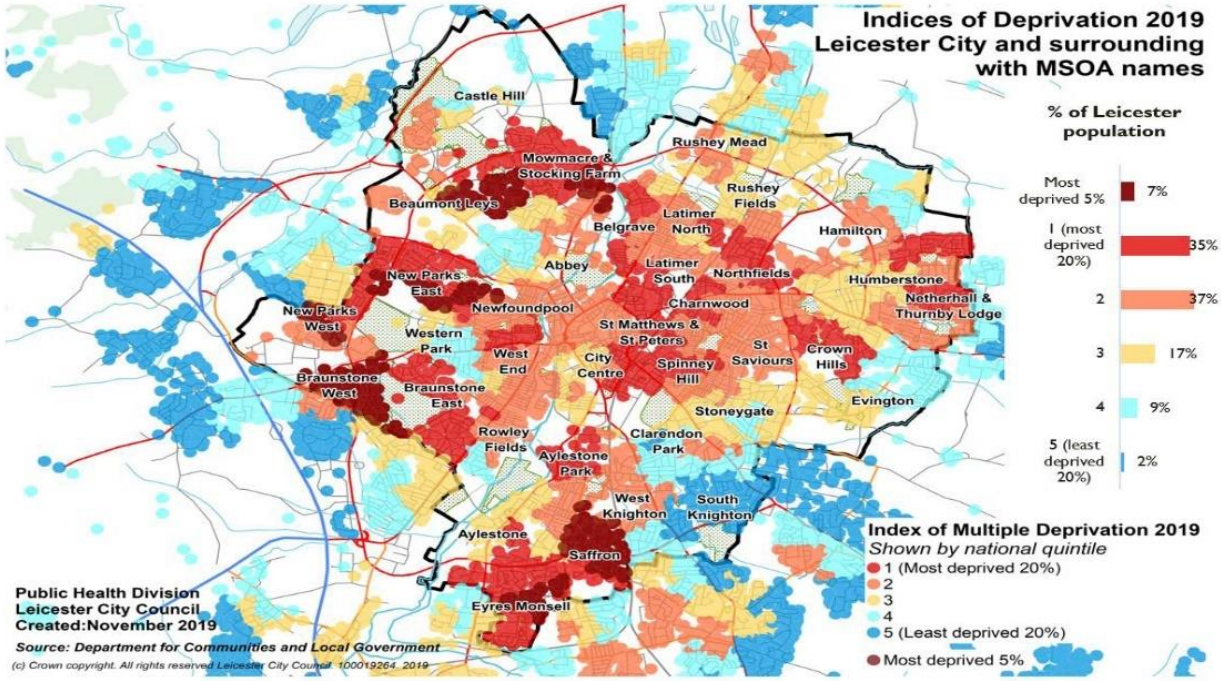


Leicester - Deprivation

Leicester is the 32nd most deprived local authority in England out of 317. 35% of the Leicester population live in the most deprived 20% areas in England and two-thirds in the most deprived 40% of areas in England. In Leicester, 23% of children live in low-income families. The percentage of people in employment is lower than the national average, 66.2% v 75.6%.

Deprivation is aligned with a range of poor health behaviours and outcomes such as smoking, obesity and alcohol misuse. Those living in our most deprived areas have significantly lower life expectancies compared to those in our least deprived areas.

Leicester - Indices of deprivation map



Leicester - Population health

The health of the people in Leicester is in the main worse than the England average. Life expectancy for both men (77.2 v 79.6) and women (81.9 v 83.2) is lower than the England average. Life expectancy is 8 years lower for men and 6.1 years for women in the most deprived areas of Leicester than in the least deprived areas.

Mortality rates for all causes are higher than the England average. Cancers 25%, Cardiovascular 28% and Respiratory 13% account for two out of every three deaths. Mortality rates from cardiovascular and respiratory diseases are higher than the England average. Infant mortality is higher than the national average.

In Year 6, 23% of children are classified as obese, worse than the average for England. Levels of teenage pregnancy, GCSE attainment and breastfeeding rates are worse than the England average.

The rate for alcohol-related harm hospital admissions is worse than the average for England. Estimated levels of smoking are worse than the England average. The rate for self-harm hospital admissions and suicide rates are better than the average for England.

Diagnosis rates for Dementia and Diabetes are above the national average. Incidence of TB is extremely high compared to the national average.

JSNA – mental health

A summary of the JSNA mental health profile is included on the next page. It draws out a number of areas in which Leicester is worse than the national average including:

- ESA claimants for mental health and behavioural disorders
- Self-reported well-being
- Prevalence of serious mental illness
- Prevalence of opiates and/or crack cocaine use
- Admission episodes for alcohol-related conditions
- Admissions for mental and behavioural disorders due to alcohol

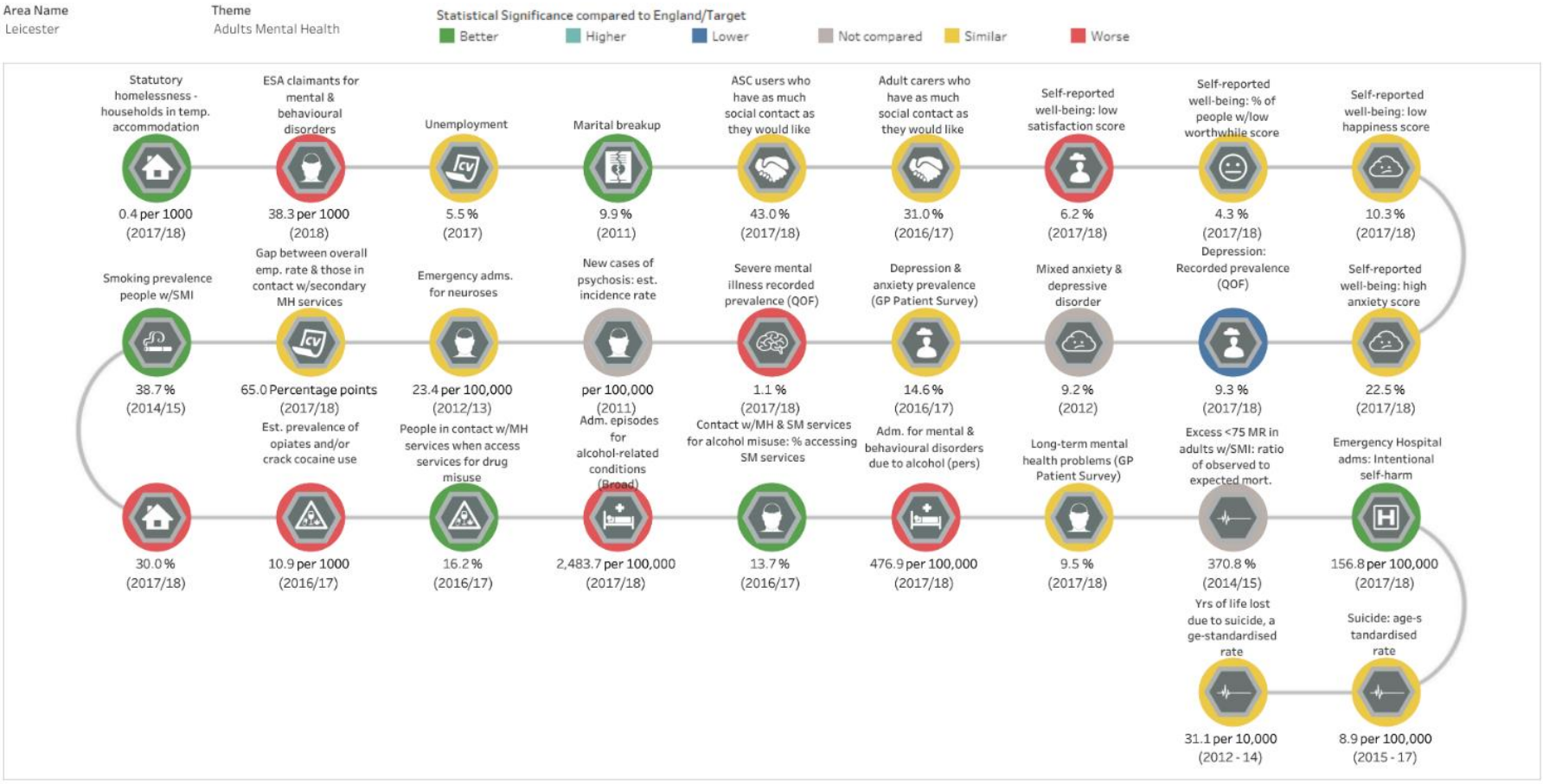
As set out above, the demographic, social and economic indicators for Leicester are consistent with the JSNA headlines.

- Higher number of young adults
- More ethnically diverse
- More deprived
- Higher levels of alcohol misuse
- Lower life expectancy

Leicester - Primary Care Networks

PCN	**List size**
Belgrave and Spinney	45,774
The Leicester Foxes	33,498
Leicester Central	46,828
Salutem	35,455
Aegis Healthcare	45,334
Millennium	50,971
City Care Alliance	38,589
Leicester City and University	45,234
Leicester City South	35,417
Leicester Health Focus	38,194

Leicester – Mental Health profile



Data Source: Public Health England, Fingertips, 2019. Produced by the Business Intelligence Service at Leicestershire County Council, 2019.

Leicestershire

Leicestershire has a population of 698,268 and is made up of a number of urban areas, towns, large villages and rural areas. Leicestershire borders Nottinghamshire, Lincolnshire, Rutland, Northamptonshire, Warwickshire, Staffordshire, Derbyshire and the city of Leicester.

Leicestershire is a unitary authority that covers 832 square miles. There are seven District Councils – North West Leicestershire; Charnwood; Hinckley and Bosworth; Harborough; Melton; Oadby and Wigston and Blaby. The largest towns are Loughborough, Ashby-de-la-Zouch, Coalville, Hinckley, Market Harborough, Melton Mowbray, Oadby, Wigston and Lutterworth.

There is one large university, Loughborough University, with circa 19,000 students. The county has two prisons, a Category B Prison at Gartree, (703) and a planned new Category C prison at Glen Parva which is due to complete in 2021 with 1,680 capacity.

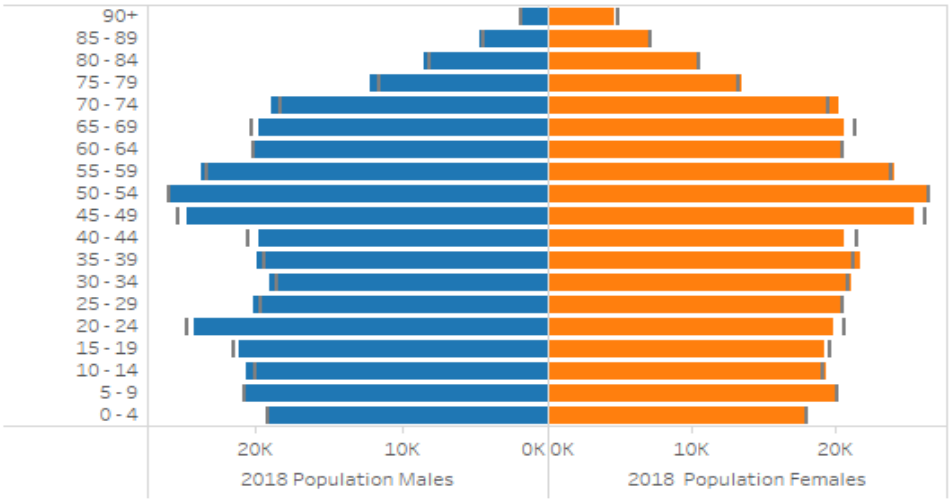
The main industries in Leicestershire are engineering, manufacturing, biomedical industries, farming, and food and drink. More recently distribution has developed along the motorway corridor, retail and the service sector. There is the regional airport, East Midlands Airport; the M1 motorway and transport hubs.

Leicestershire – Population profile

Of the total area of Leicestershire 18% is classified as Urban City and Town – 69.6% of the population live in these areas. A further 18% of Leicestershire is classified as Rural Town and Fringe - 17.5% of the population live in these areas. The greater proportion (64%) of Leicestershire is classified as Rural Village – 12.7% of the population live in these areas.

The total population of Leicestershire in 2018 was 698,268. The population is weighted towards older adults (45-59) with considerable proportion in the 65+ age bands.

- 16.9% of the population under the age of 15 compared to 18.1% for England
- 29.6% of the population aged 15-39 compared to 32% for England
- 33.2% of the population are 40-64 compared to 31.6% for England
- 20.4% of the population are aged 65 or over compared to 18.2% for England.

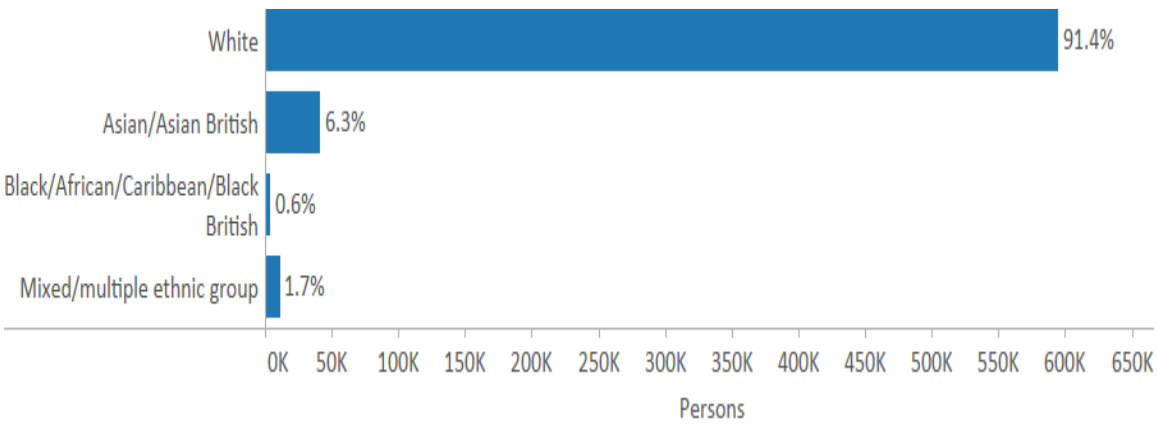


The population of Leicestershire is due to grow by 15.8 % to 787,500 by 2041, this compares to the East Midlands average of 12.4% and 12.1% for England. The greatest change is projected to occur in the 65+ age band, by 2041 there will be an additional 74,300 older people – with the greatest increase in the 75-79s and 90s. All age bands will increase faster than the East Midlands and England average.

Leicestershire – Ethnicity

The majority of the population belong to white ethnic groups. The next highest group is Asian at 6.3%. The main non-English languages are Gujarati; Polish; Punjabi; Chinese and Bengali. 60.3% of the population describe themselves as Christian and 2% as Hindus. There are 47 recognised gypsy and traveller sites in Leicestershire.

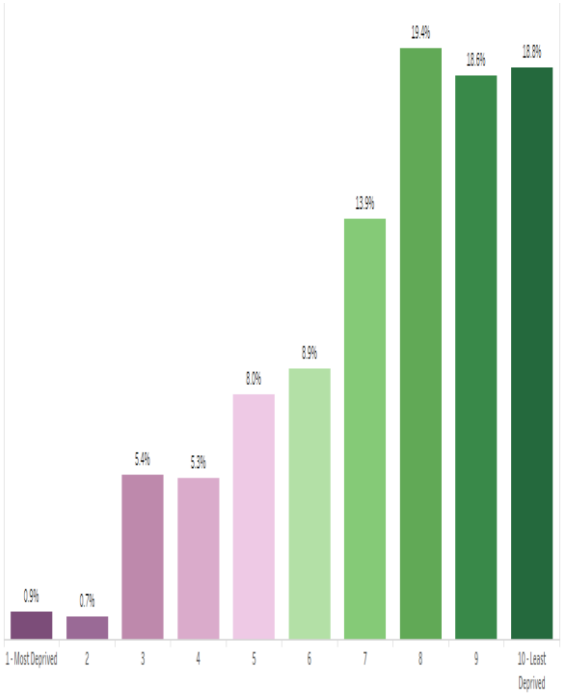
Leicestershire – Ethnicity visual



Leicestershire – Deprivation

Leicestershire is not particularly deprived being ranked 137 out of 152 upper tier authorities. At a district level, no district fits within the top half of all local authority districts. North West Leicestershire is the highest ranked (216/326) and Harborough is the lowest ranked (308/326). 10.9% (12,415) children live in low-income families which is significantly better than the England average.

Despite this there are some pockets of significant deprivation for a small proportion of the overall population. Four neighbourhoods in the county fall into the most deprived decile in England – these are in Loughborough and Coalville. There are a further three neighbourhoods that fall within the second most deprived decile in Hinckley and Loughborough. In comparison, 74 neighbourhoods fall within the tenth least deprived area. In Leicestershire, 395,000 people live within the three least deprived deciles.



Leicestershire – population health

The health of the people of Leicestershire is generally better than the England average. Life expectancy for both men (80.7 v 79.6) and women (84.2 v 83.2) is higher than the England average. Life expectancy is 6.3 years lower for men and 5 years for women in the most deprived areas of Leicestershire than in the least deprived areas.

Mortality rates for all causes are lower than the England average. Cancers 26.7%, Cardiovascular 28% and Respiratory 12.1% collectively account for two out of every three deaths. Mortality rates from cardiovascular is better than the England average. The mortality rate from cancer is lower than the England average.

Estimated levels of physical active adults are worse than the England average. Estimated levels of smoking are better than the England average. The diagnosis rates for Dementia and Diabetes are above the national average. In Year 6, 16.6% (1,187) of children are classified obese, better than the average for England.

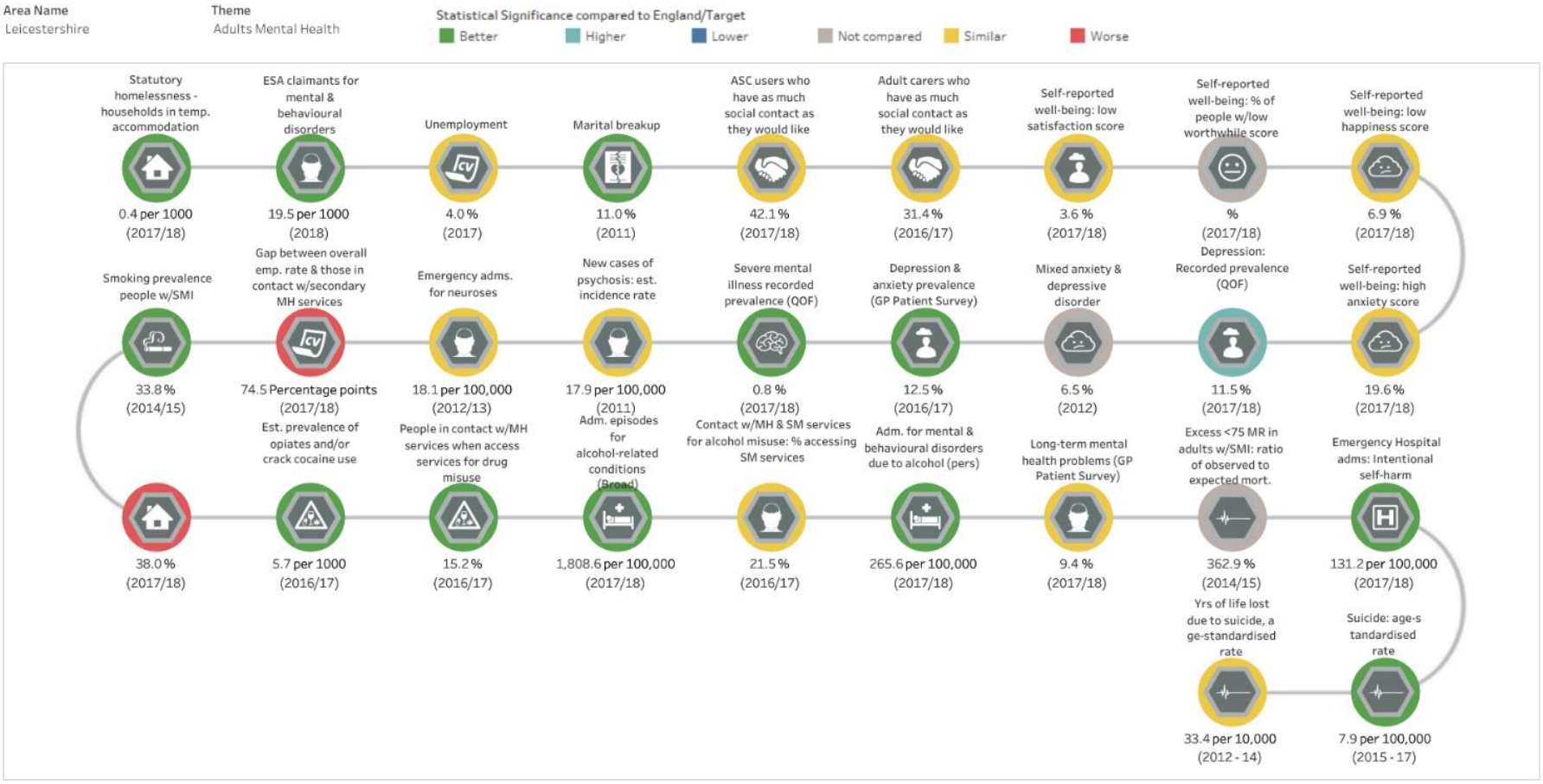
The JSNA summary highlights the gap between the overall employment rate and those in contact with secondary mental health services. For the majority of other measures, Leicestershire is in line with or better than the national average on this range of indicators. For example, self-harm and suicide rates are lower than the England average. This is consistent with the overall demographic, social and economic profile of Leicestershire. The main challenge for mental health services relate to the way in which they are provided with issues over fragmentation and long waits for certain services.

Leicestershire – Primary Care Networks

PCN	**List size**
Hinckley Central	38,507
Fosseway	43,796
North West Leicestershire	115,606
Watermead	32,171
Soar Valley	49,436
Carillon	55,591
Beacon	35,555
Bosworth	37,987
Cross Counties	42,271
Market Harborough & Bosworth	28,445
North Blaby	64,243
Oadby & Wigston	49,059
Syston, Vale and Melton	69,519
South Blaby & Lutterworth	47,188

Carillon and Beacon have been a mental health neighbourhood pathfinder since 2020.

Leicestershire – Mental Health profile



Data Source: Public Health England, Fingertips, 2019. Produced by the Business Intelligence Service at Leicestershire County Council, 2019.

Rutland

Rutland has the smallest population, 39,457, of any unitary authority in England. The county is a rural and sparsely populated county with two market towns – Oakham and Uppingham. Oakham is the largest of the two with the highest population density and it is the main service centre for Rutland – with shops and employment centres. Uppingham is the smaller of the two towns, with a more limited range of facilities and fewer employment opportunities.

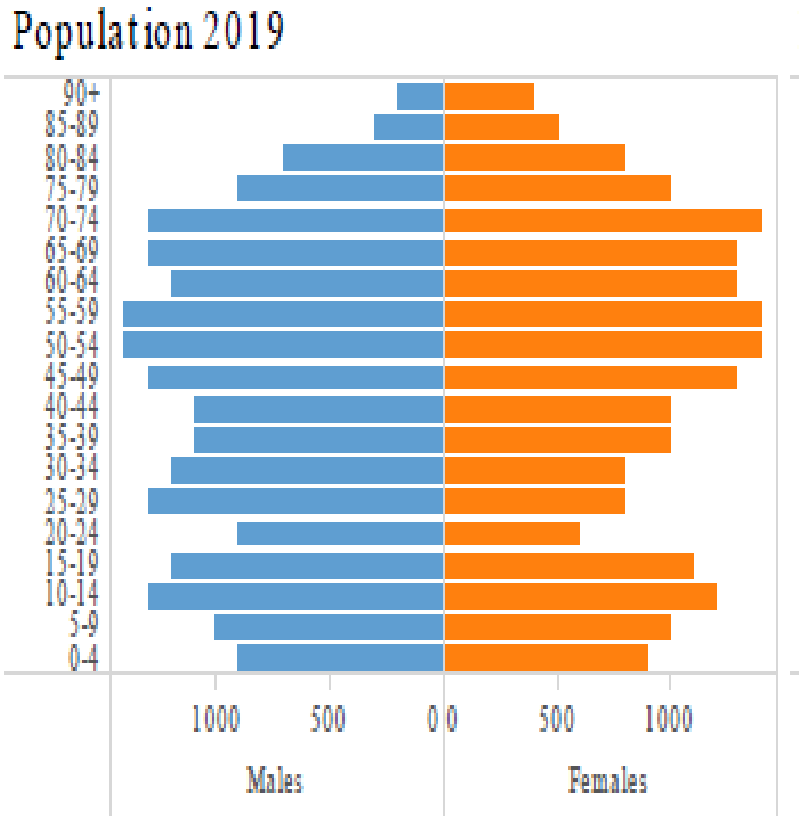
Rutland has over forty villages which range in size from small hamlets with a few houses and no facilities to larger villages with a school, shop, post office and GP surgery and some employment opportunities.

The county has large areas of farmland and is dominated by Rutland Water, an Anglian Water reservoir located in the centre of the county. The county has one category C prison in the northeast of the county with capacity for 842 male prisoners. There are two British Army barracks located in Rutland – the military population accounts for 5.8% of the resident population in the county, 2,250 in April 2018.

Rutland – Population profile

The total population of Rutland is 39,457. There are more males than females in Rutland. The county has a higher proportion of over 65s and over 85s than the England average. Of the over 65 population 6.25% live alone (2,142) which is higher than the England average.

Almost a quarter of the population (24.5%) are over 65. The working age population makes up 53.7% of the total population. Children and young people in the 0-19-year age bracket make up 21.8% of the population.

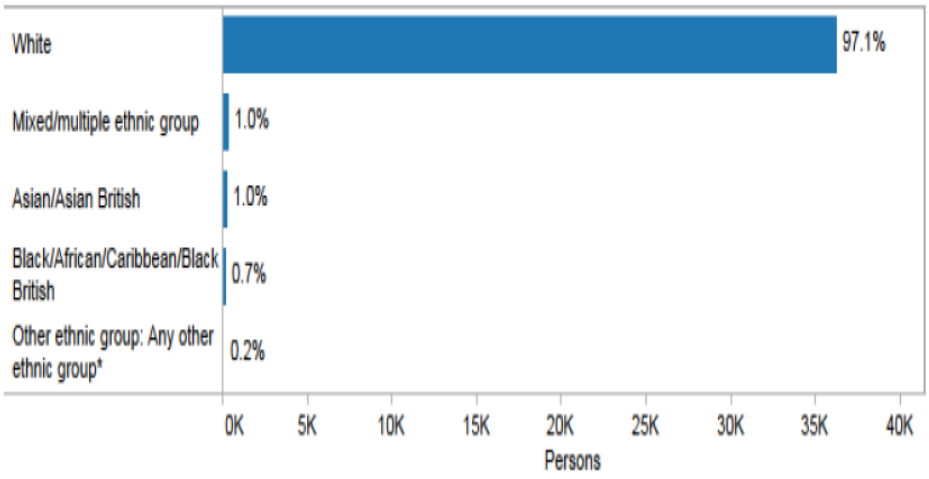


The population is due to grow by 7.9% to 41,100 by 2039. This is lower than the national average population growth. Almost half of the population live in a rural village (48.1%). In Rutland, 28.1% of the population live in areas classified as urban city and town. The remaining 23.8% live in areas classified as rural town and fringe.

Rutland – Ethnicity

The vast majority of the population of Rutland classify themselves as White. In Rutland, 98.2% of people state that English is their main language.

Figure 5 – Rutland population by broad ethnic group, 2011

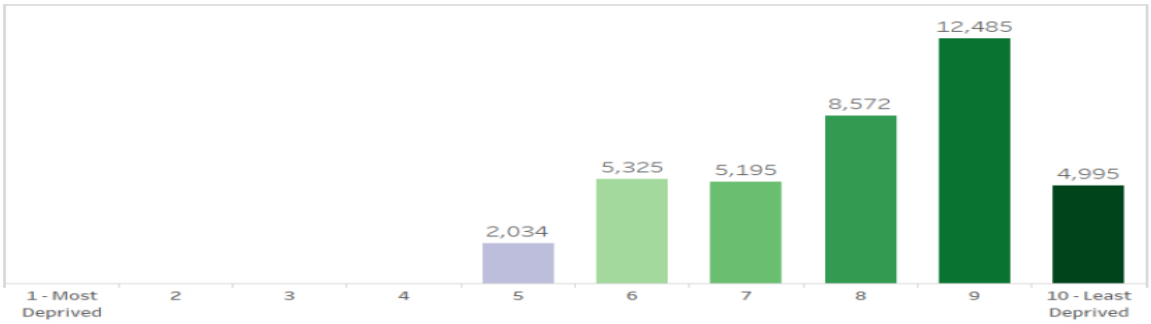


Rutland - Deprivation

The county of Rutland is ranked 148th out of 152 upper tier authorities for deprivation. 22 of the 23 Lower Supper Output Areas in the county fall within the 50% least deprived areas in England. One neighbourhood, Greetham, falls within the 50% most deprived in England. It has a population of 2,034 people.

The chart below should the distribution of the Rutland population across the Multiple Deprivation deciles (10% bands), ordered from 1 (most deprived) to 10 (least deprived).

Figure 14- 2016 population by ID2015 Multiple Deprivation national decile, LSOAs



Source: Indices of Deprivation 2015, MHCLG, 2015. 2016 Mid-year population estimates, ONS, 2017.

Rutland – Population Health

The health of people in Rutland is generally better than the England average. Rutland is one of the 20% least deprived authorities in England. Life expectancy for both men and women are higher than the England average. Mortality rates for all causes are lower than the England average. Mortality rates from cardiovascular and respiratory diseases are better than the England average. Life expectancy at birth is better than the England average.

In Year 6, 13.7% of children are classified as obese which is better than the average for England. Levels of teenage pregnancy, GCSE attainment and breastfeeding rates are better than the England average. The rate for alcohol-related harm hospital admissions is better than the average for England. The estimated levels of smoking are better than the England average.

The rate for self-harm hospital admissions is better than the average for England. The diagnosis rates for Dementia and Diabetes are low than national average.

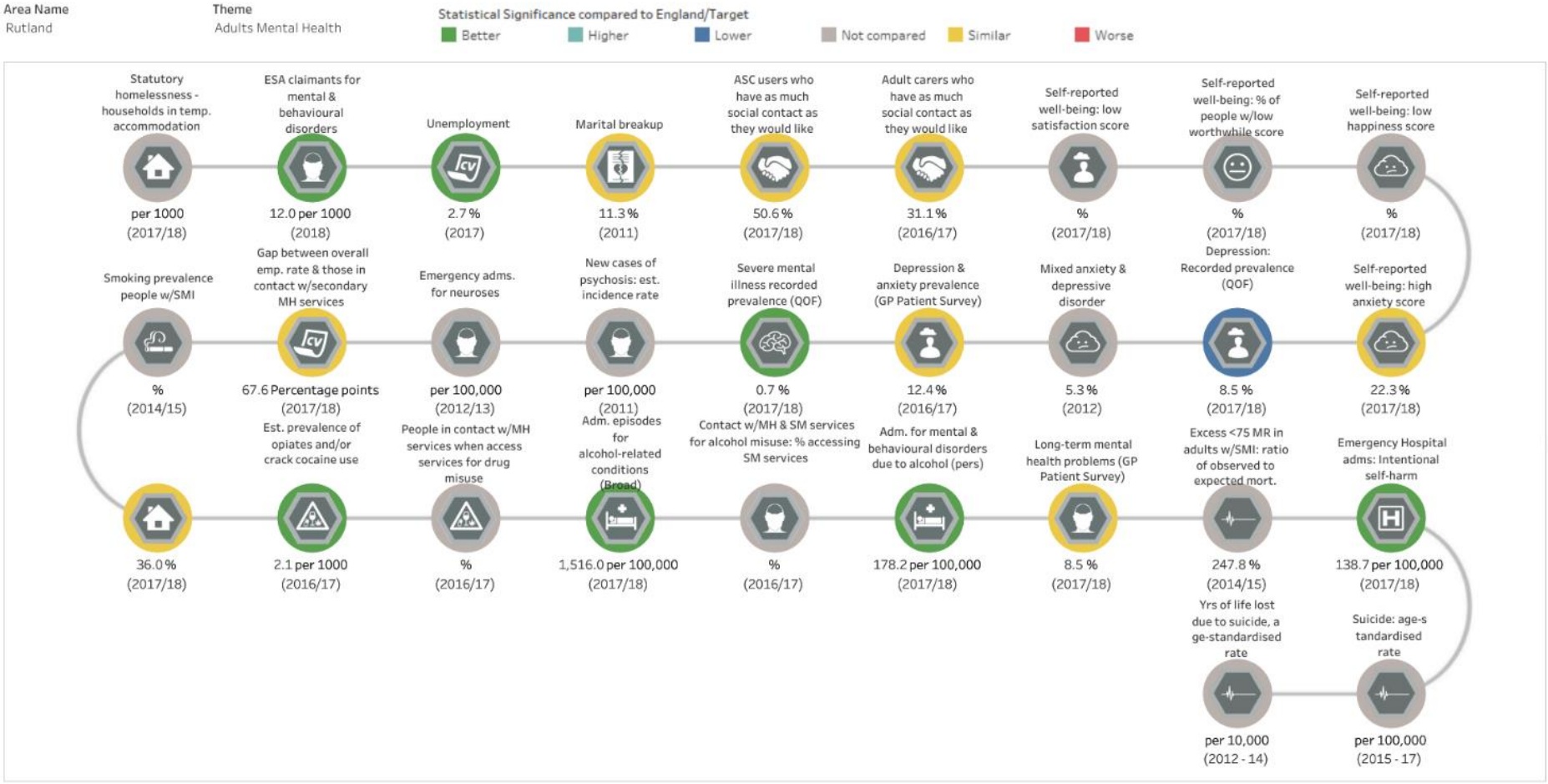
The JSNA mental health summary is included on the next page. There are no indicators against which Rutland is poorer than the national average. For a number of indicators, the profile shows that Rutland are in line with or better than the national average. A larger number of indicators are not compared to the national average due to small numbers.

Rutland - Primary Care Networks

The Rutland Healthcare PCN covers a list size of 69,519. The PCN is made up of four practices:

- Oakham Medical Practice
- Market Overton and Somerby Surgeries
- Empingham Medical Centre
- The Uppingham Surgery

Rutland – Mental Health profile



Data Source: Public Health England, Fingertips, 2019. Produced by the Business Intelligence Service at Leicestershire County Council, 2019.

3. The case for change

The case for change chapter sets out the local drivers of the plans that were subject to public consultation including the perceptions of our service users and staff, our response to Covid and the excessively long waits. It then moves on to set the service reconfiguration plans in the context of the relevant national strategies, frameworks and funding.

Step up to Great Mental Health

Step Up to Great Mental Health is the Leicester, Leicestershire and Rutland (LLR) ICS programme designed to improve mental health services in the region. The Step Up to Great programme is led by the LLR ICS through their All Age Mental Health Design Group and is led by the Chief Executive of Leicestershire Partnership NHS Trust.

The programme builds on the extensive co-design with service users, carers and staff to undertake two key overlapping phases of transformation:

- First - invest and reconfigure existing LLR mental health services so they make significant improvements to experience and outcomes for individuals. It will also organise the services to undertake the second stage.
- Second – to join LLR's mental health services with voluntary sector, social care and primary care in each neighbourhood area (Primary Care Network or equivalent sized contiguous local area).

Our consultation and this DMBC is focused on the first phase. The second phase will be co-produced with the local population, service users, the Voluntary and Community Sector and staff in each Neighbourhood area by area across the next three years.

The SUTG programme has four key elements:

- Neighbourhoods
- Integrated Community Services
- Urgent and Emergency Care
- Inpatient Services

This DMBC does not focus on inpatient mental health services or our neighbourhood plans. The inpatient services will be the subject of a separate Outline Business Case for capital. The neighbourhood plans are focused on delivering the second phase of transformation. It is currently being piloted in two Neighbourhood areas. It will then be developed, area by area, across the remaining neighbourhoods (e.g. PCN) s over the next three years.

This Business Case focuses on the first phase of transformation; Integrated Community Mental Health services and Urgent and Emergency Mental Health services. The service changes are focused on improvement and investment not service reduction or closure. The plans were subject to a public consultation in the summer of 2021.

Step up to Great planned outcomes

We have agreed these key outcomes for the LLR Step up to Great mental health programme:

- Easy for people to access the right support
- 'No Wrong Door' principle to access
- Integrated service offering
- Adding value with every contact
- Supporting recovery
- Appropriate waiting time for treatment and support
- Care delivered as close to home as possible
- People have positive experience of services
- Care and treatment in line with best practice
- Staff have a positive experience
- Balanced flow through the system
- Fair distribution of resources

These planned outcomes underpin all of the Step up to Great Mental Health service change plans set out in chapter five.

Perceptions of Mental Health in Leicester, Leicestershire and Rutland

The LLR ICS shares many of the challenges seen across the country in terms of fragmented community services and disjointed Urgent and Emergency pathway. LLR is an outlier in terms of long access waits for services. LLR underperforms against key national and local mental health standards.

Service users tell us that our services are fragmented, difficult to access and not always available within the community. Service users tell us that they want to see services that are integrated, that they can access locally, to receive the right support first time, move between services without starting again, and step up and down as needed. Service users are also often waiting in some services to be accepted by another due to long internal transfer waits. They often have to tell their story many times.

Some of our staff tell us that they feel overwhelmed by their high caseloads and that we need to improve flow to help to reduce caseloads and eradicate the lengthy internal waits for some patients. Staff also tell us that the distribution of caseloads are linked to historic service and team boundaries and structures rather than on real need. This leads to unfair and sometimes wasteful resource management.

Our regulators tell us that we are an outlier in terms of long access waits, and we underperform against national targets. We have also been a laggard in terms of introducing new modern models of integrated care.

Responding to Covid

We made a series of temporary service changes in response to Covid-19. A number of service changes were mandated by the national team under command-and-control arrangements. These changes were all part of our longer-term plans and we consulted the public on making them permanent having applied the learning from service user and staff feedback.

The temporary changes that we propose to make permanent include:

- A 24/7 Central Access Point
- An Urgent Care Hub
- A community Rehabilitation team
- Increased use of digital platforms

Excessively long waits

The LLR system has a significant problem with long waits for certain community services. The table below sets out the services, number of over one year waits and the longest wait as of October 2021.

Service	**Number of over one-year waits (October 2021)**	**Longest wait (October 2021)**
CMHTs	91 people	146 weeks
CBT	23 people	92 weeks
Dynamic Psychotherapy	14 people	116 weeks
Personality Disorders	315 people	218 weeks

The changes set out in chapter five seek to address these long waits and ensure that we do not have people waiting over four years for the support they require.

National plans and strategies

The national context for the plans on which we consulted is that we are working to deliver national frameworks and strategies in the LLR ICS area. We have set out below the most relevant of these frameworks and the relevant drivers linked to our plans.

Urgent and Emergency Mental Health Care

There are a range of national strategies, documents, commissioning intentions and developments that link to and support our plans to improve our UEC mental health offer bringing together a proper UEC pathway in LLR.

National plans to develop Crisis and Home Treatment

National guidance sets out the expectation that every area in England will have a 24/7 mental health crisis service. Every service will be 'open-access' by 2021, meaning that people and families can self-refer, including those who are not already known to services. Investment in 24/7 intensive home treatment services in every area by 2021, so people can be cared for at home instead of hospital where appropriate. Long standing restrictions on older adult access to crisis services will be removed.

National plans to improve access to Crisis Care

The NHS Long Term Plan sets an ambition for more comprehensive crisis pathways in every area that meets the continuum of needs and preferences for accessing crisis care, whether it be in:

- Communities
- People's homes
- Emergency departments
- Inpatient services
- Transport by ambulance.

National plans include mental health providers working with partners to increase capacity, improve traditional models of crisis care and deliver comprehensive accessible local crisis care pathways. Key partners include the voluntary and community sector, the police, ambulance services and A&E departments with the goals of:

- Simplifying access to crisis care
- Simple access to urgent mental health support via a three-digit number
- 24/7 support
- The nhs.uk website will be developed to incorporate a postcode search facility to support access to local central access points
- Delivering urgent care away from A&E departments

Developing Crisis alternatives

National guidance sets out how every area in England has been allocated funding to invest in alternative models of crisis support, such as crisis cafés, safe havens, and crisis houses, providing an alternative to A&E or inpatient psychiatric admission.

This funding is expected to continue over 5 years, with a total of £179 million being invested in all areas to increase the range of alternative services that can meet the range of different needs and preferences for accessing crisis support.

This investment has largely gone to the voluntary sector providers of these services, which tend to have high levels of service user satisfaction. They will all be expected to employ peer support workers, providing support from and employment to people with lived experience of using mental health services.

All areas have been asked to use this ringfenced investment to identify local inequalities in access, experience and outcomes among people who use crisis services, and to seek to implement alternative services that better meet needs of these groups, which will be prioritised based on local demographics. The guidance sets out the importance of closer working between the NHS and the voluntary and community sector. This lies at the heart of our Step Up to Great plans.

Specialist liaison mental health teams in emergency departments and general hospital wards

National guidance on support in emergency departments and on general hospital wards highlights the commitment to ensure that when people need to attend A&E, it is equipped to meet their mental as well as physical needs.

The national guidance notes the significant progress made since 2016 in introducing specialist psychiatric liaison teams into emergency departments across the country, with every hospital with a 24-hour consultant led emergency department now having a psychiatric liaison team on site; two-thirds of these teams now operate on a 24/7 basis, compared to only two-fifths in 2016; 33% are now meeting the 'core 24' service standard, compared to only 10% in 2016 (this is on track to meet the ambition of 50% by 2021 and 70% by 2023/24).

Delivering the Core 24 standards

The Core 24 service specification and guidance sets out new targets for the Emergency pathway for responses within one and four hours.

- One hour - An urgent and emergency liaison mental health service should respond to the person within one hour of receiving a referral. An emergency response consists of a review to decide on the type of assessment needed and arranging appropriate resources for the assessment.
- Four hours - Within four hours of arriving in an ED or being referred from a ward it is recommended that the person should have received a full biopsychosocial assessment, and have an urgent and emergency mental health care plan in place, and at a minimum, be en-route to their next location if geographically different, or have been accepted and scheduled for follow-up care by a responding service, or have been discharged because the crisis has resolved or have started a Mental Health Act assessment.

National Crisis Care Concordat

The national Concordat focuses on four main areas:

1. Access to support before crisis point – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.
2. Urgent and emergency access to crisis care – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
3. Quality of treatment and care when in crisis – making sure that people are treated with dignity and respect, in a therapeutic environment.
4. Recovery and staying well – preventing future crises by making sure people are referred to appropriate services.

National Community Mental Health Framework

The national framework published in late 2019, sets out a case for change, describing a range of common issues with community mental health services. These are all present in Leicestershire.

The national case for change:

- Fragmentation of separate specialist teams
- Multiple assessments for the same person
- Exclusion through rigid service specifications and/or arbitrary thresholds
- The need to improve access to appropriate care
- Unnecessary deterioration leading to more acute presentations
- Lack of personalised support
- Problems in moving between services – 20% drop out rate when people's care moves
- Problems with transition for young people moving into adult services
- Stagnation in the development of Community Mental Health Teams
- Poor use of resources
- Reductions in services for people who need longer term care in the community

There is strong alignment between the national case for change and the drivers of our own community service change programme.

Goals of the national Community Mental Health Framework

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

- Access to mental health services where and when people need it
- Individualised approaches to managing conditions and recovery
- Breaking down barriers between mental and physical health
- Integrated care
- Place based service offerings
- Increased roles for the voluntary and community organisations and social enterprises

- Local collaboration
- Working together to maximise the support offered to people when and where they need it
- Meeting people's needs in the community
- Reinvigorates community mental health provision

Investing in a new Community Mental Health model

The national community framework sets out broad detail of the expected model. We have incorporated these into our service change plans across both phases of our transformation programme:

- Place based integrated mental health support
- For people with any level of mental health need
- Greater volume and higher quality care to be provided at a local community level (30,000 to 50,000 populations – Primary Care Networks)
- Supporting people to live in their communities
- Strong focus on people with severe mental health needs including those with co-existing physical health problems
- Brings together what is provided in primary care for people with less complex needs with that provided by secondary care CMHTs
- Good quality assessment at whatever point people present
- Interventions are readily available and accessible at the location most appropriate to people's needs
- Step up and step down from specialist care
- Removing cumbersome referrals and multiple assessments
- Developing community assets to enable people to become more embedded within their community

Range of integrated community services

The national community framework sets out a range of services that should be locally accessible.

Advocacy services	Assessment, advice and consultation for mental health problems
Community assets (e.g. libraries, leisure facilities and faith groups)	Coordination and delivery of care
Effective support, care and treatment for drug and alcohol disorders	Employment, education, volunteering and training services
Evidence-based interventions for mental health problems including psychological and pharmacological treatments	NICE recommended psychological therapies for people with severe mental illness
Help and advice on finances	High quality, co-produced personalised care and support planning

Housing and social care services	Physical health care
Access to mental health information and online resources	Specific support groups

Services for people with more complex needs

Alongside the broadly accessible general services, the national framework describes a vision for services for people with more complex needs. The framework is clear that in all care for complex needs, the principle of community remains critical.

Crisis care	Inpatient care
Specialist residential care	Community eating disorder services
Intensive and assertive support	Support for people at risk of exclusion – rough sleepers, people leaving the criminal justice system and socially excluded people
Support for people with very complex needs – including psychotic disorders or difficulties associated with a diagnosis of "personality disorder"	Stepping up and stepping down care should be straightforward and seamless, so that people using the services, their carers and families do not feel or experience any gaps or boundaries

Accessing integrated community services

The national framework sets out a new approach to accessing care:

- No wrong door
- Access in a timely manner
- Wherever the patient seeks it
- Referrals from GPs, a community service, online referral or other routes
- People with the highest levels of need ad complexity will have a coordinated and assertive community response
- Evidence based interventions

Assessment and intervention in redesigned community services

The national framework sets out a new approach to assessment and intervention:

- Assessment as part of the integrated team approach
- Assessment as a collaborative process with people, families, carers and support networks
- Assessment can be undertaken by different members of the core community mental health service at the point at which a person seeks access
- Assessment will vary dependent on individual need and the complexity of their problems
- Digital technologies may be used

- Intervention detailed in an agreed, personalised care and support plan, developed mutually
- Spectrum from uni-professional care planning through to multi-disciplinary input and interventions

Coordinating and planning care

The national community framework sets out a new approach to coordinating and planning care.

Replacing the Care Planning Approach (CPA) with high quality personalised care and support planning	Using the NHS England Comprehensive Model of Personalised Care
Co-produced and personalised care plan that takes into account their needs and their rights	The level of planning and coordination of care will vary, depending on the complexity of need
Coordination will be provided by people from a range of backgrounds	The triangle of care can facilitate the greater involvement of carers
Whole family approaches pioneered in social care can increase the effectiveness of planning	There should be timescales for review, involving all relevant parties, agreed at the outset
Digital technologies can help manage care records	Shift away from risk assessment and predictive approaches to safety planning to positive risk taking

Support to connect with the wider community

The national community framework sets out a new approach focusing on community connection.

- A specific community connector or social prescribing link worker role might need to be created
- Alternatively, this may be carried out by peer support workers, recovery coaches or care coordinators
- It is part of everyone's role to work with their community
- Draw on the whole spectrum of VCS and other community services
- Strong familiarity with local resources and assets
- Assess a person's ability and motivation to engage with community activities
- NHS England committed to fund the recruitment and training of over 1,000 social prescribing link workers to be in place by the end of 2020/21

Benefits of a new model of integrated community services

The national community framework sets out a range of expected benefits that align with those of Leicestershire's Step Up to Great Mental Health programme.

- Fewer assessments
- Fewer requests to repeat their histories
- People not falling through service gaps
- Support to live as well as possible in the community
- More time for direct contact with service users
- Freeing up time to deliver evidence-based care
- Less administration and bureaucracy from an integrated system with fewer referrals
- Increased autonomy for professional judgement
- Innovation and partnership working are fostered
- Better access to expert mental health clinical advice
- Reduced waiting time for services to respond
- Fewer people who attend GP practices with unmet mental health needs

4. Pre-consultation engagement and development of our proposals

Phased approach to engagement

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

Stage 1

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

Stage 2

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

Stage 3

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

Stage 4

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

Clinical workshops

In November 2020, we ran two clinical workshops to identify key potential implementation risks and issues with two of the main changes within our community service offer. One focused on the future Step Up/Step Down approach and the second on how the four main therapy teams will be brought together to offer a more integrated MDT approach. The workshops identified training requirements, protocols that need to be developed and pre-change reviews that will be required for some service users.

Co-design approach

The programme adopted a co-design approach that had service users, carers, staff and other stakeholders regularly brought together through workshops to build a design together. Many of the plans were formed in and through the workshops. This allowed a model to be built iteratively through the stages of engagement leading to the changes described in the public consultation documents.

Co-design - developing our plans based on the engagement process feedback

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

Access

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

Assessment

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

	significantly improve the quality of first assessment and making the right first step in treatment.

Treatment

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

Discharge

Feedback	Addressed in our plans
Signpost broader community groups and activities	A higher proportion of our investment is focused on expanding the role of the VCS to support service users to identify a wider range of community-based activities to support their mental health and well-being. This will be mostly developed in second phase of our Transformation.
Clear service contact point	The Central Access Point and the Community Treatment and Recovery teams will provide clear contact points for service users available if they need to re-contact a service or seek additional support.

A helpful and informative website would help people to navigate available support better including self-help guidance.	Our UEC and Integrated Community offerings will be underpinned by high quality online support available to service users, their families and carers, and to wider professional groups.
Early planned discharge	We are increasing the focus on recovery and discharge rather than maintenance of service users. We will remove long internal waits so that service users move to treatment, recovery and planned discharge more quickly.
A focus on individual recovery	We will focus the initial MDT assessment on developing individual treatment and recovery plans. We are integrating our community teams and focusing more of their work on recovery. We are expanding the breadth of our treatment offer to better support individual recovery.
Introduce non-clinical role to teams to help connect service users and clinical staff	We are building on the new Peer support worker roles that we have recruited and expanding the numbers to support people across different services. We will also work with Turning Point and other VCS organisations to develop non-clinical navigator roles and broaden the support offer options available to service users.
Multi-disciplinary teams - integrate health and social care teams to improve joint working	We are bringing a number of our teams together to break down barriers and to improve joint working. We will use a multi-disciplinary team approach to initial assessment and to support treatment and recovery.
Introduce Peer Support Workers	Our proposals include investment to build upon the Peer Support Worker roles we have already introduced.

5. The proposed future service models and expected benefits on which we consulted

This chapter is divided to provide details of the temporary Covid related changes, followed by the detail of our plans to develop the UEC mental health pathway and then the plans to integrate our community mental health services. For each service change, we set out the expected benefits. These proposals were summarised in the consultation documents, films and event presentations.

Temporary Covid related changes

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

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

By having the Central Access Point as the new front door to mental health services we have already seen a marked reduction in the number of service users being put through for a full mental health assessment. In the first five months of the there was a 41% reduction in service users coming through to community teams as a referral for assessment. The majority of these service users have either received support from our triage clinicians or were signposted for support within the community.

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

In December 2020 the Central Access Point and crisis line (and its voluntary sector staff) came together with the Leicestershire Partnership Trust Professionals. This made it simpler for an individual to ring one number which is now free. It has led to different sector staff working as a Multi-Disciplinary Team (MDT) to introduce new needs-based support and assessment approaches to help best support individual needs.

We consulted on our plans to invest further in the Central Access Point and the Urgent Care Hub to sustain and ensure they can meet ongoing demand.

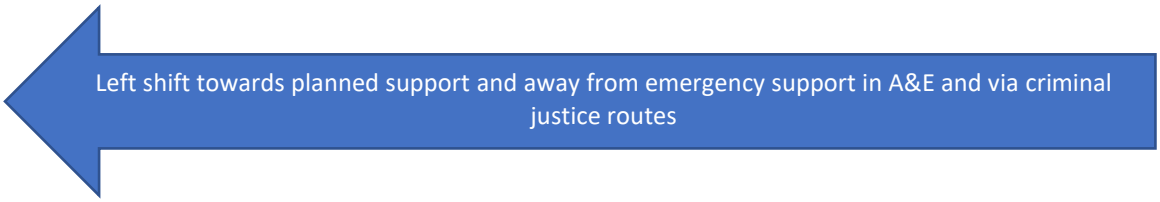
Urgent and Emergency Mental Health Care

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

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

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

Developing an Urgent and Emergency Mental Health Care pathway



Earlier support in the community	Intensive support to vulnerable groups	Central Access Point	Urgent Care Hub	Emergency service support	Improved support in A&E
Underpinned by a comprehensive online offering to service users, carers and professionals					

We have an opportunity to shift the point of access and interaction away from the criminal justice system and A&E departments towards a more planned care approach targeting vulnerable people.

Earlier support in the community

We consulted on our plans to improve the offering to LLR residents ahead of an emergency or criminal justice scenario. Strengthening and simplifying the response to people in a crisis is underway and will be developed further with our plans. We will join up and integrate services to support vulnerable people in the community. When people in a crisis come in contact with our services the clinical response will be consistent and needs orientated. We intend to expand and strengthen our Crisis Cafés and Crisis House services. The Crisis Home Treatment offer will be more consistent and offer greater continuity of care and link with a broader range of support services including those provided by the VCS. We will work with the VCS to develop a range of options for people in the community to be supported through crisis and to respond to the need in a timely manner. Through these actions we plan to reduce the number of people unnecessarily entering secondary mental health services.

Crisis cafés

We set out our plans to invest £145,000 into expanding crisis cafés in 2020 and a further investment planned each year for the next four years to increase the number of crisis cafés to stretch across large parts of the LLR geography. Crisis Cafés are a safe space for individuals struggling with emotional and mental wellbeing who do not require immediate medical care.

The cafés are run by recovery and peer support workers who offer emotional support, solution focussed problem solving and onward signposting to an extensive range of local support services. The support available includes 1:1 sessions and the use of a calm, safe and welcoming social space. As part of the Crisis Alternatives Transformation bid, we would like to expand the crisis café offer across all 25 neighbourhoods (e.g. PCNs) as well as within the three local universities.

Crisis service

We have invested £972,000 into crisis services to increase capacity to provide higher intensity crisis treatment offers when required and to undertake full crisis assessment within 24 hours (or 4 hours where required).

Our investment in the crisis service means that we will:

- Offer all service users the choice of receiving an assessment at home
- Have the ability to offer up to three visits per day as part of an intensive home treatment offer, and a viable alternative to admission
- Expand our routine out-of-hours medical response from generic 24/7 medical on-call cover to CRHT specific medical staff.
- Offer a range of interventions and services that reflect the diversity, cultural and clinical needs of the LLR population
- improve flow within the acute mental health pathway through the CRHT early discharge programme, which in turn will support the elimination of out of area placements.

Expected benefits of the expanded Crisis Service

- This is a move to an open access approach
- We will be delivering solution focussed interventions
- We will be offering intensive home treatment (up to 3 visits per day), including the provision of support to pull through via early discharge from hospital
- We will be able to support an average of 150 people under home treatment with a higher level of acuity, with an average of 30 of these people being supported for early discharge. This will also support reducing the length of stay in hospital, and 20% of the caseload being those individuals supported for early discharge, compared to our recent snapshot audit of 16%.
- CRHT gatekeeping will be used for all informal admissions (including prior to any MHA assessment if appropriate)
- We will deliver the 4-hour national and 24-hour local assessment targets
- We will offer the choice of home assessments to all service users
- We will be able to assess the needs of carers, and offering practical solutions as required.

Intensive Support to Vulnerable Groups

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

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

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

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

The investment includes increasing staffing at Police Custody suites, Crown and Magistrate courts, and the establishment of an Outreach team to improve service user engagement, providing handovers to secondary mental health services and forging engagement with partner agencies, such as housing, substance misuse services.

Self-referral via the Central Access Point

As part of our response to Covid, we introduced a Central Access Point to provide a more co-ordinated response guiding people to the right service the first time for routine and for crisis support. This has reduced handovers and hand-offs within the Trust and provided a place for individuals to directly refer themselves for mental health help, signposting and advice. The Central Access Point also supports the reduction of internal waits which are excessively high for some services in LLR. We consulted on our plans to invest £2m into the Central Access Point alongside bringing together existing crisis line (currently delivered by Turning Point) and older people mental health referral hub.

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

The Central Access Point has been further developed to improve access to mental health provision across a range of statutory and third sector organisations. We are working in partnership with the current provider, Turning Point from the third sector, to improve accessibility of resource and improve service delivery between organisations. The services will work together to best meet the needs of the service user, carer or professional through a collaborative delivery model that utilises the strengths of each organisation. Contacts with the service user will be less about medical/diagnostic model and more 'recovery' focused based on individual's perceived needs. This new version of the model was introduced on a temporary basis in December 2020.

We plan some further service developments for the Central Access Point. Development opportunities have been explored between the voluntary sector crisis partner (currently Turning Point) and NHS crisis service provider (Leicestershire Partnership Trust) to improve the accessibility of resource and improve service delivery between both organisations. This will lead to the creation of a single number and central access point for all mental health services within LLR with the third sector which will operate 24 hours per day, 7 days per week.

The case for change is clear. Our new service will:

- Enable open access for anyone looking for mental health support for themselves or others (friends, relatives, carers)
- Improve signposting and support for callers needing mental health support
- Enable a conversational and needs orientated discussion rather than a clinical discussion

The expected benefits are:

- One 24/7 telephone support helpline for people to ring which can also be accessed via NHS 111.
- Deliver low level needs-based interventions to support callers at the front door.
- Find resolutions to their needs without organisational boundary ensuring that every contact with Central Access Point focuses on the goal to improve an individual's hope, control and opportunity in relation to their mental health wellbeing.

Turning Point

Turning Point is a national health and social care provider. They have over 50 years' experience of providing the personalised care and support that you need to make positive changes in your life.

Turning Point is a social enterprise and was created to help people find a new direction in life. They can help tackle substance misuse, mental health issues, housing or employment difficulties.

Turning Point currently hold a contract for supporting and delivering aspects of the urgent and access pathway.

Making our Urgent Care Hub permanent

We were one of the first systems in the country to introduce a Mental Health Urgent Care Hub as part of COVID Temporary measures. The Hub provides a safe, professional and appropriate alternative to A&E for emergency services such as the police and East Midlands Ambulance Service to bring people in crisis. The Hub also provides expert advice to other health professionals.

We run the Hub on a 24/7 basis and will make it a key permanent feature of our Urgent and Emergency Care pathway. We consulted on our plans to invest £1,142,000 from the Mental Health Investment Standard alongside reallocation of Leicestershire internal resources to sustain the Urgent Care Hub in Leicestershire.

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

The Urgent Care Hub will reduce the number of service-users accessing mental health services via a non-specialist emergency service route such as via A&E, East Midlands Ambulance or the police. The Urgent Care Hub will also reduce unnecessary attendance to the emergency departments where the physical environment is often not conducive for someone in a mental health crisis. The UCH provides a less pressured environment which means staff are able to spend more time therapeutically with service users devising bespoke plans of care.

The Hub will also enhance the robust therapeutic engagement and support with community mental health teams, networks and/or services which in turn minimise the demands for inpatient

admissions, allowing time for longer assessment or to put crisis plans in place. The Hub can provide direct access to senior mental health medical personnel and teams, such as Mental Health Practitioners, Psychiatrists, Crisis Resolution Team, and the wards. The Hub can also provide advice, consultation, and referrals in a timely manner, even beyond the Hub to other allied professional services.

We have been developing a seamless service with other partners across the urgent care and access pathway to ensure continuity of care and consistency for service users. We have also developed our ability to house service users safely for longer periods of time to ensure that the pathway is appropriate and timely (housing and social care issues).

The Urgent Care Hub is situated at the entrance of the Bradgate Unit on the Glenfield Hospital site in Leicester. If inpatient admission is eventually required, service users are easily transferred with dignity, compassion and respect across to the wards. Also, the Place of Safety Assessment Unit (PSAU) is within close range, and the wider Bradgate team can easily be called upon to support with managing service users who are in distress. The Hub is easily accessible to friends and relatives with free parking, comfortable waiting areas and refreshments.

The Urgent Care Hub will enable us to redirect service users of all ages from A&E and East Midlands Ambulance Service to the Mental Health Urgent Care Hub for a face-to-face mental health assessment.

Working with the emergency services

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

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

We continue to work with and build on our partnerships with emergency services. The extension in the hours of the Mental Health and Policing Triage car supports a rapid response to incidents that have been alerted through the police and ambulance control rooms. Access to mental health practitioners supports the police and ambulance staff as they are able to ascertain if the person, they are concerned about is open to secondary care mental health services. They can also clarify what their collaborative care plan details about the actions to take in an emergency and what their protective factors are. They are also able to provide a response in person, undertaking mental health assessment to advice and support an appropriate pathway of care and treatment if required.

We continue to build on our partnerships with the police, providing mental health advice and support in custody suites across LLR, working to divert people from the criminal justice pathway, and get them access to support groups in both public sector and voluntary sector communities and onto recovery.

We continue also to work with EMAS, and plan to further enhance and develop pathways of care to reduce the need for those service users who ring 999 with mental health needs presenting at the Emergency department.

With the opening of the Mental Health Urgent Care Hub, we have tested a system with EMAS that supports the ambulance crew ringing the Hub to speak to the Mental Health Practitioner if they have concerns about the service users, and together determine whether the ambulance could divert via the Hub for an assessment rather than send the service user direct to A&E. We will continue to work with EMAS to explore further opportunities to reduce conveyance to A&E and seek alternative support from Mental Health services.

Delivering Core 24 in ED

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

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

Confirmation of additional funding to support the alignment and expansion to key Mental Health liaison services to achieve the Acute Psychiatric Liaison access targets was confirmed in July 2019, through the NHS England Wave 2 bid process. The partnership bid between LPT, UHL and CCGs has been supported through the NHSE East Midlands Clinical Network with professional advice, support and sponsorship being received. The partnership received a total of £532,000 for the enhancement of the service that went live in 2020.

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

The increased investment and staffing have enabled us to increase the hours of access for assessment and we are now based at Leicester Royal Infirmary. We are able to deliver the Core 24 access targets (one hour and 24-hour). We have been able to increase the support for training and education for UHL clinicians in mental health.

The impact of our investment in Core 24

- Liaison team being based on site at LRI (currently operate from a remote base at Glenfield)
- Single electronic referral system for UHL clinicians to refer is being developed to stop faxing and enable us to respond to assessment times
- Service users presenting with mental health problems (in the ED or hospital wards), and their families and carers, will benefit from 24/7 access to liaison mental health services, with a swift and compassionate assessment of their mental health needs. This will support reductions in inappropriate general hospital inpatient admissions.

- The enhanced support offer to wards by responding to all urgent referrals within 24 hours should improve discharge planning and coordination, resulting in shorter lengths of stay and reduced general hospital re-admissions.
- If service users presenting at ED are assessed as not requiring immediate support, they will be signposted to other appropriate services.
- We will use the FROM-LP tool, which clearly measures service quality and clinical effectiveness using a combination of clinician-rated outcome measures (CROMS), patient-rated outcome measures (PROMS) and service user-rated experience measures (PREMS).

Mental Health Liaison service (MHLS)

Information on this service development was included in the PCBC to provide context for the wider range of changes to develop a full UEC mental health pathway. The changes included in this particular service development were subject to a separate engagement process agreed by the CCG with the Health Overview and Scrutiny Committee (HOSC) in October 2020.

We configured and changed the services to meet the national expectation to deliver the CORE 24 standards from April 2021 whilst we formally consulted on plans to make sustain these changes.

The configuration of Mental Health Liaison service (MHLS) was to provide specialist mental health care in a physical health setting 24/7 for adults. The MHLS is based in the Leicester Royal Infirmary and provides a 1 hour response time to service users who arrive in ED and 24 hour ward based support for existing service users within the hospital and a 48 hour response time to service users at the Glenfield and the General Hospital.

The existing staff from Mental Health Triage Team (MHTT), Frail Older People Assessment and Liaison (FOPALs), Liaison Psychiatry and Psycho Oncology have joined together to form the Mental Health Liaison Service. This included recruitment of 7.6 Band 6 nurses and 2.0 new consultants.

The expected benefits are:

- To provide a 24-hour Mental Health service to service users at Leicester Royal Infirmary (LRI) whose needs are most urgent
- Timely access for urgent Mental Health within a hospital environment
- Utilising existing services such as IAPT who can provide specialist input in the community.
- Working with existing sources to support service users in the community, (i.e. IAPT).
- Ensuring that Mental Health care is available when physical health service users need it the most.
- One Multiple Disciplinary Team who are timely and responsive.

Comprehensive suite of self-help guidance and tools

We consulted on the idea of underpinning the new urgent and emergency care pathway with a suite of guidance and tools available to service users, their families and carers, and to other health professionals. There are a number of websites and other platforms that seek to support people with different aspects of their mental health. There is some duplication and there are gaps. There is a lack of broader information to support people to live well in their communities.

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

LPT would like to improve the way that the leicspart.nhs.uk website highlights to users the appropriate mental health service provision/information for them. Improving this will mean more users will receive mental health services/information that is appropriate to them. This will likely lead to a drop in the use of the central access point phone number as users have their needs met via other communication channels.

In some instances people may still need to get further guidance or seek further support. Therefore it is planned that alongside the online guidance there will be links and details for individuals to directly communicate including:

- **Calling the central access point number**

- **Online instant messaging** - We will integrate the website with a third-party instant messaging system (exact system to be confirmed).

- **Chathealth text messaging** - Where appropriate in terms of age, Chathealth text-messaging will be suggested to users as a channel for discussing their mental health concerns.

- **Call Back**- We will create a system where a user inputs a name, phone number and a description of what they would like to discuss and then requests a call-back.

Impact on other providers – Urgent and Emergency Mental Health pathway

The Urgent Care Hub has seen 3,500 service users in 2020/21. These service users received a booked slot with the Hub meaning that the police and ambulance service did not need to take them to A&E.

The police and EMAS are able to book urgent slots at the Hub. As well as being a more appropriate experience for the service users, this also means that EMAS staff and the police are not having to wait in A&E with service users and UHL staff are not having to do additional triage. They are released to undertake other work.

The impact of the Hub is significant for UHL, EMAS and the police. All three organisations are supportive of making it a permanent feature of the LLR UEC mental health pathway.

The Street Triage service undertakes 50 assessments per month on the street and are able to divert service users to the most appropriate support service, including to the Urgent Care Hub. Most of these 50 assessments would have resulted in the service user going to police custody or to A&E without the Street Triage service.

The Central Access Point has opened up a co-ordinated self-referral and GP referral channel for people experiencing mental health distress/difficulties that means a proportion of those calling do not need to ring GP, 111 or 999. It is difficult to precisely quantify what proportion of those calling the Central Access Point in mental health distress would have called 111 or 999 without the CAP in place.

The ChatHealth developments are intended to include support to those who feel unable to talk and would prefer to text. Again, it is difficult to forecast precisely how many of those who will use this service would instead have ended up calling 111 or 999, or attending A&E, but the service is intended to maximise the routes into earlier support and avoiding, where possible, unnecessary interactions with EMAS or UHL.

The creation of a co-ordinated UEC mental health pathway involving partners such as UHL, EMAS, 111 and the police aims to support as many people as possible outside of a criminal justice or acute A&E setting. The volumes of people supported in the past year from services introduced on a temporary basis as a response to Covid has been significant and the changes are well supported by our partners who share our desire to make them permanent parts of a much improved UEC pathway.

Integrated Community Mental Health services

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

The main focus of the service changes we consulted on are to make are to better integrate teams that currently work in separate silos resulting in excessive handovers, sometimes lengthy waits and extended service user journeys when service users pass between teams. We also plan to change the offer to service users in terms of the support that they can expect to receive and improving local access to more integrated services. Community mental health services need to be simpler and with a stronger psychologically driven focus on care and treatment. Within a model that can allow flexibility and that uses best practice from the learning of the past, service users should be cared for without hard onward internal referral and the inevitable delays and push back.

Establishing Community Treatment and Recovery Teams in LLR

We will bring together our Assertive Outreach support, Community Mental Health Teams and Psychological services into a more integrated and aligned offer and establish eight Community Treatment and Recovery Teams. These are organised to align to three or four Primary Care Networks where they will move to working in an integrated fashion through the second phase of the transformation.

The focus will be on supporting people to live well in the community through the provision of joined up services where people need them. We will use team assessment, team caseloads and multi-disciplinary approaches in the new community provision, in line with the national framework.

We plan to free up expert time to deliver specialist support, reduce individual clinician caseloads and internal waiting times. We will remove internal thresholds, hand-offs and excessive waits. Current waits for some psychological therapies can be several years, whilst current community teams have little access to formulations or consultation.

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

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

mental health teams by creating approaches to rapidly step up and step down intensive and assertive approaches.

Integrating our teams

We consulted on our plans to take a whole team approach to managing caseloads, stepping up care and delivering planned treatment. The treatment and care offer will be driven by standardised pathways including Personality Disorder, Psychosis and complex trauma. The new pathways will be based on NICE guidance.

We will develop a stronger person and recovery centred approach. We will work seamlessly across different teams being able to draw together expertise and interventions from other parts of the system when required (without the service user having to move between teams or being constrained to what is available in a team).

Through the second phase of transformation, we will work as one planned pathway with VCS, social care, GPs and PCN workers at a local level (e.g. PCN) eradicating unnecessary duplication and silo working. Our plans are to provide a much more timely and responsive service, stepping up and stepping down care intensity locally as required. We will deliver a blend of face to face, telephone and digital modes of contact.

To deliver this new model we will bring together a number of currently separate teams:

- Adult CMHTs/ outpatients
- Psychological Therapies – Cognitive Behavioural Therapy, Dynamic Psychotherapy Service and Therapeutic Services for People with Personality Disorder
- Clinical Psychology
- Assertive Outreach
- Employment Support
- PIER – hub and spoke
- Perinatal – hub and spoke
- Community Rehab

We will recruit 14 new staff to support implementation of structured clinical management as part of an improved personality disorder pathway. We will also recruit Peer Support workers.

The service changes will enable us to offer speedier assessment and to avoid the excessively long waits, driven by multiple hand-offs between currently siloed teams. Proper MDT arrangements will help us to reduce duplication and improve co-ordination. This should result in an improved experience for our service users by avoiding multiple referrals, assessments and attendances that are often drawn out over an extended period.

The changes will also help us to improve efficiency and ensure that we are making the most of the available staff skills. We will reduce the need to 'hold' service users because they are waiting for something else, or a suitable offer is not available. We will focus on shorter term interventions to

drive recovery. We will remove out-dated practice, which is still in place, is resource intensive and drives some of the excessively long waits for support.

The MDT approach will improve the initial formulation helping us to get the offer right for service users from the start. Service users should see quicker access to the right care, more straightforward transfers where required, more consistent care, better treatment and care offers, improved access to a range of support (particularly psychologically-informed support), all available locally in their neighbourhoods.

Through the second phase of the transformation we will be developing local network of teams with our Primary Care Network partners. The teams will include LPT mental health staff, PCN staff, social care and the VCS. Each Community Treatment and Recovery Team will support 3 to 4 local networks relating to the footprints of our PCNs. This will allow the teams to have a range of mental health expertise that work with specific networks and are large enough to be resilient to allow cross-cover of absences and vacancies. The Community Treatment and Recovery Teams will develop the integrated working with the local area networks over the next three years as the second phase of transformation.

Step Up and Step-Down approach

We consulted on our plans for the staff in the current Assertive Outreach team to become part of the eight Community Treatment and Recovery teams. A clinical workshop agreed a set of principles to be applied to the Step Up and Step-Down approach in a new model:

1. Needs and recovery focused care
2. Formulation-based assessment
3. Consistent practice
4. Increased collaboration in care provision
5. Broaden the skills and offer of the Community Treatment and Recovery Teams
6. Whole team – MDT approach
7. Step up and step down of intensity
8. Psychologically informed work across MDTs
9. Integrated model that allows Community Treatment and Recovery Teams to assertively outreach when needed-
10. 7-day service offer
11. Resilience across Community Treatment and Recovery Teams
12. A more flexible resource by changing and broadening caseloads
13. Career progression
14. Service model that can be consistently and equitably offered across the different integrated community teams
15. Informed by the evidence base (e.g. Flexible Assertive Care Team approaches)
16. An inclusive model not restricted to psychosis
17. A model that can support all the service users across the teams that need a period of increased intensity and assertive management
18. A new approach that is embedded within the Treatment and Recovery teams and delivered through MDT approach

We have begun the work to map out the new Step-Up model. The 7-day service offer will be scoped out alongside the role of the Support Workers and the approach of the caseload carrier leading the caseload and drawing other experts in. A common set of triggers for stepping up will be agreed. The plan for step down needs to be agreed at the time of stepping up with a defined and planned period of stepped up support.

The teams agreed to develop plans for buddying, clinical specialty and safeguarding supervision, peer support, PSI (Psycho Social Interventions), CBT and Psychosis training to incorporate in the Decision-Making Business Case and final implementation plan.

Work will also be undertaken on the division of the staff and caseloads via a needs profile for each of the new Community Treatment and Recovery Team patches based on local community data profile, review of SMI register and a review of current service user activity by new geographical patch. The LPT Business Team will produce a proposed weighting of need per patch.

Mental Health services for Older People (MHSOP)

The current provision of planned MHSOP community services across Leicester, Leicestershire and Rutland (LLR) consists of six Multi-Disciplinary Community Mental Health Teams inclusive of outpatient teams providing planned assessment and intervention for older people with a functional illness and adults of all age with dementia.

The service currently operates Monday to Friday 9.00 – 5.00. The CMHT currently manage the step up/down function for service users on the current CMHT caseload. If service users are on a waiting list or within outpatients and develop an urgency, these service users will be transferred to the Unscheduled Care Service for a more urgent response.

We consulted on our plans to develop a Locality working model within the Community Treatment and Recovery Teams to ensure service users are seen at the right time, in the right place by the right clinician dependant on the presenting needs of the service user. This will enable service users to access appropriate support and reduce the need for excessive internal referrals for multi-disciplinary care

We consulted on our plans to move the MHSOP service from six to eight teams so that they are fully aligned with the adult teams, social care and physical health teams that are already organised in our local geographies. This will improve joint working (particularly notable between physical health and the MHSOP teams as those physical health teams predominantly support older people and there will be ongoing shared cases). This will also ensure that MHSOP is also in the right geographical patches to work directly with the PCNs (or other local areas) alongside adult workers as part of the second phase of transformation.

We will further develop a step up/ step down model to support service users and their carers with both functional and organic illness, within their own home/care home, which will be accessible across extended hours 7 days a week over an extended day from 8.00am – 8.00pm.

We consulted on our proposals to ensure the equity of service for service users of all ages, the integration of Assertive Outreach will include MHSOP community teams.

We will also increase our workforce to offer a step up/step down home treatment offer across extended hours, 7 days a week.

The current provision does not provide a step up/step down function across extended hours 7 days. This change will ensure equity of access to a step up/step down model for older people with functional and organic illness to support them to remain in their home/care home. This will enable is to ensure service users are able to access the care they need in the right place at the right time by the right person to avoid unnecessary waiting and to avoid repetition.

The benefits from this improved offer include:

- Care being offered and delivered in a least restrictive, place-based care in the service users home where possible
- Reducing pressure on inpatient and urgent care services in both acute and mental health settings
- 7-day service
- Continuity of care for service users and carers, improvement in service user experience and better service user outcomes
- Step up and step down support across Adult and Older Adult Mental Health services

Wider Therapy services

We consulted on our plans for our separate CBT, Psychodynamic and psychology teams to come together in the Community Treatment and Recovery Teams. Our goal is to increase the psychologically informed ways of working across our community teams. We will take a more flexible approach to offering choice and the delivery of therapy and increase the number of people in LLR accessing therapy support.

The Community Treatment and Recovery Teams will manage their caseload as a whole team, working as a Multi-Disciplinary Team (MDT) to formulation of need, care planning, review and treatment. The role of the psychological worker will include a greater focus on supporting staff deliver psychologically informed care in the Community teams, participating in the initial integrated assessment/formulation alongside specific therapy activity.

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

Developing our new Therapy service offering

We agreed the principles of a new service offering with senior clinical representatives of all of our therapy services:

- An inclusive integrated model not restricted to any particular therapeutic approach
- Working together and developing a whole team MDT approach
- Increased collaboration and coordination in care provision
- Formulation-based assessment
- Developing the ability to support more people

- Needs-led approach with a recovery focus
- Developing psychologically and trauma informed work across MDTs
- A more flexible resource by changing and broadening caseloads
- Address the long waits and bring demand and capacity into alignment
- Service model that can be consistently and equitably offered across the different integrated community teams
- Informed by the evidence base
- Increased focus on effective shorter-term interventions
- Resilience across Community Treatment and Recovery Teams
- Increased delivery of psychologically informed interventions across all clinical staff in the new Community Treatment and Recovery Team

As highlighted earlier in the DMBC, the LLR system has significant issues with excessively long waits for therapy support. The LLR system has a significant problem with long waits for certain services. The table below sets out the services, number of over one year waits and the longest wait as of October 2021.

Service	**Number of over one-year waits (October 2021)**	**Longest wait (October 2021)**
CMHTs	91 people	146 weeks
CBT	23 people	92 weeks
Dynamic Psychotherapy	14 people	116 weeks
Personality Disorders	315 people	218 weeks

Our new approach to team caseloads, formulation at the outset, increasing the focus on short-term interventions and recovery, the reduction in handovers and restarts, will all help to create capacity to eradicate the long waits. We are already undertaking a review of all long-wait service users to see whether they could be offered equally or more effective support available in a timelier way.

Hub and spoke model for targeted community services

We consulted on our plans to build on the success of our Perinatal hub and spoke model to develop similar arrangements for other community services including Early Intervention in Psychosis (EIP), Enhanced Recovery, Personality Disorder support and Memory services.

We will place the majority of service delivery into community settings with a central expert resource to provide support, training and step up expertise and targeted interventions. The focus will be on recovery and supporting the majority of people in a community setting. There will be access to

more intensive and specialist support for a smaller number of people (based on acuteness or targeted needs), with a step-down community recovery focus, as per the national framework.

Perinatal hub and spoke model

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

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

Following publication of the five year forward view for mental health and the NHS long term plan, the NHS Mental Health Implementation Plan 2019/20 – 2023/24 was published in July 2019. This document provides a framework for the planning and delivery requirements in relation to the five year forward view and long-term plan. Specifically, there is a programme of deliverables required to sustain and expand specialist perinatal mental health services.

The implementation plan requires that across England by 2023/24 at least 66,000 women with moderate to severe perinatal mental health difficulties will have access to specialist community care from pre-conception to 24 months after birth with increased availability of evidence-based psychological therapies. Their partners will be able to access an assessment for their mental health and signposting to support as required.

We invested £1m in our Perinatal services in 2020/21 and plan to make further investment. This will ensure that there is adequate capacity to deliver against the planned ambitions within the implementation plan. The current team will more than double in size.

There are a range of benefits that we expect to see from this investment in perinatal services including:

- An increase in access to services
- The capacity to deliver extended period of care, increasing period of care from pre-conception to 12 months to pre-conception to 24 months.
- Fathers will have a screening assessment and be sign posted to appropriate services and provided with tools to support themselves, their partner and the wider family.
- Clinics, groups and community services will be expanded to cover the whole geography of LLR to encourage engagement and ensure that services are accessible.

- Ability to offer additional clinics for pre-conception advice and within the ante-natal and post-natal pathway, providing diagnosis and treatment plans for women.
- The entire team will work in close liaison with other professionals such as GPs, CTRT staff and acute medical staff and provide advice regarding service user's holistic care.
- Increase access to psychological interventions.
- Improved partnership working with women through the role of Peer Support Worker.
- Increased support for the community planned care and treatment teams in managing service users with SMI who are seeking to become parents, or where community teams are seeking advice and support about appropriate care and treatment for service users who are pregnant.
- Ability to flex workforce to provide a more intensive support for those women who need this.

This service development is aligned with the programme to deliver Step up to Great Mental Health Adult and Older People and to LPT's Mental Health Business Plan 2020-2022 for Leicester, Leicestershire & Rutland. The proposal is also aligned with the NHS Long Term Plan requirements of Perinatal Mental Health and to implement enhanced suicide prevention initiatives. It specifically supports delivery of metric EH15: at least 32,000 women will have access to evidence-based perinatal mental health.

Maternal Outreach Clinics

We consulted on our plans to develop a new service which addresses the service provision gap for women who have, or are, experiencing trauma and loss in relation to their maternity experience. Currently they have either no, or limited, access to specialist care. The service will work closely with the existing perinatal team, medical psychology and maternity. The combined service approach to this proposal will ensure that the skill mix will enable a specialist service to be developed which addresses the gap.

The service has chosen to bid to be an early implementer, as they have the skills and a skeleton service in place to start the service soon after funding is released. The service plans to quickly establish a fully integrated pathway for women which would be multi-disciplinary and have links to specialist community PMH teams, maternity and neonatal services, bereavement care, GPs, IAPT, reproductive and sexual health services, Children's Social Care and Early Help Services, safeguarding teams, and other critical partners, for example third sector or mental health services (CYP and adult), health visiting, other acute services. We would also want to establish peer support and recovery as an integral part of the service.

The proposed model of the Maternal Outreach Clinics Service will sit within a Perinatal Mental Health Service framework which will support the maintenance of professional links with the staff in the existing team. This framework would be best placed to support the service as the team already has the infrastructure in place and a positive and productive interface with maternity services.

The staffing model will be based on 5.5 whole time equivalents plus input from Peer Support Workers.

The Maternal Outreach Clinic service will also see women who would fall between IAPT and Perinatal Mental Health Services, therefore the Maternal Outreach Clinic Service would see women

who have a mild to moderate presentation of mental health difficulties as well as specific issues with the following (this list is not exclusive):

- Fear of childbirth
- Fear of needles
- Maternity trauma/loss
- Female Genital Mutilation (FGM)
- Preconception issues
- Loss of a baby (miscarriage, termination, infant death, local authority removal)
- Transgender people who are experiencing difficulties relating to pregnancy.
- Groups to support fathers and partners

Access to service for women who would not usually be able to access existing services due to their referral criteria, as well as the lack of a specialist team which has the skill mix to deliver specialist input which is not available elsewhere within existing health care. The service will be trauma informed throughout and below are examples of reasons for referral following difficulties relating to pregnancy and/or childbirth:

- PTSD/symptoms related to a recent experience of childbirth as traumatic (within 2 years of childbirth)
- PTSD/symptoms related to a previous experience of childbirth that have been triggered by a current pregnancy
- Mild/moderate adjustment difficulties following childbirth (including bonding difficulties)
- Bereavement related to any pregnancy/perinatal loss including neonatal loss, miscarriage, termination, stillbirth
- Preconception care, which would include some of the following issues
- Women presenting as anxious about becoming pregnant again/delaying a further pregnancy due to a prior experience of childbirth
- Tokophobia
- Trypanophobia that is preventing required medical care during pregnancy, childbirth and post-natal care.
- Women who have experienced FGM who are now pregnant and having difficulties in pregnancy in relation to this.

Women can be referred at any point of their midwifery/Obstetric care, when considering a pregnancy or up to 2 years postnatally (if no further pregnancies have occurred). The service will accept referrals from primary and secondary care, where women do not fit the peri-natal or medical psychology criteria.

The Long Term Plan included a joint PMH and maternity transformation objective: by 2023/24, 'Maternity Outreach Clinics' (now 'Maternal Mental Health Services') will be available across the country, combining maternity, reproductive health and psychological therapy for women experiencing mental health difficulties directly arising from, or related to, the maternity experience.

This ambition will contribute activity to the overall commitment for PMH in the Long-Term Plan and Mental Health Implementation Plan to enable at least 66,000 women with moderate to severe PMH difficulties to access to specialist care by 2023/24.

Psychosis Intervention and Early Recovery (PIER) Team

We consulted on our plans for the PIER team to be aligned in their hub and spoke model to work more closely and in congruence with the community treatment and recovery teams and offers. This will need to be developed under the leadership of the psychosis pathway. Closer links to the Community Treatment and Recovery teams will be important for supporting individuals with multiple-diagnosis and also estimating capacity requirements to provide step up support to all service users when needs escalate.

The PIER assessment is currently undertaken specifically by PIER staff as a gateway to PIER treatment and support. The majority of individuals assessed do not move into PIER treatment and many have further mental health assessments for other services support. Moving forwards under the ethos of Step up to Great, all clinicians undertaking assessments will be formulating people's individual needs and organising the right support and treatment, whether PIER or other treatment approaches. This will mean that individuals will not need any unnecessary duplicate assessments whilst ensuring PIER treatment is available to individuals where it is most suitable for their needs.

There will be processes formed that will better support people who will transition to Community Treatment and Recovery teams post PIER intervention. It is estimated 40-50% of service users currently are referred to community teams for this type of support. This will include how the PIER 'hub' expertise can support Community Treatment and Recovery Team staff to support service users.

Moving forwards there will be strong join between support available in local areas. This is expected to support people's recovery, independence and increase their access to inclusive activities that support independence, health and well-being and employment.

The PIER team will operate as a hub team, maintaining its current workforce and working more closely with the treatment and recovery teams.

The expected benefits of the changes to the PIER approach include:

- Creating a more seamless pathways for service users with multiple diagnosis/needs after completing support from the PIER team.
- Increasing the expertise and support to Community Treatment and Recovery teams for supporting individuals with psychosis
- Reduced duplicate assessments and improved experience in accessing mental health support
- Improving the transition to primary care for long term recovery and build on the support/offers in neighbourhoods for people.
- Improved accessibility of the PIER team with a wider number of professionals able to assess

Memory services

A new model of service delivery has already been implemented due to Covid -19 restrictions. We are already seeing a range of benefits from these changes and would like to make them permanent through this process.

The improved model places a focus on the increased use of virtual consultations wherever possible to limit the unnecessary exposure of a vulnerable service user group to a hospital setting. However, face to face consultations is used where clinically necessary or where technology cannot be used.

We now use 'Attend Anywhere' to deliver video consultations and hold telephone consultations where appropriate. We have modified our cognitive testing tools in line with the mode of delivery. The service has trialled the use of TYM (Test Your Memory).

The service no longer makes routine referrals for imaging. Scans are requested where clinically necessary. Joint working with colleagues in Primary Care on a PRISM referral form provides the relevant information to reduce delay in assessment and diagnosis. We have established joint working and education with Primary care regarding dementia diagnosis for service users in care homes.

We have extended the hours of service provision. An Advice and Guidance service has been introduced to enable potential referrers to seek advice from the service.

We used the consultation to seek feedback and views on making this service change permanent.

Personality Disorder services

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

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

The Pathway draws from guidance from NICE guidelines 77 and 78 (Antisocial and Borderline 2009), the Personality Disorder Consensus Document (2017) and Safer Care for Personality Disorder (2018).

The NICE guidelines for Borderline Personality Disorder highlight the importance of delivering psychological interventions within a compassionate, transparent, consistent, reliable and enabling environment delivered by clinicians with an appropriate level of competency, supervision and training which will include access as appropriate for specialist trainings such as Structured Clinical Management (SCM), Mentalisation Based Therapy (MBT) and Dialectical Behaviour Therapy (DBT).

The pathway will involve a specialist structured assessment as recommended by the NICE quality statements in (2015). This will then lead to a co-created care plan indicating outcomes which can include engagement with specialist treatments recommended by NICE (78, 2009) as set out below. The pathway will also recognise the importance of the relationship within the therapeutic work so there will be an emphasis on a reliable, trusting, therapeutic relationship between the service user and their pathway worker.

Guidance in relation to psychological therapies for Personality Disorder also emphasise the importance of enhancing the personal agency and autonomy of service users through taking a recovery oriented and strengths focused approach in a supported and enabling environment. In line with the evidence for what works best service users will be expected to come to clinics rather than receive home visits and they will have clear goal-focused care and treatment.

The ethos of the pathway is to work with service users as capacitious adults (unless clinical assessment indicates otherwise) supporting them to make decisions about their care and to learn skills to help them cope, reduce risk and build resilience. However, this also means that the pathway delivers interventions that require a commitment and willingness to engage from service users. If a service user indicates that this is something they do not yet feel ready to commit to then whenever possible this will be formulated with the service user and an appropriate care plan will be developed most often as part of a co-created therapeutic discharge from secondary mental health services as holding service users in services without appropriate intervention can be harmful in its own right.

The pathway whilst providing scope for service user choice, in line with NICE recommendations, does take an overall stepped approach to clinical needs and stages of recovery. As part of this the pathway and the offers at tier 2 and tier 3 levels will aim to impact on reducing hospital admissions, use of crisis team and use of tier 4 residential based interventions for personality disorder.

The pathway will be evaluated on a rolling basis in relation to demographic data, clinical outcomes, service user satisfaction, Staff satisfaction and in relation to new and emerging evidence nationally and locally. We also aim to have service user involvement as part of governance and co-design.

The pathway will include working with families and carers in assessment and discharge with the permission of the service user. As we develop more capacity within the care pathway, we will develop carer and family support and psychoeducation groups. We will look to also work with community resources and forums to enhance the quality and connect our service delivery with neighbourhoods and PCNs going forward.

We consulted on our plans for the existing therapeutic offer to convert into the Personality Disorder hub. We plan to invest £600,000 in the hub and spoke model for Personality Disorders.

We will move from a separate Personality Disorder Service (offering in the range of 11 different intervention offers) to a hub and spoke 3 tiered care-pathway provision which will work through, be integrated with and be in alignment with the Treatment and Recovery Teams. The care pathway will provide NICE evidenced assessments and interventions for people diagnosable with Personality Disorder and also support the provision of psychologically informed working for needs associated with Personality Disorder.

The Personality Disorder Service; Therapeutic Services for People with Personality Disorder (TSPPD) will maintain a hub function but with staff also working into the Treatment and Recovery Teams therefore the personality disorder service and the treatment and recovery teams will be brought together. There are 17 members of staff in TSPPD who will clinically align with the Treatment and Recovery teams whist still maintaining a separate clinical hub provision.

There will be 14 new Band 6 MHP Structured Clinical Management Posts, these will be integrated part of the Treatment and Recovery Teams with clinical supervision and case management provided from the Personality Disorder Hub provision.

The service currently has very long waits for both assessment and intervention. Part of the reason for this is that is that it sits as a separate service leading to inefficiencies in the partnership working of the services across the Adult Mental Health directorate. Through closer working alliances we will be able to better identify who is suitable for the interventions on the pathway and also support teams in their clinical work reducing the need for referral to the specialist pathway.

The current service has a number of therapy offers many of which are progressive leading to long intervention times and waits between intervention offers for some service users.

The new provision will offer a more targeted clinical offer as people enter into the secondary care services with an aspiration to provide the right therapy offer in terms of clinical need and service user readiness at the right time. This aims to reduce the bouncing of referrals between services leaving service users without a service, unsure of their needs and who will work with them in addressing their needs. The majority of service users would also receive a place-based offer in their locality teams aligned with their PCNs but the centralised hub provision will be available for those services users who present with most risk. The offers will be transparent and time-limited whilst also evidence based supporting service user choice. Collaborative care plans will align across the service provision supporting improved consistency in responses across community, urgent care and inpatient provisions.

Through increased efficiencies in the pathway, more consistent team working around who is suitable for the pathway and an embedded model of recovery aligned to time-limited therapies provisions we aim to reduce waiting times for service users. Ongoing capacity and demand work around the pathway will continue to inform this.

The services changes are in-line with the Community Mental Health Framework for adults and older adults (2019). The pathway will deliver on evidence-based interventions for Personality Disorder in-line with recommendations of enhancing and improving Personality Disorder. Structured Clinical Management will form the tier 2 provision and the tier 3 provision will draw from either MBT or DBT. The tier 1 provision will also aim to close the gap between IAPT and primary care provisions and secondary care provisions.

The Enhanced Recovery Pathway

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

The ERP will be a recovery-orientated, formulation driven and needs led. Staff in the ERP will aim to foster people's autonomy, help them to take an active part in treatment decisions and support self-management. A recovery orientated approach is in line with the Community Treatment and Recovery Teams therefore offering a coherent approach to both service users accessing adult mental health services and staff working within our pathways and teams.

We know that people with serious mental illness tend to have poorer physical health outcomes than the general population. People with serious mental illness experience some of the worst inequalities, with a life expectancy of up to 20 years less than the general population and evidence suggests that the mortality gap is widening. Inequalities in heath are largely due to inequalities in society and it is the unequal distribution of social determinants of health, such as poor housing, poverty, social isolation and unemployment, which drives inequalities in physical and mental health.

Health inequality will be addressed in the ERP as per the recommendations by NICE and Public Health England. This includes clinicians in the ERP working collaboratively with General Practitioners who take responsibility for an individual's physical health needs including health checks. The ERP will also focus on promoting healthy living including smoking cessation support, healthy eating advice,

links to neighbourhood groups and activities to increase physical activities and decrease social isolation and offering people an annual health check. The ERP will work in partnership with social services and local housing providers to support people with serious mental illness to access and maintain safe and secure accommodation. The ERP will also work with employment specialists to support people to access stable, good quality and rewarding employment where appropriate.

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

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

We will create a community enhanced recovery 'hub' team to enable rehabilitation interventions to be offered in a community setting (as recommended by recent NICE guidelines for people with a complex psychosis).

We will create the 'spoke' service where enhanced recovery staff will offer consultation, support and time-limited joint working with staff in the Community Treatment and Recovery teams. This will allow us to work with service users who are at risk of hospitalisation.

We will provide an 'in-reach' service to acute and functional MHSOP wards to identify potential service users early to increase flow through the acute inpatient services.

With the community 'hub' team we will be able to discharge people from the inpatient rehabilitation service earlier so they can complete their rehabilitation in the least restrictive setting. This will increase flow through the service.

The community 'hub' and 'spoke' team will require new posts to strengthen the MDT and to provide evidence-based interventions in a community setting. This will include the recruitment of a consultant clinical psychologist, senior clinical psychologist, assistant psychologists, occupational therapists, nursing lead, nursing team manager and peer support workers.

We currently do not offer community enhanced recovery/rehabilitation, as per NICE guidelines for the rehabilitation for adults with complex psychosis. The pathway will therefore offer recovery interventions in the least restrictive environment and aim to help people progress from more intensive support to gain greater independence.

Health inequality will be addressed in the ERP as per the recommendations by NICE and Public Health England. This includes clinicians in the ERP working collaboratively with General Practitioners who take responsibility for an individual's physical health needs including health checks.

The expected benefits to service users of these enhancements of the ERP approach include:

- The ERP will offer more choice for service users.
- Interventions will be delivered in the least restrictive environment.
- There will be more joint working from the ERP into the other AMH community teams
- The ERP will aim to reduce the need for hospital admissions in people with serious mental illness by working with the service user and their current team to offer enhanced interventions.
- The ERP will increase flow across the inpatient pathway.
- The ERP allows people to 'step up' to enhanced interventions and 'step down' as required and needed.
- The enhanced recovery 'hub' team will allow interventions to be provided in the service users own environment and community, meaning they do not have to transfer skills they have learnt in a different setting.
- ERP is developing closer working relationships with accommodation providers/social landlords to provide consultation, training and support to increase the service user's ability of maintaining their tenancy.

This change is in-line with various frameworks including the NICE guidelines for rehabilitation of people with complex psychosis, NHS 5-year plan, Community mental health framework for adults and older adults and NHS England comprehensive model of personalised care.

The ERP aligns with the SUTG programme of working differently, for example by embedding a new, needs led, formulation-based assessment approach. The ERP will be led by a consultant clinical psychologist and the pathway will be psychologically informed.

Phase two of Transformation: Local Area Mental Health Networks

A key second phase of the Step Up to Great mental health Transformation is a focus on working local area (e.g. PCN) by local area investing and building in networks of VCS, social care, mental health and PCN providers. This is being taken forward through the workstream of Getting Help in Neighbourhoods. This workstream sits outside of this Decision-Making Business Case but some headline information is included here for context. The workstream is focused on establishing a new model in local areas. This has been piloted through a pathfinder neighbourhood (Beacon & Carillon PCNs in North Charnwood). In 2021/22 this is being expanded to 12 accelerator sites in different neighbourhoods across Leicester, Leicestershire and Rutland.

The pathfinders are bringing together health, adult social care, housing, primary care networks, district councils, local VSCE organisations and service users to shape and then deliver in year the new way of working. This includes investing and re-organising the health, VCS and local authority approaches to:

- Create a common integrated and joined up approach to providing treatment and support locally
- Increase accessibility in neighbourhoods to mental health support that works for a range of people and complexities
- Maximise expertise through joint working, advice, education and targeted work
- Maximise involvement and the potential of voluntary and community sector organisations

- Create offers driven by community need (Population Health Management approach)
- Move towards the new delivery 4-week standard
- Supporting people to be able to remain in their own home and in the least restrictive place
- Develop our approach to a managed local VCS alliance (including information sharing, trusted assessment and no-wrong door processes)

The pathfinders will shape a common framework for all LLR PCNs (or equivalent areas) to ensure parity of offer and interconnection with wider system. Each PCN (or equivalent local area) will build a local offer against this framework using the same co-development approaches used in the pathfinders to ensure that local needs are being understood and met.

The managed networks within each local area will include adult social care, local authority housing and housing association providers. There will be an additional role recruited with transformation monies to support coordinator roles in each hub (e.g. 1 WTE supporting 3 to 4 local areas). They will focus on working with individuals with SMI, housing providers, partner voluntary sector works and other care practitioners to maximise opportunities to support people to live as independently as possible.

Leicester City Council have developed a specific mental health supported living offer to support step down from inpatient care to 24/7 supported housing and Leicestershire County Council are exploring the potential development of floating support services to people with a SMI living in independent housing. These approaches will be developed further as part of our Enhanced Recovery Pathway.

Over the next three years we plan to offer more accessible mental health support in local areas and to have a more integrated approach between primary care, secondary care, voluntary community sector and local authority to support people across the spectrum of mental health needs.

We will increase the capacity and skills to undertake trusted assessment within local areas that will improve the speed of which people can receive support relevant to their needs. We will also increase the mental health expertise and advice offered by specialist mental health services to stakeholders working with people in local areas.

These plans will see a range of organisations from a variety of sectors (primary care, secondary care, voluntary community sector and local authority) brought together to work together in local areas. Professionals from a range of organisations will work closely together to support service users through a range of advice, guidance and the coordination of care. We will recruit 75 Peer Support workers and a team of Recovery Coaches.

These plans will address the long waiting times to access support, gaps for meeting the needs of some of the population and the variability in skills and expertise to support people with mental health needs.

The expected benefits for service users from the planned changes include:

- Improvement in access to mental health support particularly those who fall into gaps between current service provision (collective aim of 4 weeks from assessment to support)
- Improvement in support for people with Serious Mental Illness (SMI) in local areas
- Addressing health inequalities in particular the life expectancy gap for SMI (circa 20 years)

We will expand to twelve accelerator sites in 2021/22, to 18 in 2022/23 and 25 in 2024/25.

Inpatient services

The mental health inpatient services are not a feature of the service changes being consulted upon within the DMBC. We have included some headline information to provide context and to highlight the recent success in driving down out of area placements.

There are 228 acute mental health beds (not including psychiatric intensive care, forensic or rehabilitation) provided locally through Leicestershire Partnership NHS Trust. Of these 140 are supporting adults with acute mental health needs, 40 have targeted focus on supporting individuals with needs associated with dementia and 48 support older people with 'functional' mental health needs. The services support people with acute mental health needs that cannot be supported safely within community setting including individuals who are detained under the mental health act. There has historically been significant demand pressure on acute mental health beds that has led to individual not being able to be accommodated within Leicestershire beds and needing an out of area placement. This has significantly improved over the last year with a reduction from a height of 1,050 bed days out of area in August 2019 to a sustained position of no inappropriate out of area placements from April 2020.

A national scheme was introduced in 2020 to eradicate dormitory accommodation from mental health inpatient environments to improve the safety, privacy, dignity and experience of people using the services. Capital funding has been made available to LLR to renovate 8 acute wards and convert dormitories into single room accommodation. The physical changes started in 2021.

Equalities and health inequalities

In December we undertook some detailed analysis of our service users which is included as appendix five. We used this analysis, alongside the demographic information in chapter two, to inform an Equality Impact Assessment of our plans and Business Case.

We bought in external support to undertake the Equality Impact Assessment. This was to bring independence and expertise to the EIA process. The Equality Impact Assessment was undertaken through a workshop approach with VCS organisations focused on equalities within Leicester, Leicestershire and Rutland. The outcome of the workshop was shared with the participants for comment. We agreed to continue to work with these equality focused VCS partners through the consultation and in implementing our service changes. The final EIA analysis was used to inform our consultation plans.

LLR has a very diverse population across its 25 neighbourhoods (PCNs). The proposed new model of care is built around delivering services within neighbourhoods using a network of voluntary sector, health and social care and other key partners. In 2020/21 a pathfinder commenced to focus on developing approaches that deliver localised care within a wider system-based framework.

This framework is being co-produced with VCS, PCN, MH providers, district council and service users' representatives. It is intended that dedicated proportion of the transformation monies will be used to:

- develop local VCS organisations in each neighbourhood to help improve access, offers and approaches work and are trusted by all elements of the local communities
- Provide seed funding for small initiatives for grass root initiatives

- To support a statutory or voluntary organisation at a hub level to support the governance, information sharing and quality standards of the small organisations in the network

Our planned investment will support the recruitment of three paid peer support workers from and representative of, that local community (including at least one older person). There will also a dedicated resource to manage a network of volunteers that are representative of the local population and support 'checking in' with individuals with SMI and help support them to engage with help when needed.

The mental health partners will commit to diverse recruitment panels, anti-racist programmes and organisational development initiatives. Local partners will be enabled to understand ongoing inequalities in terms of service users' access services and recovery rates. The system will support the use of local knowledge to evolve services which address these changing issues. The system will specifically be analysing how individuals with different cultural backgrounds and protected characteristics use the whole system through the development of a data warehouse of all statutory partners (allowing usage of service to be tracked across different health providers, social care and substance misuse services). This will be used to feedback to local neighbourhoods and providers to iterate and improve services and tackle health inequalities for service users with SMI.

Measuring the success of the UEC and Community elements of the Step Up to Great programme

A range of measures will be used to monitor and measure the success of the planned changed to Community Mental Health services and the Urgent and Emergency Mental Health pathway. Wherever possible, we have tried to use relevant national mental health standards. For some we have used local standards and for others it is focused on compliance with guidance (e.g. moving to a NICE compliant model).

Integrated Community Mental Health

Step/measure/target	**Expected post-implementation position**
Inappropriate out of area placements	Maintained at zero
52 week waits	Eradicate 52 week waits
Six week routine target to access Planned adult mental health services – 95%	Consistently deliver local target
Six week routine target to access Planned older adult mental health services – 95%	Consistently deliver local target
Memory services – 18 week Referral to Treatment (RTT)	Consistently deliver national target
ADHD – 18 week Referral to Treatment (RTT)	Consistently deliver national target
First Episode of Psychosis 60%	Continue to consistently deliver national target

Step/measure/target	Expected post-implementation position
Early Intervention in Psychosis – new model that supports the fidelity score (NICE expectations)	Deliver a new model that meets level 3 NICE concordance
Personality disorder pathway – 18 weeks referral to treatment	Consistently deliver national target
Personality Disorder – NICE compliant model	Deliver NICE compliant model set out in DMBC
Therapy offer – 18 weeks referral to assessment	Consistently deliver national target
Enhanced recovery pathway – NICE compliance (rehabilitation for complex psychosis community pathway)	Deliver NICE compliant model set out in DMBC
Mental Health Older People – memory clinics – 18 week Referral to Treatment (RTT) – 18 weeks	Consistently deliver national target
CPA – 7 day follow up – 95%	Consistently deliver national target
CPA – 12 month reviews – 95%	Consistently deliver national target
Perinatal access – offer broader range of services set out in DMBC	Establish broader access offer
Perinatal – emergency referrals seen within four hours – 95%	Consistently deliver national target
Perinatal – urgent referrals seen within forty eight hours – 95%	Consistently deliver national target
Perinatal – routine referrals seen within four weeks – 95%	Consistently deliver national target
Perinatal – access to NICE concordat based specialist perinatal mental health service – 1,180 (21/22 target)	Consistently deliver national target
Reduction in specialist placements (through improved personality disorder pathway and enhanced recovery)	Reduced usage of specialist placements for needs associated with personality disorder and for rehabilitation

Urgent and Emergency Mental Health pathway

Step/measure/target	Expected post-implementation position
No 12 hour A&E mental health waits	Maintain at zero
National expectation to establish open access	Deliver the national expectation (crisis fidelity standards)
Long Term Plan expectation to establish a 24/7 mental health crisis service	Deliver the national expectation
Urgent Care Hub activity Maintaining use of the Hub rather than A&E, EMAS or police custody	Manage an average of 1,200 service users per quarter
Urgent Care Hub Full assessment in two hours of arrival	Consistently achieve local standard
Street triage 50 MH assessment per month undertaken by street triage nurses	Consistently achieve the local standard
Criminal Justice and Diversion services 750 cases per month of telephone based support	Consistently achieve the local standard
Core 24 – one hour target (assessment in ED)	Meeting the national target
Core 24 – 24 hour target (assessment in acute wards)	Meeting the national target
National expectation - Range of complementary and alternative crisis services within local mental health crisis pathways	Achieve the national expectation
Crisis cafés – coverage by 2024	Establish at least one Crisis Café in each neighbourhood/PCN footprint in LLR
Crisis service – full crisis assessment targets 4 hours	Consistently deliver national target
Reducing avoidable conveyance to Emergency Department (through MH Urgent Care Hub, CAP and triage car support)	Reducing trend (when adjusting for any overarching changes to MH demand)
Reduced attendances at Emergency Department (through MH Urgent Care Hub, CAP and triage car support)	Reducing trend (when adjusting for any overarching changes to MH demand)

Step/measure/target	Expected post-implementation position
Reduction in re-offending (through Triage car, vulnerability pathway and liaison and diversion support)	Reduced re-offending trend
Reduced length of stay in acute hospitals for individuals with an identified mental health illness (through Acute Liaison service)	Overall reduced length of stay for individuals within acute hospital that have an identified mental health illness

6. The consultation process

This chapter sets out the formal 12-week public consultation for Step-up to Great Mental Health that commenced on Monday 24 May and ran until Sunday 15 August 2021.

Leading the consultation

The consultation process was run and delivered by the Clinical Commissioning Groups in Leicester, Leicestershire and Rutland (LLR CCGs) in partnership with Leicestershire Partnership NHS Trust.

The LLR CCGs have a legal duty to involve and consult the public on service reconfigurations, as set out in the National Health Service Act 2006. They have led the process in partnership with Leicestershire Partnership NHS Trust.

Consultation material

The public consultation commenced on Monday 24 May 2021. Full details are still available on the Step-up to Great consultation website. The public consultation was undertaken using Cabinet Office principles (updated January 2016) and NHS England guidance 'Planning, assuring and delivering service change for patients' (published in November 2015).

The public consultation provided a wide range of opportunities for people to participate, both online and offline.

The full Pre-Consultation Business Case, Consultation Document and Communications and Engagement Plan were made available to view on the consultation website.

Purpose of the consultation

The purpose of public consultation was to:

- Give people a voice and opportunity to influence final decisions
- Inform people how the proposal had been developed
- Describe and explain the proposals
- Seek people's views and understanding of the impact of the proposals on them
- Ensure that a range of voices were heard reflecting the diverse communities involved in the public consultation
- Understand the responses made in reply to proposals and take them into account in decision-making.

CCG duty (s14Z2)

In undertaking a public consultation the clinical commissioning groups are fulfilling a duty to involve the public. In looking specifically at the duty which statute has placed on clinical commissioning groups, s.14Z2 of the NHS Act 2006 (as amended) states:

Public involvement and consultation by clinical commissioning groups:

1) This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by a clinical commissioning group in the exercise of its functions ("commissioning arrangements")
2) The clinical commissioning group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways):
   a) in the planning of the commissioning arrangements by the group,
   b) in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and
   c) in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

Equalities and Human Rights Implications

The public consultation took account of the range of legislation that relates to CCG decision making including:

- Equality Act 2010
- Public Sector Equality Duty Section 149 of the Equality Act 2010
- Brown and Gunning Principles
- Human Rights Act 1998
- NHS Act 2006
- NHS Constitution
- Health and Social Care Act 2012

Consulting in a pandemic

The Step up to Great Mental Health Consultation was conducted in the pandemic with social restrictions in place. It was necessary for the NHS as a public body to exercise their functions, while adapting and moving forward, even as it consulted during the pandemic. Although in the final four weeks, restrictions were lifted, opening up more face-to-face consultation opportunities.

In putting together mechanisms for the public consultation we took the learning from the 'Building Better Hospitals for the Future' consultation. We improved, doing more enhanced activities, particularly investing in and developing community relationships.

The public consultation allowed us to engage a more diverse range of people as we expanded our online activities, as well as capitalise on the reduction in Covid-19 restrictions from 19 July 2021 to undertake offline work.

The range of routes to reach out and involve and consult the public allowed us to operate more effectively, efficiently and economically, whilst acting in a safe and responsible manner. The result is that we have created a very strong basis on which to form robust future partnerships which will help to empower communities and harness the community assets to help address the determinants of health including social, political, cultural and economic.

What we have consulted on

The LLR CCGs in partnership with Leicestershire Partnership NHS Trust (LPT) consulted the public about proposals to invest in and improve adult mental health services for people in Leicester, Leicestershire and Rutland when their need is urgent, or they need planned care and treatment. The proposals included:

- **Provide an additional comprehensive suite of self-help guidance and tools** that is easily accessible in different ways e.g. telephone, text
- **Introduce a Central Access Point –** a single telephone number for all service users who need mental health support, reinforced by a principle of 'no wrong door' should people ask for help through other services such as their GP.
- **Introduce an Acute Mental Health Liaison Service** – joining together existing teams to introduce the Acute Liaison Service to work in emergency department to support identifying need, commencing support and referring service user appropriately for other support to prevent them being admitted. Also work with service users on wards receiving care for a physical need who could also benefit from support with their mental health.
- **Establish a Mental Health Urgent Care Hub** at the Bradgate Unit to quickly assess and provide treatment when the need is urgent.
- **Expand and strengthen the number of Crisis Cafés available** by working with voluntary and community services to develop a range of options for people
- **Improve and expand the Crisis Service** so that people can self-refer to the service via the Central Access Point and be assessed. People would also be helped to be discharged from an inpatient bed into the community and at home.
- **Expand the hours and use of the Triage car to** ambulance crews as well as with police incidents involving people who need mental health support.
- **Integrate or join up community mental health service by:**
    - Creating eight new Community Treatment and Recovery Teams focused on the mental health needs of adults who are of working age and eight Community Treatment and Recovery Teams for older people
    - Introducing new therapy services to reduce long waits
    - Improving services for older people, including those with dementia
    - Creating/moving other services into a community setting and improving the way they are provided
    - Expand the service available for perinatal women from pre-conception to 24 months after birth
    - Improve the support for women who are experiencing trauma and loss in relation to a maternity experience
    - Improve psychosis intervention and early recovery service
    - Enhance the memory service introducing different ways of providing it

- Dramatically cut the waiting times to access Personality Disorder Services
- Help more people to live independently and people who are in independent placements

Service we are consulting on	How it is provided now	How we propose to provide it
Introduction of a Central Access Point	New service introduced temporarily during the pandemic	Single telephone number and digital access manned by staff from voluntary sector and Leicestershire Partnership NHS Trust.
Introduce an Acute Mental Health Liaison Service	Provided by Mental Health Triage Team, Frail Older Persons Advice and Liaison Service, Liaison Psychiatry and Psycho Oncology. Service was based at Glenfield Hospital	Create an Acute Mental Health Liaison Service by joining together the existing teams and base them at Leicester Royal Infirmary close to the emergency department to support people efficiently. Also support people already in an inpatient. Service is available 24 hours a day, 7 days per week.
Establish Mental Health Urgent Care Hub	New service introduced temporarily during the pandemic.	At the Bradgate Unit taking referral from the Central Access Point. Service users will be quickly assessed and provided treatment when the need is urgent.
Expand and strengthen the number of Crisis Cafés	We currently have three Crisis Cafés and wish to increase this to 25.	Additional Crisis Cafés developed in 25 community locations in Leicester, Leicestershire and Rutland. Created by working with voluntary and community services to develop a range of options for people.
Improve and expand the Crisis Service	Call handlers from by Turning Point and Leicestershire Partnership NHS Trust, 24/7 taking referrals mainly from GPs.	Provided by Turning Point and Leicestershire Partnership NHS Trust - people can self-refer or be referred from their GP via the Central Access Point and be assessed in four hours and after 24 hours. Home visits can be offered up to three per day. People would also be helped to be

Service we are consulting on	How it is provided now	How we propose to provide it
		discharged from an inpatient bed into the community and at home.
Expand the hours that the Triage car is provided	Operates 10pm – 2am taking calls from police incidents and provides support to manage situations. Calls are managed by staff operating the Triage car.	Operates 8am to 2am and in addition to police incidents, it would also provide support to ambulance crews. Calls would be managed by the Central Access Point, leaving operations staff to support incidents.
Provide an additional comprehensive suite of self-help guidance and tools	Currently provided in separate places and is text heavy and difficult to navigate	Provided in one place on a section of the Leicestershire Partnership NHS Trust website. Different ways to access via Central Access Point, online instant messaging and Chathealth text messaging.
Integrate or join up community mental health service	Many services not provided currently in the community and some not provided at all. Long waits for therapy services with people passed between services and professionals, often ending up in the emergency department	Create eight Community Treatment and Recovery Teams focused on adults and 8 Community Treatment and Recovery Teams focused on older people • Introducing a new therapy offer to reduce long waits. Improving services for older people including those with dementia. Creating/moving other services into a community setting and improve the way they are provided • Expand the service available for perinatal women from pre-conception to 24 months after birth. • Improve the support for women who are experiencing trauma and loss in relation to maternity experience

Service we are consulting on	How it is provided now	How we propose to provide it
		• Improve psychosis intervention and early recovery service. (PIER) • Enhance the memory service introducing different ways of providing the service. • Dramatically cut waiting times to access Personality Disorder Services • Help more people to live independently and people who are in independent placements.

Consultation Activities

In the context of the Mental Health Public Consultation, we used a multi-channel approach in exercising our statutory functions. We used online technology to hold meetings, share information and recordings of meetings, which enabled a wider reach across communities.

When the Covid-19 restrictions lifted, we undertook off-line and face-to-face communications and engagement activities in order to reach people who may not be digitally enabled or active. This included attending events, hosting focus groups and conducting one-to-one interviews.

The consultation used a variety of both online and offline tools and techniques to communicate with the people of Leicester, Leicestershire and Rutland. These include, but are not limited to, the following activities:

- Commissioning 40 voluntary and community organisations to reach out to seldom heard and often overlooked communities to encourage and support them to participate (with a focus on protected characteristics of age, race, disability, pregnancy/maternity, sexual orientation);

- Extensive media coverage in county-wide and locality specific media including the Leicester Mercury, BBC Radio Leicester and BBC East Midlands Today as well as local weekly newspapers;

- Advertorials in a number of community magazines and newsletters across Leicester, Leicestershire and Rutland with a circulation of circa 50,500. These include:

    - Birstall Post
    - Glenfield Gazette
    - Roundabout Hinckley

- Roundabout the Villages
- Swift Flash

- Commissioning of extensive 6-week radio advertising across cultural and community specific radio stations with a combined listenership of approximately 210,000 people. Adverts supported by numerous in-depth feature discussions on the proposals, lasting up to one hour. Stations include:

  - EAVA
  - Kohinoor
  - Sabras Sound
  - Sanskar
  - Seer

- Shows included:

  - Breakfast Health Show (Hindi/Gujarati
  - Caribbean Vibes Show
  - Community Lunch Show (English/Somali
  - East Africa Show (Somali/Swahili
  - Polish Show
  - South Asian Community Show (Hindi/Punjabi)

- Commissioning of extensive four-week radio advertising across local commercial and community radio stations with a combined listenership of 377,000 people. These include:

  - 103 The Eye
  - Capital FM
  - Fosseway
  - GHR Stamford and Rutland
  - Hermitage FM
  - HFM
  - Three Counties Radio.

- Targeted TV advertising, using smart technology, of residents aged, 25+, 35+, and 45+ 55+ and above and those less likely to be digitally enabled or regular users of social media. This activity has reached an anticipated 129,594 households across Leicester, Leicestershire and Rutland;

- We used social media, including local NHS-owned platforms and paid for advertising to target Facebook, Instagram and Snapchat users in Leicester, Leicestershire and Rutland. Activity and reach across main social media platforms for both paid content, and other online advertising, is at least 628,000 users;

- Widespread utilisation of organic social media, including 115 Facebook communities including Spotted pages across Leicester, Leicestershire and Rutland reaching at least 628,000 users;

- 70 online public events including public workshops, as well as events for specific communities/organisations including Parish Councils, Patient Participation Groups, GPs and users of mental health services;

- 74 events hosted by voluntary and community groups (online and offline) including events live streamed via Facebook Live and Instagram, focus groups with army and navy Veterans, Face-to-Face interviews with convicted army veterans in prison and carers groups;

- 15 service user events (online and offline) including one to one interviews, People's Council, a Recovery Café event and 8 wards visits to gather the views of inpatients.

- Sharing of key messages with residents by local authorities via their own email lists

- Briefing and/or letter to all MPs and councillors (city, county, district and parish) providing information about the proposals, the consultation, and asking for any support in dissemination within their community;

- Email marketing to 1,000 + voluntary and community sector groups, schools and key business across in Leicester, Leicestershire and Rutland;

- Engaged with 25 hairdressers and beauty clinics who supported the promotion of the consultation and encouraged participation through QR codes in salons;

- Engaged with 108 HR department of local businesses who reached out to their employees promoting the consultation and encouraging participation.

- Engaged with Leicester City Football, Leicestershire County Cricket, Leicester Tigers and Leicester Riders who supported the consultation and helped post social media messages and opportunities to work with the sports clubs community departments;

- Engaged with Leicestershire and Rutland Sport to reach grassroot level clubs to make sure all sports clubs received communication on the consultation;

- Over 100 staff briefings and written communications with LPT staff reaching circa 6,000 staff. This included: weekly e-news articles; all-staff consultation events; individual team sessions will all directorate of mental health (DMH); presentations to the staff representative groups and to the LPT leadership forum. DMH sessions were also used to brief staff on how to engage service users, carers and families and how to encourage them to take part. Leaflets were also sent to the community health teams for staff to take out to patients on their visits.

- Staff briefing and written communications with CCG staff and written communications to UHL and local authority staff reaching circa 25,000 staff;

- Business cards with consultation QR code, posters, leaflets and pull up banners and additional information provided to the following vaccination centres and shopping centre:

Vaccination centres:

- Leicester City Football Club
- Loughborough Hospital
- Peepul Centre
- Shree Prajapati Samaj
- The Kube

Shopping Centres:

- Beaumont Leys
- Fosse Park
- Haymarket
- Highcross
- Loughborough Market

- Posters and information provided to approximately 16 local community venues including libraries throughout Leicester, Leicestershire and Rutland. Local Area Coordinators and the Homeless Mental Health Service also distributed information within their communities.

Overall, we are confident that our activities during the public consultation allowed us to meet both our statutory and common law duties.

Consultation events

Event date	Name of the event	Event host	Audience engaged	Number of participants	Geography	Targeted stakeholder
27/05/2021	Not recorded	Equality Action	BAME	1	Leicestershire	Ethnicity (not white British)
27/05/2021	Eritrean Easter & Eid Event	The Race Equality Centre	BME / Refugees and Asylum seekers / new arrivals	15	LLR	Ethnicity (not white British)
27/05/2021	Launch of consultation	Leicester Council of Faiths	Faith Leaders	80	Leicester	Religion / belief
28/05/2021	Virtual public event	Leicester Council of Faiths	Faith Leaders	80	Leicester	Religion / belief
01/06/2021	Not recorded	Equality Action	BAME	1	Leicestershire	Ethnicity (not white British)
01/06/2021	Public meeting	LLR CCGs	General public	17	LLR	General
03/06/2021	Chill & Chat	The Race Equality Centre	Refugees / New arrivals / BME	8	LLR	Ethnicity (not white British)
04/06/2021	All services workshop	Leicester Council of Faiths	Faith leaders	80	Leicester	Religion / belief
04/06/2021	LCOF Mental Health 'Community Recovery' meeting	Leicester Council of Faiths	Faith Leaders	80	Leicester	Religion / belief
07/06/2021	Women's health & wellbeing	The Race Equality Centre	BME; Women; Refugees; Asylum Seekers; New arrivals	6	LLR	Ethnicity (not white British)
08/06/2021	Facebook, social media communications	The Race Equality Centre	BAME, TREC Members & general public	Not recorded	LLR	Ethnicity (not white British)
09/06/2021	Leicester Deaf Forum subgroup meeting	Leicester Deaf Forum	Deaf Community	3	Leicester	Disability
10/06/2021	Step Up to Great Mental Health Consultation - All Services Workshop	LLRCCG	General Public	14	LLR	General

Event date	Name of the event	Event host	Audience engaged	Number of participants	Geography	Targeted stakeholder
10/06/2021	LCOF Mental Health 'Community Recovery' meeting	Leicester Council of Faiths	Faith Leaders	25	Leicester	Religion / belief
11/06/2021	Public meeting	Leicester Council of Faiths	Faith Leaders	80	Leicester	Religion / belief
12/06/2021	Public meeting	LLR CCGs	General public	8	LLR	General
13/06/2021	Community Discussion	Project Polska	Polish Community	5	LLR	Ethnicity (not white British)
15/06/2021	Step Up to Great Mental Health Consultation - Public Meeting and Discussion	LLR CCG	General Public	8	LLR	General
16/06/2021	SUTGMH VASL Workshop	VASL	Carers	11	Leicestershire	Carers
16/06/2021	Leicester City CCG GP PLT	Leicester City CCG	GP's	71	Leicester	Staff
17/06/2021	Not recorded	RCV	Existing Service User	1	Rutland	Disability
17/06/2021	Gujarati video	Leicester Council of Faiths	Faith Leaders	80	Leicester	Religion / belief
18/06/2021	Hinckley & Bosworth District Council Health and Well Being Partnership board	Hinckley and Bosworth District Council	Councillors and local organisations	22	Leicestershire	Councillors
19/06/2021	Not recorded	RCV	Carer	1	Rutland	Carers
19/06/2021	Step Up to Great Mental Health Consultation - All Services Workshop	CCG	General Public	4	LLR	General
21/06/2021	Step Up to Great Mental Health	Dear Albert - The Stairway Project	Lyndon Lodge (Sanctuary supportive living)	5	Leicester	Disability
22/06/2021	TIER 3 EVENT – ALL SERVICES WORKSHOP	NHS CCG LLR	service users (incl. 3 carers, one person working for mental health	4	LLR	Carers

Event date	Name of the event	Event host	Audience engaged	Number of participants	Geography	Targeted stakeholder
			charity but not responding on behalf of an organisation)			
22/06/2021	Focus Group	Shama Women's Centre	general public	5	Leicester	Gender (women)
22/06/2021	Focus group	Shama Women's Centre	general public	5	Leicester	Gender (women)
22/06/2021	Recovery Substance organisation	Dear Albert - The Stairway Project	General Public (drop in)	1	Leicester	General
22/06/2021	Homeless forum	Dear Albert	Homeless	6	Leicester	Homeless
22/06/2021	Sharing CCG public meeting details	Leicester Council of Faiths	Faith Leaders	80	Leicester	Religion / belief
23/06/2021	Substance Use Recovery Community	Dear Albert	Recovery	1	Leicester	Addiction / recovery
23/06/2021	Substance use recovery community	Dear Albert - The Stairway Project	Recovery	1	Leicester	Addiction / recovery
23/06/2021	Substance use recovery community	Dear Albert- Stairway project	Recovery	1	Leicester	Addiction / recovery
23/06/2021	Facilitator Survey	Shama Women's Centre	Service users	7	Leicester	Gender (women)
23/06/2021	Focus group	Shama Women's Centre	Service Users	3	Leicester	Gender (women)
23/06/2021	TIER 1 PUBLIC EVENT & DISCUSSION	NHS CCG LLR	General Public	13	LLR	General
24/06/2021	Substance Use Recovery Community	Dear Albert/The Stairway Project	Recovery	1	Leicester	Addiction / recovery
24/06/2021	1-1 interview	The Carers Centre	Carers	1	LLR	Carers
24/06/2021	Step Up to Great MH	Adhar Project	Adhar Project Team	8	Leicester	Disability
24/06/2021	Maternity Voices Partnership	Maternity Voices Partnership	Mothers, health professionals, maternity advocates	11	LLR	Maternity / pregnancy

Event date	Name of the event	Event host	Audience engaged	Number of participants	Geography	Targeted stakeholder
24/06/2021	CCG promo video in different languages	Leicester Council of Faiths	Faith Leaders	12	Leicester	Religion / belief
25/06/2021	Step Up to Great MH	Adhar Project	Service User Support Group	4	Leicester	Disability
25/06/2021	Step Up to Great MH	Adhar Project	Adhar Project service users (BAME Community)	3	Leicester	Ethnicity (not white British)
25/06/2021	Step up to Great Mental Health - Consultation with Dosti Leicester	Trade Sexual Health	South Asian LGBT	6	Leicester	Sexuality
28/06/2021	1-1 Interview	The Carers Centre	Carers	1	LLR	Carers
28/06/2021	1-1 Consultation	The Carers Centre	Carers	1	LLR	Carers
28/06/2021	1-1 Interview	The Carers Centre	Carers	1	LLR	Carers
28/06/2021	Clinical Commissioning Group Briefing - Step Up to Great Mental Health Consultation	NW Leicestershire Council	Councillors	12	Leicestershire	Councillors
28/06/2021	Wellbeing Workshop	Project Polska	Polish Community	4	LLR	Ethnicity (not white British)
29/06/2021	Facilitator Survey	Shama Women's Centre	Service Users	6	Leicester	Gender (women)
30/06/2021	1-1 Interview	The Carers Centre	Carers	1	LLR	Carers
30/06/2021	LLR CCG Member Briefing: Mental Health Consultation	Melton Borough Council	Councillors	Not recorded	Leicestershire	Councillors
30/06/2021	Charnwood Borough Council Member Services meeting	Charnwood Borough Council	Councillors	12	Leicestershire	Councillors
30/06/2021	VCS Meeting Tier 2	LLR CCG	Yes	6	LLR	General
01/07/2021	Leicester Deaf Forum	Leicester Deaf Forum	Deaf community	5	Leicester	Disability

Event date	Name of the event	Event host	Audience engaged	Number of participants	Geography	Targeted stakeholder
01/07/2021	Facilitator session	Shama Women's Centre	Service users	8	Leicester	Gender (women)
01/07/2021	SUTGMH and GP Survey PPG network meeting	CCG	PPG Members	22	LLR	General
01/07/2021	Push for people to complete survey	Leicester Council of Faiths	Faith leaders	80	Leicester	Religion / belief
01/07/2021	Step up to Great Mental Health - Consultation with Trade volunteers	Trade Sexual Health	Volunteers	3	LLR	Sexuality
02/07/2021	Together We Care Group (Carers of Adults) Step up to Great Mental Health Consultation	The Carers Centre	Carers	9	LLR	Carers
02/07/2021	1-2-1 Feedback	Equality Action	BAME (Sikh Woman)	1	Leicestershire	Ethnicity (not white British)
05/07/2021	LGBT+ adult group	Leicester LGBT Centre	LGBT+	5	Leicester	Sexuality
06/07/2021	LPT YAB Teams Meeting	LPT	Young People	8	LLR	Age (young people)
06/07/2021	1-1 Interview Step up to Great Mental Health Consultation	The Carers Centre	Carers	1	LLR	Carers
06/07/2021	Together We Care Group (Carers of under 25's) Step up to Great Mental Health Consultation	The Carers Centre	Carers	4	LLR	Carers
07/07/2021	1-1 Interview Step Up to Great Mental Health Consultation	The Carers Centre	Carers	1	LLR	Carers
08/07/2021	Public event	CCG	General public	4	LLR	General
09/07/2021	Recovery Cafe - MH	Leicestershire Partnership NHS Trust	Users of LPT services	7	LLR	Disability

Event date	Name of the event	Event host	Audience engaged	Number of participants	Geography	Targeted stakeholder
	Consultation - Have your Say					
10/07/2021	Community chat	Project Polska	general public, Polish community	15	LLR	Ethnicity (not white British)
10/07/2021	Community services workshop	LLRCCG	general public	1	LLR	General
12/07/2021	SUTGMH Rutland County Council All members briefing	LLR CCG	Councillors	19	Rutland	Councillors
12/07/2021	Not recorded	Equality Action	BAME	1	Leicestershire	Ethnicity (not white British)
12/07/2021	Mental Health Consultation	Leicester Jain Temple	members of Jain Faith	150	Leicester	Religion / belief
13/07/2021	Step up to Great Mental Health Consultation 1-1 Interview	The Carers Centre	Carers	1	LLR	Carers
13/07/2021	Leicester Deaf Action Group	Leicester Deaf Action Group	Deaf people	1	Leicester	Disability
13/07/2021	Leicester BSL Tutor group	Leicester BSL Tutor group	Deaf people	1	Leicester	Disability
13/07/2021	Leicester Deaf Club	Leicester Deaf Club	Deaf people	1	Leicester	Disability
14/07/2021	Step up to Great Mental Health Consultation 1-1 interview	The Carers Centre	Carers	1	LLR	Carers
14/07/2021	Focus Group: Chai & Chat Mental Well-being Consultation	for Leicester Ageing Together Community and Belgrave Lunch Club	South Asian	75	Leicester	Ethnicity (not white British)
14/07/2021	Step Up to Great Mental Health Consultation - Perinatal and Maternity Services Workshop	LLR CCG	General public	1	LLR	Maternity / pregnancy
15/07/2021	Leicester Deaf Asian	Leicester Deaf Asian	Deaf people	1	Leicester	Disability

Event date	Name of the event	Event host	Audience engaged	Number of participants	Geography	Targeted stakeholder
15/07/2021	SUTGMH Healthwatch Leicester and Leicestershire event	Healthwatch LLR	Yes	1	Leicester	General
16/07/2021	Step up to Great Mental Health Consultation 1-1 Interview	The Carers Centre	Carers	1	LLR	Carers
16/07/2021	Leicester over 50 club	Leicester over 50 club	Deaf people	1	Leicester	Disability
16/07/2021	Leicester Open House	Leicester Open House	Deaf people	1	Leicester	Disability
16/07/2021	Leicester Deaf Forum	Leicester Deaf Forum	Deaf people	1	Leicester	Disability
17/07/2021	Public meeting	LLR CCGs	General public	5	LLR	General
18/07/2021	Minding the Mind	ASHIOMA CONSULTS	RCCG YOUTH GROUP	70	LLR	Age (young people)
18/07/2021	Youth Engagement Event	Ashiedu Joel	Black African Community	95	LLR	Ethnicity (not white British)
19/07/2021	LGBT+ adult group	Leicester LGBT Centre	LGBT+	5	Leicester	Sexuality
20/07/2021	All-Member Briefing - Step Up to Great Mental Health Services consultation - Leicestershire County Council	Leicestershire County Council	Councillors	23	Leicestershire	Councillors
20/07/2021	Mental Health Consultation	Voluntary Action Leicestershire	General Public	6	LLR	General
21/07/2021	Leicester City Council Faiths Engagement Group	Leicester City Council	Faith members	13	Leicester	Religion / belief
21/07/2021	Promote CCG Carers workshop	Leicester Council of Faiths	Faith Leaders	80	Leicester	Religion / belief
21/07/2021	Step up to Great Mental Health - Consultation with gay and bi men/MSM living with HIV	Trade Sexual Health	Gay and bisexual men living with HIV	4	LLR	Sexuality
21/07/2021	LGBT+ 50+ years old group	Leicester LGBT Centre	LGBT+	5	Leicester	Sexuality

Event date	Name of the event	Event host	Audience engaged	Number of participants	Geography	Targeted stakeholder
21/07/2021	Trans and Non-binary group	Leicester LGBT Centre	LGBT	5	Leicester	Sexuality
22/07/2021	Mind Apples	Leicester Uni/Julian Harrison	Service users and general public	19	Leicester	Disability
22/07/2021	STRENGTH FROM MY FAITH	ashioma consults / African network	members of the various African communities	30	LLR	Ethnicity (not white British)
22/07/2021	Carers	CCG	General Public	7	LLR	General
22/07/2021	Emailed feedback	na	public	1	Unknown	General
22/07/2021	Mental Health Consultation One to One	Voluntary Action Leicestershire	General Public	1	Leicestershire	General
23/07/2021	EAVA FM Group 2	EAVA FM	Young People	8	Leicester	Age (young people)
23/07/2021	EAVA FM Group 3	EAVA FM	Young people	7	Leicester	Age (young people)
23/07/2021	Leicester Deaf Church	Leicester Deaf Church	Deaf people	2	Leicester	Disability
27/07/2021	share CCG elderly care workshop	Leicester Council of Faiths	Faith leaders	80	Leicester	Religion / belief
28/07/2021	Stepping up to mental health	Dear Albert Recovery Consultancy	Recovery	1	Leicester	Addiction / recovery
28/07/2021	Not recorded	RCV	Young people in employment	6	Rutland	Age (young people)
28/07/2021	FOCUS GROUP	Shama Women's Centre	GENERAL PUBLIC	4	Leicester	Gender (women)
28/07/2021	Step Up to Great Mental Health Consultation - Elderly Care Workshop	LLR CCG	Yes	7	LLR	General
28/07/2021	promote LCOF YP meeting	Leicester Council of Faiths	Faith Leaders	80	Leicester	Religion / belief
28/07/2021	Trans and Non-binary group	Leicester LGBT Centre	LGBT+	5	Leicester	Sexuality
29/07/2021	Racial Minority Voluntary Sector Assembly	The Race Equality Centre	BAME	Not recorded	LLR	Ethnicity (not white British)
29/07/2021	Chai and Chat Asian Women's Consultation	SAHA with Jain Bhagini and Shree	South Asian Women	115	LLR	Ethnicity (not white British)

Event date	Name of the event	Event host	Audience engaged	Number of participants	Geography	Targeted stakeholder
		Sanatan Mandir				
29/07/2021	LCOF Young People and Mental Health Consultation Zoom event	Leicester Council of Faiths	young people from faith communities	24	Leicester	Religion / belief
30/07/2021	GENERAL INFORMATION & FEEDBACK SESSION	ASHIOMA CONSULTS	GENERAL PUBLIC - AFRICAN COMMUNITY REPS	5	LLR	Ethnicity (not white British)
30/07/2021	Not recorded	RCV	Employed People aged 35-55	2	Rutland	General
01/08/2021	SUTGMH Veterans Focus Group	CCG	Veterans	14	LLR	Armed forces veterans
02/08/2021	crisis care workshop	LLR CCG	Yes	7	LLR	Disability
02/08/2021	Crisis Care Workshop	LLR CCG	Yes	7	LLR	Disability
02/08/2021	Workshop	Project Polska	Polish women	5	LLR	Ethnicity (not white British)
02/08/2021	Not recorded	Equality Action	BAME	1	Leicestershire	Ethnicity (not white British)
03/08/2021	Somali Community Mental Health Event	Hashim Duale	Somali Community	28	LLR	Ethnicity (not white British)
04/08/2021	Stocken Prison Veterans Breakfast Club	Stocken Prison	Veterans	8	Rutland	Armed forces veterans
04/08/2021	Eritrean Community consultation, Group 1	The Race Equality Centre	BAME / Refugees and asylum seekers and new arrivals	3	LLR	Ethnicity (not white British)
04/08/2021	Celebrate our Similarities (COS)	LLR CCG	Yes	5	LLR	General
04/08/2021	LGBT+ 50+ years old group	Leicester LGBT Centre	LGBT	5	Leicester	Sexuality
04/08/2021	LPT all staff event	LPT	LPT Staff	29	LLR	Staff
05/08/2021	Steps up to Mental Health	Dear Albert	Recovery Service User	1	Leicester	Addiction / recovery
05/08/2021	Step up to Mental health	Dear Albert	Recovery Service User	1	Leicester	Addiction / recovery
05/08/2021	EavaFM Group 10	Eava FM	General Public 19-26	9	Leicester	Age (young people)

Event date	Name of the event	Event host	Audience engaged	Number of participants	Geography	Targeted stakeholder
05/08/2021	Service User Meeting	Leicestershire Partnership NHS Trust	Service Users of LPT services	1	LLR	Disability
05/08/2021	Not recorded	Rutland Out of Hours Club	Young adults with additional learning needs	15	Rutland	Disability
05/08/2021	Service User Testimony	Voluntary Action Leicestershire	Voluntary Sector (MH Group)	1	LLR	Disability
06/08/2021	Step up to mental health	Dear Albert	recovery community	6	Leicester	Addiction / recovery
07/08/2021	SUTGMH - Veterans Breakfast Club Oakham	Veterans Club	Veterans	35	Rutland	Armed forces veterans
08/08/2021	SUTGMH Leicester Servicemen's Club - Veterans	Leicester Servicemen's Club	Veterans	18	Leicester	Armed forces veterans
09/08/2021	Step Up to Great Mental Health	Dear Albert	Recovery	1	Leicester	Addiction / recovery
09/08/2021	Jamila's Legacy meeting	Jamila's Legacy	MH volunteers	12	Leicester	Disability
09/08/2021	Not recorded	Equality Action	BAME	1	Leicestershire	Ethnicity (not white British)
09/08/2021	Promote final push for consultation	Leicester Council of Faiths	Faith Leaders	80	Leicester	Religion / belief
09/08/2021	LLR NHS Staff Workshop	LLR CCG	Yes	5	LLR	Staff
10/08/2021	Chill & Chat Group	The Race Equality Centre	BAME / Refugees and asylum seekers and new arrivals	11	LLR	Ethnicity (not white British)
10/08/2021	Eritrean Community Consultation Group 2	The Race Equality Centre	BAME / Refugees and asylum seekers and new arrivals	8	LLR	Ethnicity (not white British)
10/08/2021	Speaking English with confidence	Equality Action	General public	Not recorded	Leicestershire	General
10/08/2021	African Communities Event	Leicestershire CCG's	General Public	13	Leicestershire	General
10/08/2021	LGBT+ Youth Group	Leicester LGBT Centre	LGBT+	6	Leicester	Sexuality

Event date	Name of the event	Event host	Audience engaged	Number of participants	Geography	Targeted stakeholder
11/08/2021	Arabic Clients 121	The Race Equality Centre	BAME / Refugees and asylum seekers and new arrivals	9	LLR	Ethnicity (not white British)
11/08/2021	Step Up to Great MH	Adhar Project	Iskcon Leicester (Temple) - Mental Wellbeing Team	6	Leicester	Religion / belief
11/08/2021	LGBT+ Youth Group	Leicester LGBT Centre	LGBT	2	Leicester	Sexuality
11/08/2021	1-1 interview with lesbian woman	Leicester LGBT Centre	LGBT+	1	Leicester	Sexuality
11/08/2021	1-1 interview with gay man	Leicester LGBT Centre	LGBT+	1	Leicester	Sexuality
12/08/2021	Step up to Great Mental Health	Dear Albert	Recovery Community	1	Leicester	Addiction / recovery
12/08/2021	discussion	Equality Action	BAME	2	Leicestershire	Ethnicity (not white British)
12/08/2021	South Asian Males Event	SAHA and community partners	South Asian	10	LLR	Ethnicity (not white British)
12/08/2021	Not recorded	Equally Action	General	1	Leicestershire	General
12/08/2021	Step Up to Great MH	Adhar Project	St. Peter's Church - congregation members and service users	11	Leicester	Religion / belief
13/08/2021	Leicester Open House	Leicester Open House	Deaf people	1	Leicester	Disability
13/08/2021	Mental Health & Wellbeing Skegness Trip	The Race Equality Centre	BAME / refugees / asylum seekers / new arrivals	33	LLR	Ethnicity (not white British)
14/08/2021	WOMEN'S EVENT	ASHIOMA CONSULTS	women who have experienced mental health issues	10	LLR	Gender (women)
27/08/2021	Client update meetings	The Race Equality Centre	BAME / Refugees and asylum seekers and new arrivals	11	LLR	Ethnicity (not white British)

Event date	Name of the event	Event host	Audience engaged	Number of participants	Geography	Targeted stakeholder
Not recorded	Harborough Borough Council all members briefing	Harborough Borough Council	Councillors	12	Leicestershire	Councillors

Outputs of the consultation process

The Midlands and Lancashire CSU has provided independent support to the consultation process, receiving and aggregating comments and responses to the questions on support for specific changes. The CSU has also monitored the breadth of the community responding to the consultation. Further detail on this is included in the Report of Findings from the CSU and considered in the Equality Impact Assessment.

The CSU Report of Findings was received on 19 November and has been shared on the consultation website. It was also shared with the LPT workforce through an all-staff email on Monday 22 November. Following this, the Patient Experience and Involvement Team shared it with the People's Council who have been representing service users throughout the consultation.

Celebration and learning

We held a Celebration event on Friday 8 October 2021, with the voluntary and community sector organisations who had worked with us to promote the consultation and ensure the voices of their communities were heard. The event also shared best practice and particularly captured the learning and how we all want to work together in partnership going forward. A second event is being coordinated in December to further explore partnership working, setting a blueprint for future collaboration, that results in community empowerment and improved health and wellbeing.

Assurance through the Public and Patient Involvement Assurance Group

On Wednesday 1 December 2021, the system Public and Patient Involvement Assurance Group (PPIAG) reviewed the Report of Findings. They integrated the information to assess whether:

- the proposals to improve mental health services in Leicester, Leicestershire and Rutland been developed with appropriate and sufficient public and patient involvement
- the NHS have sufficient insights and business intelligence from a diverse range of service users, staff, carers and public, to inform decision of the CCG Governing Body regarding mental health services

The PPIAG were able to assure in both areas, acknowledging the extend of work that had been undertaken. The group noted that there was strong support for the proposals. They also recommended that the qualitative insights and business intelligence provided by people is carefully considered and that co-production remains at the forefront of implementation.

7. Consultation feedback and our response

This chapter sets out the feedback we received through the consultation process described in chapter 6 and our response to it. There was strong support for all of our proposals. We also received a rich set of comments that will influence how we implement, promote and link the individual service change proposals.

Consultation feedback

The CSU Report of Findings sets out the detail of the responses received and the profile of the people who responded to the consultation. The report is included as an appendix of this document.

We received an excellent response to the consultation with over 6,500 responses. This was compromised of 3,635 completed online main questionnaires, 212 completed postal questionnaires, 205 completed online easy read questionnaires, 41 completed postal questionnaires, 41 correspondence (letters and emails). There were also 2,516 participants/focus groups and one-to-one interviews across 164 events.

Consultation feedback and response by service change proposal

In this chapter, for each service change, we have captured the proposed investments, improvements and developments as set out int eh main consultation document. We have then captured the responses in terms of support and then the comments which have been coded and aggregated by the CSU. In the interests of transparency, we have included the full tables of coded comments. For each service change we go on to respond to the main points made. We will carry these and the other detailed comments into the implementation planning phase.

Additional comprehensive suite of self-help guidance and tools

The consultation proposals

Advice and guidance are a key component of mental health support. A lot of websites and platforms can be accessed that provide supporting materials for different needs. This includes a section of the Leicestershire Partnership NHS Trust website. However, at the moment there is no standard set of guidance for service users and no single place that people are signposted to receive self-help. Information is often text heavy and difficult to find and navigate.

We would bring together all of this information and provide it in a single place or provide access to it. The guidance and tools would be easily accessible and simple to navigate and available on the website of Leicester Partnership NHS Trust, with links to additional information provided on other websites e.g. First Contact Plus.

We also propose offering people different ways of accessing information depending on what the preference is. This could include:

- Calling the Central Access Point telephone number
- Call back service. Through the Central Access Point, the service user would talk to a Recovery Worker from Turning Point in the first instance. If they need clinical support, they would either be transferred to an appropriate person or team. If this is not possible immediately then they would be asked to provide their name and phone number and a call back would be arranged. People can expect to be called back as soon as possible and within four hours for urgent care, or within four working days if the call is not classed as urgent.
- Online instant messaging allowing chat with staff, who would be able to direct people to the most appropriate information or solution to address their query.
- Introduction of Chathealth instant and text messaging which would be suggested to people as a way of discussing their mental health concerns.
- Accessibility features such as British Sign Language, as well as language interpretation facilities, are being incorporated into the planning of these services
- A service user and carer engagement group is helping provide input into the development of these services. This consultation will also influence how self-help guidance is provided.

The consultation feedback

Support

	Standard survey online	Standard survey paper	Easy read online	Easy read paper
Strongly agree	1635	79	104	11
Agree	1389	65	64	25
Neither agree nor disagree	324	17	16	4
Disagree	155	18	11	0
Strongly disagree	94	19	8	1
Not applicable	15	4	0	0

Specific comments

Q2 in the consultation document - Advice and guidance are key components of mental health support. There is a lot of information out there and we would bring this all together in a single place online. This would help people to find the information they need and receive further help. - Please explain why you agree or disagree with this proposal.

Comments	Count survey	Count event
Proposal will support patients to access the appropriate information and services (e.g. quicker, better signposting)	306	16
Concern over lack of access to technology or knowledge how to use them	199	10
Mental health patients require human interaction (e.g. face-to-face support, somebody to listen, advice from familiar person)	99	2
Agreement with proposal	92	31
Concern over mental health patients' capacity to understand information and engage (e.g. patient deny problems, too ill)	89	5
Ensure that information is accessible for everyone (e.g. hard copies at GP surgeries, libraries, BSL videos)	74	21
Ensure that information provided in self-help guidance is appropriate (e.g. up to date, detailed, clear, accessible language)	51	3
Consider improving access to mental health support (e.g. waiting time, referral process)	46	1
Consider improving quality of mental health care (e.g. holistic approach)	33	0
Self-help guidance is useful only as a supplementary tool (e.g. should not replace professional help)	33	3
Ensure that self-help guidance reflects the needs of the diverse community (e.g. multiple languages)	29	4
Mental health patients require support of professional staff	20	2
Other	20	0
Utilise different channels to promote and advertise self-help guidance (e.g. health care settings, public places, charities)	17	5
Consider the needs of vulnerable groups (e.g. complex needs, elderly, deaf community)	17	15

Disagreement with proposal (e.g. would not use it)	13	12
Self-help guidance is not required (e.g. already exists, not useful)	13	0
More details about the proposal are required	11	3
Proposal will improve integration between mental health services providers	10	0
Ensure appropriate staffing for mental health services (e.g. staffing levels, trained staff)	10	1
Consider that each mental health patients require different support (e.g. triage is needed)	10	0
Concern that proposal is about saving money not improving quality of mental health care	9	0
Concern that proposal will increase health inequalities (e.g. discriminating)	9	0
Consider provision of telephone support (e.g. helpline, call back)	9	1
Consider increased provision of mental health services across the county	8	0
Consider the need for continuity and consistency of care	8	0
Self-help guidance may have negative impact on patients' health (e.g. incorrect diagnoses, delay help)	8	1
Proposal is not good use of NHS money (e.g. should be spent on improving services)	7	0
Concern over confidentiality of using online sources	7	1
Self-help guidance helps to improve people's self-care	6	0
Consider the need to implement proposal effectively (e.g. review effectiveness)	6	1
Consider improving communication with patients and their families and carers	6	0
Consider the need for more funding and resources to support mental health services	5	1
Consider the need for a user-friendly website	5	2
Concern over the removal of existing services (e.g. Assertive Outreach services)	5	0
Provide details on how to access mental health support available (e.g. including resources outside of the NHS)	5	3
Assertive Outreach team provided good quality of care	5	0
Unsure (e.g. don't know)	4	3
Provide information on how to maintain mental health and manage mental health problems	4	0
Consider the need for greater integration with other services (e.g. substance misuse services)	4	0
Comment about the survey	4	0
No comment	3	0
Consider improving access to mental health service for children and teenagers	3	0
Consider the need to reduce the stigma of asking for mental health support	3	0
Consider the need to raise awareness about mental health (e.g. how to recognise issues)	3	0
Crisis Cafés are good idea	2	1
Consider the need for preventive measures and early intervention	2	0
Consider provision support for families and carers of mental health patients	2	2
Proposal will help to reduce stigma of asking about mental health support	2	0
Proposal helps the NHS identify gaps in service provision	1	0
Provide information about commonly used medications (e.g. side effects)	1	0

Consider provision of support on how to access self-help guidance and navigate through it	1	5
Consider the need for support groups (e.g. peer support, social inclusion groups)	1	0
Comment about consultation	1	0
Concern that proposal will increase staff workload		1
Proposal will help to reduce pressure on mental health services		1
Further consultation about the proposal is required (e.g. with community led charities and partner organisations, GP's)		2

Q3 in the consultation document - Advice and guidance are key components of mental health support. There is a lot of information out there and we would bring this all together in a single place online. This would help people to find the information they need and receive further help. - In your opinion, what self-help and guidance would support people (e.g. you, your family or friends) in managing their own condition?

Comments	**Count survey**	**Count event**
Provide details on how to access mental health support available (e.g. support outside of LPT, waiting time)	131	4
Provide information on prevention and managing of mental health problems (e.g. coping strategy, loss and grief assistance, self-help leaflets)	126	7
Mental health patients require support of professional staff (e.g. counsellor, social prescriber, nurse)	88	0
Consider the need for support groups (e.g. peer support, social inclusion groups)	85	6
Consider the need to improve access to mental health support (e.g. reduce waiting time, out of hours, drop-in service, home visits)	73	1
Mental health patients require human interaction (e.g. face-to-face, someone to talk)	69	3
Provide information about different mental health conditions (e.g. list of symptoms)	56	8
Self-help guidance is useful only as a supplementary tool (e.g. back up of professional staff/mentor is needed, initial triage is needed)	46	1
Ensure that provided information is appropriate (e.g. up to date, evidence-based, clear, practical)	42	6
Support for carers and families of mental health patients is required	41	2
Concern over mental health patients' capacity to understand information and engage (e.g. deny illness, too ill)	41	3
Ensure that information is accessible for everyone (e.g. hard copies, video, leaflets, BSL videos)	35	14
Consider provision of online support (e.g. live chat, webinars)	31	3
Consider the need to improve quality of mental health care (e.g. talking therapy, less medicalised care, regular review)	31	1
Other	27	0
Consider provision of wellness classes (e.g. meditation, yoga, free activities, self-defence course)	24	1

Self-help guidance will support patients to access the appropriate information and services (e.g. quicker, better signposting)	21	10
Provide information about medications (e.g. side effects, order online)	20	1
Provide information about different therapies (e.g. alternative therapies)	20	1
Consider increased provision of mental health support (e.g. in the community)	19	0
Self-help guidance is not suitable for all mental health patients (e.g. complex mental health issues, crisis)	19	0
Ensure adequate staffing of mental health services (e.g. more staff, friendly staff, trained staff, staff from different communities)	18	2
Consider provision of telephone support (e.g. helpline with simple phone number)	18	1
Unsure (e.g. don't know)	17	0
Reflect the needs of vulnerable groups of patients (e.g. disabled, elderly, autism, dementia, complex needs, deaf people)	16	10
Consider the need for guidance on how to get support from services outside of mental health (e.g. social care, housing, financial)	15	0
Consider the need to reduce the stigma of asking for mental health support (e.g. advice how to ask for help)	15	1
Consider improving communication with patients and their families and carers	13	1
Ensure that guidance reflects the needs of the diverse community (e.g. different languages, culturally appropriate)	12	7
Consider that people rely on support of family and friends	12	0
Consider the need for mental health education (e.g. workshops)	11	3
No comment (N/A)	10	0
Consider the need for continuity and consistency of care	10	2
Self-help guidance is not required (e.g. already exists, not useful)	10	0
Consider provision of self-diagnosis (e.g. self-assessment form)	10	0
Consider provision of one-to-one support	10	1
Consider promotion of information about healthy lifestyles (e.g. life skills)	10	2
Consider greater involvement of GP in mental health care (e.g. first point of contact, training about mental health)	9	2
Consider the need for support of Assertive Outreach team	9	0
Consider the need to improve mental health support for children and young people	8	1
Consider the need for early intervention and prevention	6	2
Consider provision of information about care delivered by each service	5	0
Consider the need for guidance for patients and employer on how to engage with employers/employees about mental health problems	4	0
Consider the need for a user-friendly website	4	2
Utilise different channels to promote and advertise self-help guidance	4	1
Consider collaboration with other organisations in development of self-help guidance (e.g. Recovery College)	3	0
Consider the need for self-referrals	3	0
Self-help guidance may have negative impact on patients' health (e.g. escalate problems, wrong self-diagnosis)	3	1
Further consultation about the proposal is required (e.g. more clinical input, ask service users)	3	1

Comment about the survey (e.g. too broad equation)	3	0
Consider improving provision of crisis care	3	0
Self-help guidance will help to look after yourself and manage mental health problems	3	0
Mental health services should be free	2	0
More details about the proposal are required	2	1
Proposal is not good use of NHS money (e.g. investment in a team of mental health first aiders)	2	0
Consider provision of information on social prescribing	2	0
Consider the need for mental health support 24/7	2	1
Consider that each mental health patient requires different support	2	3
Central Access Point provides poor quality of care	1	1
Ensure confidentiality of service users	1	0
Consider the need for chronic pain centres	1	0
Consider training hairdressers and barbers to provide mental health services	1	0
Consider provision of support on how to access self-help guidance and navigate through it	1	1
Proposal is about saving money not improving quality of care	1	0
A mixture of home care and support outside the home is needed	1	0
Proposal will free-up resources for other needs	1	0
Let's Talk service is ineffective	1	0
Concern over lack of access and knowledge around technology	1	3
More investment in mental health services is required	1	0
Provide links to places to get out in the community	1	0
Ensure that self-help reflects the needs of LGBT+ community		1
Ensure that self-help reflects the needs of trans community		1

Level of support

There is very strong support for the proposals – 83% agree or strongly agree.

Our response to the feedback

Type of information

The self-care guidance that has been developed to date already includes a wide range of information. We will add to this following the consultation with a focus on more material that focuses on maintaining good mental health and healthy lifestyles and on common mental health related medications.

Simplicity of the information

The self-care guidance that has been developed to date will be tested with the service user advisory group. The focus has been on making the information as clear, simple and accessible as possible. The information written to date and that will be developed is in simple jargon free language. We will develop a glossary of commonly used terms. We will also commit to seek wider views of the local community to ensure it is helpful, simple and understandable.

Ease of use

One of the key roles of our service user advisory group has been in guiding and testing the ease of navigation and use of the website. We will continue to test this and seek feedback to inform improvements in the presentation of the material.

We will develop a range of guidance including videos and help sheets as pdf documents that can be printed.

We will provide support to find and understand the information via the Mental Health Central Access Point for people unable to navigate or understand the information on the website.

Access routes to the information and the need to make hard copies available

In response to the consultation, we will develop a series of standalone pdf documents that can be printed as hard copy. We will translate these help sheets into BSL and the main languages in Leicester, Leicestershire and Rutland.

We will make the key information available as a support booklet that explains to people how to access more detailed information on the self-care website or who to contact to receive hard copy information. We will make these booklets available to GP practices and in other community locations.

To help with version control and to ensure access to the most up to date information, we will share a QR code on posters and business cards in a wide range of settings including GP practices.

Places to go to access the information

In response to the consultation we will pilot the use of publicly accessible IT terminals to access the self-care guidance. A review of the usage should inform a decision as to whether to roll out this provision. All of the material is available on the internet and therefore accessible from existing public use terminals in libraries and other community locations with IT provision.

Link to the Mental Health Central Access Point and self-referral

When people accessing the self-care information require support, the Mental Health Central Access Point will help users to navigate the information and provide hard copy information, if required. The self-help guidance plans include links to the Mental Health Central Access Point, Samaritans and other support organisations. There will be the provision of a direct escalation link from the self-care guidance to the Mental Health Central Access Point. This will take the form of an online button in the self-care area to access the service via phone or text.

Introduction of a Mental Health Central Access Point

The consultation proposals

In April 2020, during the first wave of the coronavirus pandemic, a new central point for accessing mental health service in Leicester, Leicestershire and Rutland was introduced, combining two existing crisis helpline numbers. Known as the Mental Health Central Access Point, the service is available 24 hours per day, seven days per week. Anyone who is looking for urgent mental health support for themselves or other people including friends, relatives and carers can call this service.

People call a single number - 0808 800 3302. The phone line is manned by staff from Turning Point called Recovery Workers. The Recovery Worker will explore the needs of the caller then transfer them to appropriate staff from Leicester Partnership NHS Trust. This may be a triage nurse or a clinician. This could be a direct telephone transfer, or it may be a call back. People can expect to be called back within four hours for urgent care. An assessment of need would be within 24 hours. If not classed as urgent, the call back would be within four working days. These specialist staff assess needs and advise, support, signpost or refer people directly to the appropriate service. Work is under way to introduce an electronic method of seeking access to the Central Access Point.

If the caller requires an assessment, they will be referred, as appropriate, to a community mental health team, specialist Child and Adolescent Mental Health Services (CAMHS) practitioners for children and young people, or Leicester Partnership Trust's crisis and home treatment team. The team is also supported by a consultant psychiatrist.

As well as providing assessments and early interventions where needed, the service aims to help reduce the pressure on other services, particularly emergency services, by offering a local alternative to NHS111 and the emergency department.

The consultation feedback

Support

	Standard survey online	Standard survey paper	Easy read online	Easy read paper
Strongly agree	2046	96	102	12
Agree	1137	64	65	27
Neither agree nor disagree	247	21	18	1
Disagree	82	3	11	0
Strongly disagree	80	6	5	1
Not applicable	14	4	1	0

Specific comments

Q5 in the consultation document - We propose to develop the Central Access Point and introduce a call back service; introduce online instant messaging allowing a real time online conversation with trained mental health staff; incorporate accessibility features such as British Sign Language and

language interpretation facilities into these services. - Please explain why you agree or disagree with this proposal.

Comments	Count survey	Count event
Proposal improves access to appropriate mental health support (e.g. quicker, easier)	162	13
Agreement with proposal	135	43
Consider greater promotion of Central Access Point services (e.g. unaware about it)	107	8
Online instant messaging service will benefit specific groups of patients (e.g. with social anxiety, afraid to call)	82	6
Ensure appropriate staffing (e.g. staffing level, trained staff, diverse staff which speak different languages, skill mix, specialist BSL)	82	18
Consider the need for a response time threshold (e.g. immediate response for patient in crisis, threshold for call back)	51	7
Central Access Point provides poor quality of services (e.g. unsafe, not useful)	50	1
Consider poor access to Central Access Point (e.g. calls are unanswered, no call back)	50	4
Ensure support is available 24/7	39	6
Consider the need for face-to-face care	36	2
Ensure appropriate triage and navigation of patients	34	0
British Sign Language and language interpretation services will ensure equal access to services for vulnerable groups	29	3
Virtual support is not suitable for mental health patients (e.g. can't pick up all clues, physical examination is required)	27	0
More details about these services are required	26	7
Concern over lack of access and knowledge around technology	26	3
Consider improving access to mental health services (e.g. waiting time is too long, access to treatment)	25	3
Concern over lack of capacity and resources to cope with demand	24	3
Ensure effective referral process from and to CAP (e.g. too slow, allow online referral, criteria to be referred)	22	0
Consider the need for continuity and consistency of care	22	1
Mental health patients need human interaction not message machine (e.g. needs to talk to someone, help of professional staff)	22	0
Ensure appropriate communication with service users and their families (e.g. be sympathetic, listen)	19	1
Type of support should depend on patient's needs (e.g. virtual consultation is not for everyone, multi-access point is needed)	19	0
Concern that mental health patients will not use the service (e.g. staff should be proactive, hard to speak to a stranger)	19	2
Central Access Point provides good quality of care	17	1
Other	17	0
Consider the need to implement the proposal effectively	16	2

Consider improving quality of mental health care (e.g. meet patient needs)	14	2
Ensure that service is accessible for vulnerable patients (e.g. learning disabilities, hearing difficulties, ethnic minorities, deaf people)	13	12
Ensure that service reflects the needs of the diverse community (e.g. language, culturally sensitive, staff should understand minority groups)	13	3
Consider the need to improve integration between Central Access Point and other services (e.g. GP, support groups, multi-disciplinary teams)	11	1
No comment (e.g. as above, N/A)	10	0
Disagreement with proposal	8	10
Proposal is not good use of NHS money	7	0
Proposal helps to reduce pressure on other services (e.g. emergency services, carers)	5	2
Consider the need for preventive measures and early intervention	5	0
Central Access Point creates an extra obstacle in patient pathway (e.g. GP should signpost)	5	0
Consider the need for family or carers to refer mental health patients (e.g. without their consent)	5	0
Consider the need to improve mental health support for children and young people (e.g. through CAP)	5	0
Consider provision of information about support provided by this service (e.g. what is not available, criteria who can use the service)	5	0
Concern that proposal will reduce quality of care (e.g. less personal contact)	5	0
Consider increased provision of mental health services across the county (e.g. in Rutland)	4	0
Consider the impact of COVID-19 on people's mental health	4	0
Ensure confidentiality of service users (e.g. security)	4	3
Consider separate this service into a crisis and emotional support line (e.g. Different specialist phone lines for different issues)	4	1
Concern over removal of other services (e.g. psycho oncology)	4	0
Assertive Outreach team provided good quality of services	4	0
Consider the need to use recognised number for call back	3	0
Support for carers and families of mental health patients is required	3	0
Proposal will help to improve communication between healthcare professionals and service users	3	1
Consider the need for one simple telephone number to access CAP	3	3
Proposal is focused on reducing cost rather than improving quality of mental health care	2	1
Consider the need for more funding and resources to support mental health services	2	1
Mental health services should reflect the needs of different local areas	2	0
Mental health services should be free (e.g. helpline)	2	0
Consider provision of non-medical support for mental health patients (e.g. physical activities, support groups)	2	0
CAP is appropriate only for people experiencing problems for the first time	2	0
Consider the needs of patients with autism	2	0
Central Access Point works well, and no improvement is required	1	0
Ensure sufficient number of beds in crisis centres to meet demand	1	0

More helplines for mental health patients are required	1	1
Call back service should be optional (e.g. patient choice)	1	1
Concern over effectiveness of interpreter services (e.g. establishing rapport with patients)	1	2
Comment about the survey	1	0
Consider the need to raise awareness about mental health issues (e.g. starting in school, ethnic minorities)	1	1
CAP duplicates the services delivered by the voluntary sector	1	0
Introduce a texting service for people without access to Internet	1	2
Consider changing name of the service (e.g. already have Single Point of Access)	1	0
GPs should be able to refer mental health patients directly to specialist care	1	0
Proposal will help to reduce stigma of asking about mental health support	1	0
Consider the needs of people experiencing homelessness	1	0
Consider provision support and guidance for volunteers	1	0
Consider the need for CAP phoneline be aligned with the national NHS one (e.g. NHS 111)		2
Ensure that service reflects the needs of LGBT+ community		4
Consider the need to use various communication methods to interact with service users (e.g. interactive app)		5
Unsure		5
Consider the need to promote the service as a social support not medical		1
Proposal will have positive impact on health outcome (e.g. prevent problems)		1

Level of support

There is very strong support for the proposals – 88% agree or strongly agree.

Our response to the feedback

Promotion and awareness of the CAP

The existing development and implementation plans include promotion of the service. This includes QR codes, posters and a wider promotional materials for the Urgent, Emergency and Access mental health pathway. Specific feedback from the consultation will be included in a refresh of these plans.

Access routes for vulnerable groups

The existing development and implementation plans include plans to support access to the Mental Health Central Access Point from vulnerable groups. Promotion of the CAP is a key element of the wider vulnerable group pathway. LPT will work with a wider network of voluntary and community sector groups to support and advocate for vulnerable groups as part of the wider UEC pathway.

Providing support to families and carers

The CAP is available to families and carers. The CAP is a gateway service providing signposting and support to access support and services within and beyond LPT. The signposting includes support to families and carers.

A broader theme of the consultation is the development of specific support packages for families and carers. This will be developed across the mental health pathway and promoted through the CAP.

The CAP and the Urgent and Emergency Care Steering Group will be expanded to include family and carer representatives to develop and test material.

Interpreter and BSL support

The CAP service provides telephone and video interpreting support and access to BSL interpreters through an external provider. The CAP also employs staff who speak some of the main languages used by the communities in Leicester, Leicestershire and Rutland. The CAP will develop stronger links with local Voluntary and Community Sector organisations to further enhance the range of language support offered through CAP.

The development of a wider range of language and BSL support will be undertaken with other health providers in the ICS. There needs to be a consistent ICS-wide approach to support which will also bring a critical mass for immediate access to BSL and main languages, economies of scale and resilience. These developments will also link to the ICS 111 provider as the health system moves towards a 111 first approach. Our language support developments therefore need to be consistent with those in 111.

Improving responsiveness, setting and sharing performance standards

The CAP has a set of quality standards that have recently begun to be reported to the LPT Board. These standards will be reviewed in light of the consultation feedback and performance of them will be made more widely available via the LPT website. The CAP will use other digital offers to support video based calls by sending a link as a text message. We plan to make greater use of this capacity in response to the feedback.

Reviewing the demand, capacity and workforce models

The performance data and future activity modelling will support the development of a refreshed capacity and workforce plan.

LPT will complete the CAP recruitment and capacity expansion plans and model whether the increased staffing is sufficient to manage demand particularly at peak times. The modelling will include providing support to those who need it to access, navigate and understand the self-care guidance.

The service will work with a 111 partner to share learning on managing peak demand and language/BSL support. This will include consideration of caller ID to bypass repeat information gathering and recording.

The CAP will also undertake a further review of efficiency and the use of technology to reduce the administrative elements of calls.

Use of technology to improve the support offer

The review of capacity will include modelling the workforce required to introduce a call-back service, a text access route and caller ID to reduce repeat administration.

Link to self-care

The feedback from the consultation to the questions on self-care and the CAP point to the importance of linking the support from these two service enhancements - people can help themselves where appropriate (self-care) and the role of the CAP in supporting those who need more support than self-care. The UEC pathway development will continue to build the links between these two service areas.

Expand and strengthen the number of Crisis Cafés by working with voluntary and community services to develop a range of options for people

The consultation proposals

We would expand the number of Crisis Cafés available for people in Leicester, Leicestershire and Rutland, which are currently run by Turning Point. At the moment there are three Crisis Cafés, two in Leicester and one in Loughborough. We plan to create over the next four years a total of 25 additional Crisis Cafés which would provide more support closer to where people live, without the trauma of travelling. Through this consultation, we want to know where people feel would be the best location to provide this service from. This could include university locations.

We plan that the additional Crisis Cafés would involve other appropriate organisations in providing the best and most appropriate care meeting the wellbeing needs of a range of people. This means that there would be a mixture of expertise on hand, so that there is 'no wrong door' in receiving support and service users won't be bounced around a range of health and care services. In year one, there would be an additional ten crisis cafés, in year two an additional four, and in year three an additional five. Three crisis cafés would also be set up during this time at universities in the city and county. We will be approaching a range of voluntary and community sector organisations to help run them.

A Crisis Café offers a safe space for people, who identify themselves as experiencing a mental health crisis, but do not require an immediate medical assessment. The Crisis Café provides a supportive alternative for people when seeking help at times of crisis.

The Cafés are staffed by experienced Recovery and Peer Support Workers from Turning Point's local Crisis House Services. Support in the Cafés is tailored to the emotional needs of the individual and includes strengths-based problem solving. Service users are offered immediate coaching, guidance and targeted interventions. This is in addition to signposting them to a wide range of local services appropriate to their needs. This could include the possibility of on-going support through the Crisis House Outreach Service.

The Crisis Café is a calm and welcoming environment providing 1:1 sessions that can last up to 50 minutes and are arranged and discussed at the point of referral.

The consultation feedback

Q7 in the consultation document - There are currently two Crisis Cafés in Leicester and one in Loughborough. Over the next four years, we are proposing opening a further 22 Crisis Cafés across Leicester, Leicestershire and Rutland. - Please explain why you agree or disagree with this proposal.

Support

	Standard survey online	Standard survey paper	Easy read online	Easy read paper
Strongly agree	2030	90	113	13
Agree	1028	60	61	25
Neither agree nor disagree	364	22	17	3
Disagree	108	8	8	0
Strongly disagree	68	9	4	0
Not applicable	13	5	0	0

Specific coded comments

Comments	Count survey	Count event
Proposal will help patients to access the appropriate support	214	14
Crisis Cafés are not for everyone (e.g. people would not attend, not for severe mental health and patients with social anxiety)	162	5
Consider greater promotion of Crisis Cafés (e.g. signposting from GP, not heard of them)	122	13
Agreement with proposal	120	30
Proposal will allow service users to connect with others (e.g. lessen isolation)	101	4
More details about proposal are required (e.g. who can access the service)	70	18
Ensure Crisis Cafés are accessible (e.g. location, transport)	64	4
Ensure appropriate staffing (e.g. trained, sympathetic)	46	3
Consider changing the name of Crisis Cafés (e.g. negative associations of crisis)	32	13
Proposal will provide support for managing mental health conditions (e.g. prevention, management of symptoms)	30	2
Crisis Cafés provide a safe place	28	0
Proposal will ensure timely access to support (e.g. less waiting time)	25	4
More Crisis Cafés are needed (e.g. 22 is not enough)	20	5
Consider access to support out of hours	18	6
Proposal is not good use of NHS money and resources (e.g. invest in treatment)	17	0
Concern over lack of capacity and resources to implement this proposal	17	1
Ensure safeguarding measures are in place (e.g. when further care is needed)	15	0
Consider staffing with volunteers who have used the service before (e.g. peer support)	13	2
Concern about the ability of Crisis Cafés to deal with complex mental health issues	12	0
Mental health patients require help of professional staff	12	0
Disagreement with the proposal	11	3

Ensure confidentiality of users of the service	11	2
Consider the need to provide one-to-one support	11	0
Crisis Cafés will support the removal of stigma around seeking help	10	1
Concern over Crisis Cafés removing or replacing existing services	10	1
Concern about misuse of Crisis Cafés (e.g. used by people not in crisis)	9	0
Consider the needs of disabled service users (e.g. access)	9	0
No comment (e.g. N/A)	8	0
Consider the needs of diverse ethnic and religious groups (e.g. single sex cafés, multiple languages)	8	6
Consider the need to signpost to other services when required	8	1
Other	8	0
Consider the need to implement proposal effectively	6	1
Concern about length of time to implement proposal	5	0
Mental health patients require face-to-face support	5	0
Concern that Crisis Cafés will have negative impact on mental health patients (e.g. not safe care)	5	0
Consider co-location of other services with Crisis Cafés (e.g. counselling, addiction, debt)	4	1
Concern over the stigma of attending Crisis Cafés (e.g. everyone knows it's for mental health)	4	1
Crisis Cafés will provide short-term support	3	0
Crisis Cafés will reduce pressure on other health services	3	0
Consider the need for support for carers and families of mental health patients	3	1
Consider the need to provide fun activities to occupy service users (e.g. arts and crafts, massage, knitting, gardening)	3	0
Concern that proposal will lead to restricted access to other mental health services (e.g. delay treatment)	3	0
Consider improving quality of mental health care	3	0
Consider provision of online support for service users	2	0
Consider the need for security at Crisis Cafés	2	0
Consider the needs of domestic violence victims	2	0
Consider the need to provide alternative therapy services (e.g. mindfulness, EFT)	2	0
Consider utilisation of Community hubs for Crisis Cafés	2	1
Consider the need for continuity of care	1	1
Fewer Crisis Cafés are needed (e.g. 22 is too many)	1	0
Proposal will encourage social exclusion and discrimination	1	0
Concern over the need to be referred to the Crisis Cafés	1	0
Consider the need to improve access to mental health services now	1	0
Crisis Cafés should provide mental health assessment	1	0
Consider the needs of patients with personality disorders	1	0
Consider improving access to mental health services (e.g. waiting time)	1	0
Concern over lack of support for mild and moderate mental health conditions (e.g. focus on crisis)	1	0
Consider the need for prevention and early intervention	1	1

Crisis Cafés should be like a normal place to go 'out' (e.g. provide support without drawing attention)	1	0
Assertive Outreach team provided good quality of services	1	0
Ensure that Crisis Cafés are available in high-risk areas	1	1
Ensure that Crisis Cafés are available at high-risk areas	0	1

Q8

There are currently two Crisis Cafés in Leicester and one in Loughborough. Over the next four years, we are proposing opening a further 22 Crisis Cafés across Leicester, Leicestershire and Rutland. - Please tell us where you would like the new Crisis Cafés to be located?

Comments	**Count survey**	**Count event**
Ensure easy access to a Crisis Café in each local area / borough (e.g. spread out)	172	14
Central location (e.g. city centre)	134	12
Ensure provision in the county and rural areas (e.g. villages, less travel time)	104	12
Community settings (e.g. community centres, libraries, shopping centres, high streets, faith centres)	88	18
Consider accessibility to Crisis Cafés (e.g. public transport, main road)	75	5
Hinckley	51	0
Market Harborough	36	2
Coalville	32	3
Fosse Park / Blaby area / Glen Parva	30	5
Loughborough (e.g. student population at the university)	30	2
Melton Mowbray	29	1
Consider a discreet location (e.g. no stigma attached, GP surgeries, health centres)	28	2
Consider where there is the greatest need	27	2
No comment (e.g. as above, N/A)	27	0
Rutland	24	4
Oakham	23	4
Wigston	22	1
Other	20	0
Lutterworth	19	1
Oadby	17	2
Beaumont Leys	16	1
Consider providing some services near or in healthcare setting (e.g. hospitals, near GP surgeries)	15	1
Consider the need to provide parking (e.g. free parking, direct access)	14	0
Don't know (e.g. not sure)	14	0
Consider the needs of diverse ethnic and religious groups	11	4
Ashby-de-la-Zouch	11	1
Highfields	10	0

Consider areas with the greatest social deprivation	10	2
Consider a mobile service (e.g. pop-up Cafés in villages)	10	1
Other	10	1
Aylestone	9	1
More details are required	9	0
Narborough Road	9	0
Belgrave	9	1
Earl Shilton	8	0
Shepshed	8	0
Syston	8	0
Crisis Cafés are not needed	8	0
New Parks	7	0
Braunstone	7	1
South of county	6	0
Glenfield	6	0
Barwell	5	0
Uppingham	4	2
Consider the need for this service in secondary schools/colleges	4	2
Thurmaston	4	1
Burbage	4	0
Consider changing the name of Crisis Cafés (e.g. negative associations of crisis)	4	3
Consider provision of wellness hubs in communities to support people more widely (e.g. not only in crisis)	4	1
Consider providing a wellness café on wheels	4	1
Ensure service is open out of hours	4	3
Concern that people in crisis will not attend Crisis Cafés	4	1
Further promotion of Crisis Cafés is needed	3	1
Bosworth	3	0
Ensure accessibility for student populations	3	1
Enderby	2	0
Highcross shopping centre	2	0
Consider providing services close to the elderly population	2	0
Outside of city centre	2	0
More details about Crisis Cafés are required (e.g. provided services)	2	1
Consider the need for approval of local population for provision of Crisis Cafés	2	0
Disagreement with proposal about Crisis Cafés (e.g. no need)	2	0
Consider the need for informal environment (e.g. Dear Albert, Turning Point)	2	0
Southfields	1	0
Thurnby Lodge	1	0
Sileby	1	0
Hathern	1	0
Abbey Park	1	0
Consider integration of Crisis Cafés with other services	1	0

Garden centres or parks	1	0
Westcotes	1	0
Consider provision of Crisis Cafés in all towns	1	5
Concern over stigma to attend Crisis Cafés	1	1
Falcon Centre	1	0
22 Crisis Cafés is too many (e.g. 4-5 is enough)	1	0
Next to schools	1	0
Concern over people who do not have money to buy anything in such cafés	1	0
Appropriate staffing is more important than location of Crisis Cafés	1	0
Consider the need to improve quality of mental health care	1	0
Crisis Cafés are not good use of NHS money	1	0
Consider people who cannot drive (e.g. provide volunteer transport)	1	0
Proposal will allow service users to connect with others (e.g. lessen isolation)	1	0
Mental health patients need private space	1	0
Consider provision of support out of hours		1
Consider provision of Café for deaf people		2

Q9

There are currently two Crisis Cafés in Leicester and one in Loughborough. Over the next four years, we are proposing opening a further 22 Crisis Cafés across Leicester, Leicestershire and Rutland. - Please tell us what mental health support services should be provided in the new Crisis Cafés?

Comments	**Count survey**	**Count event**
Crisis Cafés should provide a safe space (e.g. a place to talk, safe place to stay, somewhere to get advice)	165	16
Service should signpost and refer to other services when required	157	15
Ensure appropriate staffing (e.g. knowledgeable, compassionate, trained, not volunteers)	157	9
Provide both talking and listening services (e.g. a person to talk to, a person to listen to me)	116	11
Consider the need to provide support in groups (e.g. social support, peer support, befriending)	107	11
Consider the need to provide specialist services (e.g. counsellors, psychiatrists, social prescribers, social care advisers)	102	4
Consider the need to provide fun activities to occupy service users (e.g. arts and crafts, massage, knitting, gardening)	88	8
Provide accessible written and digital guidance to take away (e.g. leaflets, local services, telephone numbers)	72	2
Provide one-to-one support	61	10
Consider the need to provide advice on how to manage symptoms of mental health (e.g. coping strategy)	48	0

Consider the need to provide alternative therapy services (e.g. mindfulness, EFT)	47	2
Ensure refreshment facilities are available at Crisis Cafés (e.g. free food, food bank)	44	3
Provide financial support services (e.g. benefits, debt)	41	2
Consider the need to provide different spaces for different services (e.g. areas to sit alone, meeting areas)	37	5
Provide practical support for daily life (e.g. housing)	34	1
Crisis Cafés should carry out mental health assessments (e.g. triage)	32	3
Consider the need to provide wellness classes (e.g. yoga, Pilates, healthy eating)	30	2
Other	24	0
Offer support for a wide range of mental health conditions (e.g. depression, anxiety, personality disorder)	21	4
Provide employment support (e.g. finding a job, help with CV)	20	1
No comment (e.g. N/A, as above)	18	1
Consider the need to provide IT services for service users	17	0
More details about proposal are required	13	2
Crisis Cafés should be able to provide immediate help if required (e.g. first aid)	13	3
Consider providing support for carers and families of mental health patients (e.g. drop-in sessions, information)	13	1
As many services as possible should be provided at Crisis Cafés	12	0
Provide face-to-face support	12	0
Ensure the building provides a therapeutic environment	10	0
Consider providing support for different groups separately (e.g. women-only and men-only days, different age groups)	10	1
Unsure (e.g. don't know)	9	0
Provide services that focus on personal growth (e.g. confidence building, generating interests)	8	0
Consider the needs of diverse ethnic and religious groups (e.g. multiple languages)	8	7
Disagreement with proposal	6	0
Consider the need for continuity and consistency of support (e.g. same staff)	6	0
Café is not a suitable place to provide mental health services (e.g. should be in clinical setting, no need for cafés)	6	0
Ensure service is open out of hours	5	1
Consider greater integration of Crisis Cafés with other services and organisations (e.g. council, housing, universities, refugee services)	5	0
Consider staffing with volunteers who have used the service before	5	0
Concern that people will not use the service (e.g. not private, too ill to go there)	5	0
Consider providing support for people at risk of suicide	5	1
Provide childcare services (e.g. creche)	4	1
Provide bereavement support services	4	0
Consider the needs of patients with autism	4	0
The service should provide the same support as Crisis teams	3	0
Crisis Cafés will support the removal of stigma around seeking help	3	1

Concern over removal of existing services (e.g. Assertive Outreach team)	3	0
Proposal is not good use of NHS money	3	0
Consider the need to raise awareness about mental health	3	0
Ensure service user feedback is used to improve the service	2	0
Proposal will have positive impact on family members	2	1
Consider changing the name of Crisis Cafés (e.g. negative associations of crisis)	2	3
Consider the need for greater promotion of Crisis Cafés	2	1
Consider provision of telephone support	2	2
Crisis Cafés are useful only for social support, but not in crisis	2	0
Provide services which work well in other Crisis Cafés	2	0
Concern over lack of confidentiality at Crisis Cafés	2	1
Utilise different channels to communicate with services users (e.g. text messages, email)	2	0
Ensure equality in the service (e.g. inclusivity)	1	0
Consider the needs of domestic violence victims	1	1
Consider improving access for disabled people	1	1
Consider provision of beauty services	1	0
Consider recommendations of The Independent Review of the Mental Health Act 1983	1	0
Consider improved provision of services for patients who find it hard to engage	1	0
Comment about consultation	1	0
Consider the need to reduce waiting time for mental health services	1	0
Ensure appropriate staffing level in mental health services	1	0
Each Crisis Café should cater for different mental health conditions	1	0
Consider provision of wellbeing cafés instead	1	0
Consider the needs of trauma patients	1	0
Consider provision of space for overnight stay	1	0
Consider the need to improve quality of mental health care (e.g. meet patient needs)	1	1
Provide support for single parents	1	1
Consider provision support for drug and alcohol addicted people		1
Ensure that Cafés reflect the needs of different groups of people (e.g. veterans, farmers)		1
Consider the needs of deaf people (e.g. specific time for them, BSL interpreter)		3
Consider provision of Crisis Cafés in schools		1

Level of support

There is very strong support for the proposals – 85% agree or strongly agree.

Our response to the feedback

Support

We welcome the very strong support for the proposals and will implement them as set out in the pre Consultation Business Case.

Intended outcomes

The intention is to use the Cafés to create connection and tackle isolation. The feedback from other systems that have introduced similar cafés is very positive in creating community connection and worthwhile rewarding activity.

Locations and diverse offerings

We agree that the Cafés need to be situated carefully to maximise access. We will work with local communities and voluntary and community groups to identify suitable locations. The Cafés will also vary in their approach responding to the feedback on the need to consider diversity and ethnicity. We intend to co-locate with other services and to link with wider community assets.

We will use the feedback on potential locations to influence the development of our plans. We agree that the environment needs to be welcoming and therapeutic.

Finding a different name

We will also work with local communities and service user groups to inform the names of the Cafés to identify a different term or terms for the cafés. We will promote the Cafés as they are established.

Complimenting other services

The Crisis Cafés are not intended to replace other services and we agree that they will not be right for everyone. Through the wider Step Up to Great Mental Health investment and service improvement programme, we are seeking to improve access routes to crisis services. We will provide signposting to other services. We will provide written information linked to our self-care programme.

The number of Cafés

We currently have three Crisis Cafés. We plan to introduce a further 22 but will consider more if they are successful. We note the feedback arguing for more than 22 (and the feedback arguing for fewer or none).

Investment and staffing

We believe that the investment in Crisis Cafés is a good use of funding to provide earlier intervention and support. We could spend the funds on treatment but in global terms this is a relatively low cost investment in an effective mechanism to reduce the need for treatment by providing support and reducing isolation at an earlier phase.

We agree on the need for appropriately trained staff and have set out our investment plans. We will work with service users, their families and local voluntary and community groups (VCS) to create volunteering opportunities for people with mental illness to support others through the Café network.

Activities in the Cafés

We welcome the ideas for different activities and classes. We will continue to co-design the Café's offering. The Cafés will be open to families and carers as well as service users.

We will trial the provision of different support services including group sessions. We will work with other agencies and the VCS to provide practical support for daily life including financial support services on benefits and debt, housing and employment.

As part of our self-care programme we intend to trial the provision of IT access and will test this in some of our Crisis Cafés.

An improved and expanded Crisis Service

The consultation proposals

The Crisis Service was provided by staff from Turning Point and Leicester Partnership NHS Trust and open 24 hours a day, seven days a week. Referrals were predominantly made by GPs. People had a specific number to ring and a call handler worked to understand the needs of the caller and the service user would have been triaged, assessed and if appropriate, home treatment would have been offered to the person in crisis.

During the early days of the pandemic, improvements were made to the Crisis Service, enabling people to be referred or to self-refer into the service through the Central Access Point. This provided easier access to specialists, if needed. For the most urgent cases, assessments are completed in four hours. For those with less urgent needs, the assessment is completed within 24 hours by staff from either the Community Mental Health Team or the Crisis and Home Treatment Team.

If a service user needs home treatment, a home visit would be offered. If there is a need then the improved service would have the capacity to provide a home visit up to three visits per day, providing the least intrusive and restrictive care.

The Crisis Service would also have the capacity to help more people to be discharged from an inpatient bed by ensuring that services are provided in the community and at home. This includes providing more psychological interventions.

It is also proposed that the Dementia Service and Unscheduled Care Team would be combined into the Crisis Team. They would provide crisis care to older people living in care homes and in the community, including those with dementia. Where there is an urgent need, they would help to provide coping strategies, rapid support and guidance, helping people to live where they are now.

The consultation feedback

Support

	Standard survey online	Standard survey paper	Easy read online	Easy read paper
Strongly agree	1997	83	114	13
Agree	1136	64	69	27
Neither agree nor disagree	272	25	10	1
Disagree	88	8	5	0
Strongly disagree	86	10	5	0
Not applicable	18	5	0	0

Specific coded comments

Q11 in the consultation document

The Crisis Service would enable people to seek help directly through the Central Access Point, without needing to contact their GP. It would give them easier access to a specialist, if needed. The most urgent assessments would be completed in four hours. Those with less urgent needs would be assessed within 24 hours. Home visits would be offered when appropriate. Services in community settings or at home would be provided to enable people to be discharged from an inpatient (hospital) bed. - Please explain why you agree or disagree with this proposal.

Comments	**Count survey**	**Count event**
Proposal will improve access to mental health support (e.g. easy pathway, no need for GP referral, home visits)	247	9
Agreement with proposal	98	30
Ensure appropriate staffing (e.g. more staff, proficient and trained staff)	71	5
Consider greater promotion of Central Access Point and Crisis service (e.g. unaware about it)	68	2
Crisis service and CAP provided poor quality of services (e.g. not useful, lack of continuity)	54	0
Consider improving response time (e.g. 4 hours and 24 hours are too long)	43	6
Ensure sufficient capacity and resources to cope with demand (e.g. local capacity, more hospital beds)	42	2
Concern over poor access to the Central Access Point (e.g. unanswered calls, no call back)	38	0
Consider the need for continuous and consistent mental health support (e.g. after crisis, follow-up)	37	1
Consider provision of face-to-face support/assessment (e.g. more home visits)	28	0
Crisis service will help to reduce pressure on other services (e.g. hospital, GP)	25	0
Consider improving access to mental health support before and after crisis (e.g. waiting time for therapy)	25	1
Proposal will have a positive impact on patient health outcomes (e.g. quicker recovery, save lives)	24	0
Consider the need to implement proposal effectively (e.g. be transparent)	24	1
Ensure appropriate triage and navigation of patients (e.g. proper assessment)	24	0
More details are required to comment this proposal	23	7
Crisis service and CAP provided good quality of services	20	0
Consider improving quality of mental health care (e.g. use Open Dialogue model)	19	0
Other	19	3
Concern over lack of GP involvement in mental health patient's pathway (e.g. inappropriate self-referrals, GPs know patients)	18	0
Ensure integration between Crisis service and other services (e.g. GP, schools, charities)	15	1

Consider improving communication with service users and their families (e.g. listen, discuss care after discharge)	12	0
No comment (e.g. see above, N/A)	10	0
Disagreement with proposal	10	5
Concern that proposal will lead to quick discharge from hospital (e.g. reducing hospital beds)	10	1
Consider improving access to mental health specialists (e.g. locally)	9	0
More resources and funding are required to improve the service (e.g. community services)	8	0
Concern over the removal of existing services (e.g. Assertive Outreach services, exterior day care facilities)	8	0
Proposal will help to improve quality of mental health services	8	0
Mental health services should be available 24/7	8	2
Consider provision of support for carers and families	7	0
Concern over lack of access to technology or knowledge how to use it (e.g. concern over elderly people)	7	0
Proposal is focused on reducing cost rather than improving quality of mental health care	6	0
Concern that mental health patients will not use the service (e.g. staff should be proactive)	6	2
Consider improving referral process (e.g. from CAP and Crisis service, hospital should refer)	6	0
Consider improving mental health services for children and young people (e.g. expand CAP to children's service)	5	1
Unsure (e.g. don't know)	4	2
Crisis team is not fit for purpose	4	0
Home visits will benefit vulnerable groups (e.g. disabled)	4	4
Consider raising GP awareness about mental health issues	4	0
Consider the need for family or carers to refer mental health patients without their consent	4	1
Consider the need to reconsider criteria for who are patients in crisis	4	0
Consider greater use of virtual consultations (e.g. they work well)	4	0
Assertive Outreach provided high quality of care	4	0
Concern that home visits will not work (e.g. doesn't work in crisis, could have negative impact)	4	0
Consider the need to monitor response time and phone calls	3	0
Ensure the services reflects the needs of the diverse community (e.g. language, culture)	3	4
Concern over restricted access to Crisis service for new service users (e.g. require referral from GP)	3	0
Consider the need for prevention and early intervention (e.g. regular monitoring)	3	3
Consider the need for clear guidance and definitions (e.g. urgent and non-urgent cases, services specifications)	3	0
Response time should depend on patient needs	3	0
Consider the need for further consultation about the proposal	2	3
Consider the need for simple phone number to access mental health support	2	0

Consider the need for other services to refer to CAP/Crisis service (e.g. social workers, teachers, support workers)	2	1
Proposal will lead to duplication of services (e.g. don't need this)	2	0
More mental health services are needed	2	0
Consider improving quality of care provided by crisis team before expanding its role	2	0
Consider impact of COVID on mental health	2	0
Concern that services will be run by private companies	2	0
Consider increased provision of Crisis Houses	1	0
Consider provision of services for people with dementia by Crisis service	1	0
Proposal will improve service efficiency	1	0
Consider the need for access standards for non-urgent patients	1	0
Consider the needs of patients with autism	1	0
Concern over lack of services for psycho oncology patients	1	0
Proposal will reduce quality of services (e.g. dilute specialisms)	1	0
Ensure that Crisis service is available for everyone (e.g. elderly people)	1	0
Consider the need for emergency department in mental health hospitals	1	0
Consider recommendations of The Independent Review of the Mental Health Act 1983	1	0
Use recognised telephone number for telephone appointments	1	0
Consider improving other services to tackle mental health problems (e.g. housing)	1	0
Ensure that service reflects the needs of deaf people (e.g. accessible for them)		11
Consider the need to raise awareness about mental health issues among ethnic minorities		1
Ensure that service reflects the needs of trans people		1

Level of support

There is very strong support for the proposals – 87% agree or strongly agree.

Our response to the feedback

Support

We welcome the very strong support for the proposals and will implement them as set out in the Pre-Consultation Business Case. The proposals seek to improve access to mental health support. Part of the intention of the investment is to increase the resources available and improve response times. Our plans include the ability to increase home visits up to three times per day.

Improving the existing offer

We note the praise and criticism of the existing service provided through the CAP and Crisis Teams. The investment and improvement plans are intended to improve the effectiveness of the service.

We will develop our implementation plans to recruit the staff described in the Pre-Consultation Business Case.

Promotion and awareness

As outlined under our CAP and self-care proposals, we intend to promote the range of Urgent and Emergency Care (UEC) services and build awareness of the support available across the pathway. We will continue to monitor the demand for these services and the capacity required to deliver our response time standards.

Earlier support and intervention

As part of a wider pathway, this service is intended to provide support that averts the need for more intensive intervention. By investing in the whole pathway, we intend to improve triage and navigation of service users.

Working with Primary Care

We will continue to involve GPs in the care and treatment of service users. We will promote self-referral but not at the expense or instead of GP referral. We will seek GP involvement in the UEC pathway steering group.

Improving communication

We will work with our UEC service user group to consider options to improve communication with service users and their families as part of our implementation and on-going review processes.

Providing mental health care from an emergency department setting and on acute hospital wards

The consultation proposals

An enhanced Acute Mental Health Liaison Service launched in November 2020. The service will be fully operational by April 2021. The Service combines a number of existing teams into one integrated team. Those services are Mental Health Triage Team, Frail Older Persons Advice and Liaison Service, Liaison Psychiatry and Psycho Oncology. These services worked in isolation of each other and duplicated some of the services they provide. The teams were based at a remote base in Glenfield. They are now based Leicester Royal Infirmary.

The improved service works in the emergency department and on wards providing support 24 hours a day, seven days per week to people of working age presenting with a mental health problem. It would also provide support for older adults from 9am – 5pm, seven days per week. Family and carers of service users would also be helped through the service.

The Team would provide a 1 hour response time to service users who arrive in the emergency department. There would also be 24 hour ward based support for service users already in Leicester Royal Infirmary and a 48 hour ward based service for people on wards at Glenfield Hospital and Leicester General Hospital. This would reduce the length of stay in hospital and reduce the number of people being readmitted into hospital.

Staff within the service comprise of Liaison Psychiatrists working at the crossing point or interface between physical and mental health. They would provide a specialist mental health assessment and treatment for people with a range of problems including self-harm, adjustment to illness and physical and psychological conditions. They will also provide support to people through up to 4 sessions in the community.

Clinicians at University Hospitals of Leicester and the Acute Mental Health Liaison Service would use a single electronic system (computer system). This replaces faxes to share service user information, which is very outdated and inefficient. It is expected that the time it takes to assess a service user would greatly reduce.

The service users that are currently receiving care from the Liaison Psychiatry and Psycho Oncology Teams in a community setting would be reviewed and alternative support provided if required. Individuals who would have previously been referred to the liaison psychiatry or psycho-oncology teams will be offered a wider range of support through Improving Access to Psychological Therapy Service (IAPT), community mental health services or wider provision depending on their needs. This is expected to increase the range of support for these individuals and delivered more locally.

This improvement means that we are able to deliver something called Core 24. This has been introduced nationally by NHS England and Improvement to ensure that no acute hospital is without a mental health liaison service in emergency departments and inpatient wards, available for everyone regardless of their age.

The consultation feedback

Q17

An Acute Mental Health Liaison Service launched in November 2020. We brought together existing teams, to work as one team in the emergency department and on hospital wards. They provide support 24/7 to people of working age with mental health needs. The team offers a one-hour response to patients who arrive in the emergency department and a 24-hour response to people in a ward.

Alongside making this change permanent our proposals would also see this team supporting older adults from 9am to 5pm, seven days a week. Please explain why you agree or disagree with this proposal.

Support

	Standard survey online	Standard survey paper	Easy read online	Easy read paper
Strongly agree	1997	86	117	15
Agree	1136	66	63	24
Neither agree nor disagree	272	22	12	1
Disagree	88	5	7	0
Strongly disagree	80	2	3	0
Not applicable	18	12	0	0

Specific comments

Comments	Count survey	Count event
Agreement with proposal	100	23
Concern over restricted access to the service for older adults	88	7
Acute Mental Health Liaison Service should be available 24/7 for everyone	88	7
Proposal will improve access to appropriate mental health support (e.g. shorter waiting time, easy to access)	73	0
Ensure appropriate staffing (e.g. staffing levels, skills mix, BSL skills)	38	6
Consider improving waiting time for response to patients (e.g. meet one-hour target, 24 hours is too long)	33	2
More details about proposal are required (e.g. where staff are based)	25	4
Other	21	0
Consider improving quality of mental health care (e.g. meet patient needs)	19	0
Co-location of mental health services with emergency one will improve quality of care	18	2
Consider greater promotion of Acute Mental Health Liaison Service (e.g. GP unaware)	17	2
Consider extending access to the service for other groups of patients (e.g. children, young people)	16	2

A&E is not a suitable place for mental health patients	15	0
Consider improving mental health support provided by A&E and inpatient departments (e.g. no support provided)	12	1
Concern that proposal will lead to removal of existing services (e.g. psycho oncology team, FOPAL)	12	0
Consider the need to implement the proposal effectively (e.g. be transparent)	11	1
Proposal will help improve patient's outcome (e.g. save lives)	11	0
No comment (e.g. N/A, unsure)	10	3
Consider the need for continuous and consistent mental health support (e.g. follow-up care)	9	0
Proposal disadvantages residents of the county (e.g. too centralised)	8	1
Consider the needs of vulnerable patients (e.g. dementia, mobility problems, elderly, deaf people)	8	11
Acute Mental Health Liaison Service provided poor quality of care	6	0
Acute Mental Health Liaison Service overlap with existing services (e.g. mental health urgent care hub, FOPALS)	6	0
Ensure that service is accessible (e.g. for people who cannot travel, provision at home)	6	1
Acute Mental Health Liaison provided good services	5	0
Consider greater integration between mental health services and social services (e.g. housing, benefits)	5	0
More resources and fundings are required to improve healthcare services	5	0
Consider the needs of children and young people in crisis	5	0
Further consultation about this proposal is required (e.g. take into account plans for the mental health urgent care hub, ask frontline staff, service users)	5	0
Proposal helps to reduce pressure on other services	4	0
Consider the need for preventive measure and early intervention	4	0
Mental health needs to be treated the same as physical health	4	1
Consider the need for evidence that this system is working	4	0
Consider the need for safe discharge	4	0
Consider increased provision of mental health services (e.g. crisis services, local services)	4	1
Consider improving communication with patients and their families	3	1
Consider separate area for mental health patients in A&E	3	0
The services are not needed	3	0
Concern that targets are unachievable (e.g. two hours is more realistic)	3	0
Concern that proposal will increase staff workload (e.g. lead to reduction of staff)	3	0
Comment about name of the service (e.g. too long)	2	0
Ensure appropriate triage and navigation of patients	2	0
Consider improving other mental health services first (e.g. CAMHS)	2	0
Consider the need for specialist team for older people	2	0
Consider improving communication between staff (e.g. joint working)	2	0
Consider the need for clear guidance and service specifications	2	0
Ensure that service reflects the needs of diverse communities (e.g. languages, ward is multiculturally based, appropriate food)	2	0

Ensure sufficient funding to implement proposal	2	1
Mental health urgent care hub provided good quality of care	1	0
Proposal will reduce quality of care (e.g. lost specialists' skills)	1	1
Consider involving volunteers in running this service	1	1
Patients in a ward should be seen within six hours	1	0
Consider provision support for carers and families of mental health patients	1	0
Disagreement with proposal	1	6
Proposal will help to improve communication between different teams	1	0
Mental health patients require one-to-one support	1	0
Concern that having the mental health urgent care hub and services within A&E will cause confusion for patients and carer	1	0
Leicester Royal Infirmary provided poor mental health support	1	0
Proposal will help to meet increased demand on mental health services due to pandemic	1	0
The service should be based in mental health hospital	1	0
Proposal helps to save money for NHS and patients	1	0
Concern that services will be run by private companies	1	0
Proposal will help to improve access to mental health support for people experiencing homelessness	1	0
Consider recommendations of The Independent Review of the Mental Health Act 1983	1	0
Consider the needs of patients with schizophrenia and bipolar disorder	1	0
Consider stopping onward referrals to social care	1	0
Concern over lack of specialist service to support Deaf people in Leicester		1

Level of support

There is very strong support for the proposals – 88% agree or strongly agree.

<u>Our response to the feedback</u>

Support

We welcome the very strong support for the proposals and will implement them in line with the plan set out in the Pre-Consultation Business Case.

Investment and staffing

Our investment plans of over £500,000, set out the intended increase in resources to provide adequate staffing. Recruitment to this service is on-going and some new staff are due to start with the service soon and undergo induction.

Improving waiting times

One of the key drivers of the investment and improvement plans is the goal of improving waiting times and the existing acute liaison support.

Awareness and promotion

Our implementation plans will include promotion of the improved service as part of the wider awareness building of the UEC pathway. The promotion of this service focuses on UHL staff and the awareness of all wards and departments of the service.

Working with other services

The Acute Liaison Service is an integral part of the wider UEC pathway and the linkage between services is key to improving the overall package of support. There are close links to the Mental Health Urgent Care Hub and Crisis Service.

Location and hours

The service is based in the acute hospital's settings in Leicester. It provides support in an acute hospital setting and as such, needs to be provided from the acute hospitals. The service is already available 24/7.

Mental health training for acute hospital colleagues

We will continue to provide support and development training to acute hospital colleagues including to A&E staff in mental health awareness. We are working with UHL to develop a training programme for acute hospital staff on mental health.

Mental Health Urgent Care Hub

The consultation proposals

Also, during the Covid-19 pandemic, our local health system was the first in England to introduce a Mental Health Urgent Care Hub. We now wish to consult on making this permanent.

The Urgent Care Hub is located at the Bradgate Unit on the site of Glenfield Hospital and is run by Leicestershire Partnership NHS Trust.

People are referred to the Urgent Care Hub by the emergency services including 999, NHS 111, the ambulance service and police. They may also be referred if they have gone to the emergency department. Staff from Leicester Partnership NHS Trust and the Central Access Point can also refer people into the Hub.

The Mental Health Urgent Care Hub is staffed by mental health practitioners who are trained and have the expertise to treat people of all ages – children, young people and adults. It is staffed by Team Leaders, qualified nurses, support workers and administrative support. There is also consultant input.

When people are referred to the Urgent Care Hub, they would be assessed within two hours to understand their needs. If required, immediate treatment would be given along with support and guidance. Service users will also be observed and if needed a crisis plan will be put in place to help manage their condition. People are not expected to need to stay in the Urgent Care Hub for more than 24 hours. There are no inpatient beds for overnight stays.

If their assessment requires them to have inpatient support, then the service user would be transferred with compassion and respect to an appropriate ward. Alternatively, support in the community might be more appropriate, which will be set up.

The Bradgate Unit was selected during the Covid-19 pandemic as a suitable location for this service for a number of reasons:

- It was possible to develop the service quickly on this site as it was adjacent to other mental health services and staff.
- The building is already open 24 hours a day, seven days per week.
- There is access to mental health clinicians on the site 24 hours a day, seven days per week.
- If the service user is distressed, then staff from the Place of Safety Assessment Unit can be quickly called up given they are close by, to manage the service user. In addition, the Management of Actual or Potential Aggression Team can be easily called upon for support.
- It is located away from the emergency department at Leicester Royal Infirmary and therefore won't overwhelm the site with more services.
- There is free car parking on site and comfortable waiting areas and refreshments for friends and family.

Staff working in the hub would also provide specialist and expert advice to other professionals if needed.

In 2020/21, we plan to invest to ensure the long-term future of the Mental Health Urgent Care Hub. We would hope that over time, the service would reduce the number of people attending the emergency department.

The consultation feedback

Q15 in the consultation document

During the COVID-19 pandemic, we introduced a mental health urgent care hub. The hub is at the Bradgate Unit, on the Glenfield Hospital site. People are referred to the hub by the emergency services, social care or health professionals. It is staffed by mental health practitioners who have the expertise to treat people of all ages; this includes mental health nurses, support workers, and consultants. Those referred would be assessed within two hours to understand their needs. If required, immediate treatment would be given along with support and guidance. - Please explain why you agree or disagree with this proposal.

Support

	Standard survey online	Standard survey paper	Easy read online	Easy read paper
Strongly agree	2242	93	102	15
Agree	1035	65	73	25
Neither agree nor disagree	222	22	15	0
Disagree	48	5	10	0
Strongly disagree	49	2	2	0
Not applicable	14	12	1	0

Specific comments

Comments	Count	Events
Proposal will improve access to appropriate mental health support (e.g. less waiting time, easy to access)	106	8
Agreement with proposal	96	31
Consider increased provision of mental health urgent care across the county (e.g. rural area, Rutland, community care)	50	1
Consider greater promotion of mental health urgent care hub (e.g. don't know about it)	48	6
Concern over access to Glenfield Hospital (e.g. poor public transport, too far)	47	3
Ensure appropriate staffing (e.g. more staff, trained staff, BSL skills)	35	9
Bradgate Unit provided poor quality of services (e.g. unhelpful)	34	0
Consider the need to improve referral process (e.g. self or carer referrals, walk-in centre, drop in service, criteria for referrals)	33	2
Proposal will reduce pressure on other services (e.g. emergency services, hospitals)	26	1

Mental health urgent care hub provided good quality of services (e.g. good team)	22	0
Proposal will improve quality of mental health care (e.g. safer)	21	0
More details about the proposal are required	18	5
Other	18	2
Consider improving quality of mental health care (e.g. meet patient needs)	17	1
No comment (e.g. as above)	16	0
Proposal will improve patient health outcome (e.g. save lives)	16	0
Proposal will improve patients' experience	16	0
Bradgate Mental Health Unit is not fit for purpose (e.g. has bad reputation, claustrophobic, should be shut down, patients will not go)	15	0
Consider improving integration between mental health urgent care hub and other services (e.g. hospitals, housing, police, social care)	14	0
Consider the need to implement proposal effectively	14	1
Consider the need to improve access to mental health support and treatment (e.g. waiting time)	14	0
Consider the need for continuous and consistent mental health support (e.g. follow-up care)	13	0
Concern over lack of capacity and resources to meet demand (e.g. lack of beds)	12	1
Consider the need to meet two-hour target (e.g. does not meet it currently)	11	0
Ensure appropriate triage and navigation of patients to this service	10	0
Consider improving communication with service users and their families (e.g. listen)	8	0
Consider improving facilities for patients at Bradgate Unit (e.g. patient-friendly, accommodation to stay, waiting area)	8	1
Consider the need for provision of specialists care at this hub (e.g. psychiatry service)	8	0
Mental health urgent care hub duplicates existing services (e.g. Crisis service)	7	0
Consider the need for external review of the service (e.g. its efficiency, clinical outcome)	7	0
Concern over accessibility of this service for patients who cannot travel (e.g. offer home visits)	7	0
Service should be available 24/7	6	0
Consider the needs of vulnerable people (e.g. people with special educational needs, dementia, deaf people)	6	11
Consider the need to reduce the stigma of asking for mental health support (e.g. shame to come to a mental hospital)	6	0
Consider the need for preventive measures and early intervention	5	0
Concern that proposal will lead to the removal of existing services (e.g. Assertive Outreach services)	5	2
Consider other location for mental health urgent care hub (e.g. Arnold Lodge, more central location)	5	0
Consider the need to improve parking at Glenfield Hospital (e.g. parking fees)	4	0
Disagreement with proposal (e.g. unachievable)	4	8

Consider co-location of mental health urgent care hub with other services (e.g. emergency department, substance misuse team, inpatient)	4	0
Mental health urgent care hub should be available at all hospitals	4	0
Ensure that hub reflects the needs of patients of all age groups	4	0
Concern over poor signposting of the unit	3	0
More resources and funding are required to improve mental health services	3	0
Consider the need for clear guidance and service specification	3	0
Consider changing the image of the Bradgate Unit	3	0
Ensure safe discharge	3	0
Concern over provision of services for children in the hub (e.g. should be separate from adult)	2	1
Consider the impact of COVID-19 on mental health	2	1
Consider the need for family or carers to refer mental health patients without their consent	2	0
Quality of care is more important than meeting targets	2	0
Consider the need for a response time threshold (e.g. schedule for call back)	1	0
Proposal will support the removal of stigma around seeking mental health support	1	0
Ensure that the hub reflects the needs of the diverse community	1	0
Ensure appropriate use of this service	1	0
Assertive Outreach team provided good services	1	0
Consider provision of training in mental health for all urgent care staff	1	0
Comment about the survey	1	0
Consider provision support for carers of mental health patients	1	1
Concern that mental health urgent care hub will inappropriately prevent patients being admitted to hospital	1	0
Proposal will save the NHS money	1	0
Comment about the consultation (e.g. not clear)	1	0
Consider greater use of technology (e.g. video chat)	1	0
Concern that having the hub and services within A&E will cause confusion for patients and carers	1	0
Consider recommendations of The Independent Review of the Mental Health Act 1983	1	0
The service is not fast (e.g. remove word ‘urgent’)		1
Ensure confidentiality of services users		1
Ensure that service reflets the needs of LGBT+ community		1
Ensure that service reflets the needs of trans people		1
Neither agree nor disagree		1

Level of support

There is very strong support for the proposals – 91% agree or strongly agree.

Our response to the feedback

Support

We welcome the very strong support for the proposals and will implement them as set out in the Pre-Consultation Business Case. We recognise the contribution that the Mental Health Urgent Care Hub has in improving service user experience and outcomes.

Promotion and awareness

As part of our implementation plans, we will focus on wider promotion to other health care professionals of the Mental Health Urgent Care Hub.

Location

We do not have the funding or staff resources to offer multiple Mental Health Urgent Care Hubs throughout Leicester, Leicestershire and Rutland. However, we are developing the wider Urgent and Emergency Care pathway to offer a range of responsive services across LLR. The Mental Health Urgent Care Hub is open to all residents of Leicester, Leicestershire and Rutland.

Having the Mental Health Urgent Care Hub on the Glenfield Hospital site allows us to take advantage of the good transport links and parking facilities at the site. Having the Mental Health Urgent Care Hub in the Bradgate Unit means we have the advantages of co-location with other mental health support services.

In response to the feedback on the environment of the Bradgate Unit, we will undertake an options appraisal to assess whether this remains the best site for the Mental Health Urgent Care Hub. We will undertake this options appraisal using structured criteria developed with service users. If the Bradgate Unit is confirmed as the best long-term location for the Mental Health Urgent Care Hub, then we will develop proposals to enhance the therapeutic nature of the environment.

Tone and welcome

As part of our implementation plans, we will include staff training in customer care to strengthen the nature of the welcome.

Linking with other services

Our plans to develop a network of Crisis Cafés and to promote self-referral through the Central Access Point will address the feedback on support for people to self-refer or walk up. The Central Access Point can signpost to a wider range of appropriate support services including the Urgent Care Hub.

Expand the hours that the Triage car is provided

The consultation proposals

The police have to manage situations where mental health is a significant factor in incidents they attend. Police need specialist support to help deal with these incidents. A triage car has been in place for some time. It is staffed jointly by police and mental health practitioners. The service takes calls from police incidents and provides advice to manage the situation. Staff also go out to the site of the incident and support people with their immediate mental health crisis.

The service has previously operated from 10pm-2am. New extended hours were introduced in March 2020 moving the service to run 8am-2am. We propose to add an additional triage car, which is being piloted at the moment. While the first car is based at Keyham Lane police station in Leicester, the second triage car would be out and about more in the community, able to improve the service and response times. The service would also be expanded to provide support for ambulance crews.

In addition, rather than calls being managed by staff operating the triage car, they would be managed through the Central Access Point. This will free up the time that the crew operating the triage car would spend providing support to individuals.

The consultation feedback

Q13 in the consultation document

In March 2020, we extended the hours of the Triage Car Service to run from 8am to 2am. We are also proposing:

- Adding a second triage car, which would be based in the community, enabling us to improve the service and response times
- Broadening access to the service to include ambulance crews
- Managing the calls through the Central Access Point to allow the service to focus on providing support to those in need - Please explain why you agree or disagree with this proposal.

Support

	Standard survey online	Standard survey paper	Easy read online	Easy read paper
Strongly agree	2324	96	119	13
Agree	1016	60	62	23
Neither agree nor disagree	187	20	15	3
Disagree	39	5	5	0
Strongly disagree	34	1	1	0
Not applicable	14	14	1	0

Specific coded comments

Comments	Count survey	Count survey
Agreement with proposal	115	29
Proposal will improve access to mental health support (e.g. easier, quicker)	97	6
Service should be available 24/7	87	6
Consider increased provision of Triage car service across the county (e.g. more Triage cars)	60	11
Proposal will improve quality of care of patients in crisis (e.g. provides correct support)	60	5
Police are not suitable to deal with mental health patients (e.g. lack of training, could frighten potential users)	58	2
Triage car service helps to reduce pressure on other services (e.g. emergency services, police, hospitals)	42	4
Ensure appropriate staffing (e.g. more staff, trained staff, representative of communities they work in)	31	6
Ensure effective collaboration between Triage car Service and other services (e.g. police, ambulance, fire services, social care)	25	0
Proposal will have a positive impact on health outcome for patients (e.g. save lives)	24	2
More details about the proposal are required (e.g. what is a Triage car)	18	4
Data analysis is required to identify if service should be extended	16	0
Triage car provided good quality of care	15	1
Other	13	0
Concern over managing the calls through the Central Access Point (e.g. separate line is needed, use 999 or NHS 111, police should have direct access to support)	12	0
Ensure sufficient capacity and resources to meet demand	11	0
Consider provision of training for public emergency services on mental health (e.g. paramedics)	11	3
No comment (e.g. N/A)	9	0
Consider greater promotion of Triage car service (e.g. don't know about it)	9	3
Consider the need for continuous and consistent mental health support (e.g. followed-up referrals)	8	0
Ensure appropriate response time from Triage car team (e.g. current waiting time is too long)	6	0
Provide training for police officers to identify different mental health conditions and deal with them instead of extending the Triage car service	6	0
Ensure appropriate triage and navigation of service users	6	0
Ensure that service reflects the needs of vulnerable patients (e.g. autism, learning disabilities)	5	11
Consider improving quality of mental health care	5	3
Disagreement with proposal	4	6
Proposal will help to improve safety in community (e.g. reduce crime)	4	0
Ensure that service reflects the needs of diverse communities (e.g. culturally sensitive, bad relations between the police and BAME communities)	4	0

Consider improving communication with carers and families of the person in crisis (e.g. listen)	3	0
Mental health services require improvement	3	0
Ensure safety of staff	3	0
Expanding the service is not good use of resources (e.g. spend the money on hiring more psychiatrists)	3	1
More investment in mental health services is required (e.g. invest in secondary and tertiary care)	3	1
Concern over lack of prevention and early intervention	3	0
Consider increased demand on mental health services due to COVID-19	2	0
Mental health crisis emergency service is as important as a physical crisis emergency service	2	0
Comment about consultation	2	0
Proposal will help to create trust between the community and the police	2	0
Consider the need for clinical psychiatrist in Triage car	2	0
Consider the need for provision of face-to-face support	2	0
Triage car provided poor quality of care	1	0
Assertive Outreach team provided good services	1	0
Concern that proposal will increase pressure on ambulance	1	0
Consider extending volunteer transport services	1	0
Consider provision of a Triage car for children	1	0
Concern that proposal is about saving money not improving quality of care	1	0
Consider provision of information on how to access the service	1	0
Consider broadening access to the service to include firefighters	1	0
The service is not accessible currently	1	0
Consider the need to raise awareness of mental health issues to public	1	0
Non-uniform police officers would be better in some instances	1	0
Consider the need for CAP to refer patients directly	1	0
Consider recommendations of The Independent Review of the Mental Health Act 1983	1	0
Concern that proposal will lead to using Serenity Integrated Mentoring approach	1	0
Consider the need to use Triage car appropriately	1	0
Ensure that the services reflect the needs of LGBT+ community		1
Ensure confidentiality of service users (e.g. privacy)		1
Neither agreed nor disagreed		4
Consider provision of Crisis Cafes at police stations		1

Level of support

There is very strong support for the proposals – 92% agree or strongly agree.

Our response to the feedback

Support

We welcome the very strong support for the proposals and will implement them as set out in the Pre-Consultation Business Case.

Coverage and hours

The intention is to expand the provision of supported triage to work with East Midlands Ambulance Service as well as the police. We will also increase the hours that the service is available. We will continue to monitor the use of the service and potential demand to see whether there should be further investment and expansion towards or to 24/7 provision.

Linking with other services

Our implementation plans will address the comments raised about appropriate staffing, links to other services and building awareness.

The service will be run and be supported through the Mental Health Central Access Point and Mental Health Urgent Care Hub to ensure that expert mental health support is available. The service can be triggered via 999 and 111 but our strong preference is for a model that links to the wider UEC pathway and provides access to expert mental health support.

Mental health training for police and ambulance colleagues

We will develop mental health awareness training alongside the police and ambulance services. We now provide training for police officers on managing mental health presentations. EMAS have a proposal to train paramedics and technicians in mental health as well training being provided to the police (Mental Health First Aider Training being rolled out for some officers).

Intensive Support to Vulnerable Groups

The consultation proposals

Leicestershire Partnership NHS Trust has three different teams working with vulnerable groups. These teams are called:

- The Homeless Service, which works in Leicester City
- Proactive Vulnerability Engagement Team that works with the police to support people who frequently present to the service
- Liaison and Diversion Service that works with the Criminal Justice System

Across these three services there is duplication and triplication of services.

We propose that these services would work together to provide a dedicated service to people who are vulnerable. This would mean that care would be provided more efficiently and effectively, and the service would be able to see more people. There will still be these three separate teams in the future, but they will work a lot more closely. People accessing these services will benefit from this closer partnership working as they will find the support offered is more streamlined and they will not keep having to repeat their story so much.

The consultation feedback

Q19 Leicestershire Partnership NHS Trust has three different teams working with vulnerable groups:

- The Homeless Service, which works in Leicester City
- Proactive Vulnerability Engagement Team, which works with the police to support people who frequently present to the service
- Liaison and Diversion Service, which works with the criminal justice system

We propose bringing these teams together into one dedicated service to help more vulnerable people access the care they need. - Please explain why you agree or disagree with this proposal.

Support

	Standard survey online	Standard survey paper	Easy read online	Easy read paper
Strongly agree	1,550	76	88	10
Agree	1,040	45	67	28
Neither agree nor disagree	636	40	27	0
Disagree	232	7	13	2
Strongly disagree	100	10	7	0
Not applicable	31	10	1	0

Specific comments

Comments	Count survey	Count event
Proposal will reduce quality of services (e.g. dilute specialisms, increase bureaucracy, service users have different needs)	162	11
Agreement with proposal	90	19
Proposal improves access to support for vulnerable groups (e.g. easier pathway)	66	4
Concern over staff reduction due to merger of the services (e.g. increase staff workload)	64	4
Concern over merging services for vulnerable people with criminal justice service (e.g. homeless people are not criminals)	60	0
More details are required to comment on this question	49	4
Concern that proposal is a cost-cutting exercise	42	0
Unsure (e.g. don't know)	38	4
Proposal will improve service efficiency (e.g. less duplication)	29	3
Consider expanding provision of services for vulnerable across the county (e.g. Rutland, Loughborough)	28	3
Ensure effective collaboration of these teams	26	0
Ensure appropriate staffing (e.g. trained staff, staffing levels)	26	2
Proposal will improve quality of services for vulnerable groups (e.g. coherent service)	23	4
Consider greater integration between support for vulnerable groups and other services (e.g. housing, social care, substance misuse, ambulance)	19	1
Proposal will increase stigma of asking about support	19	0
Other	15	3
Consider the need to implement proposal effectively	11	0
Consider the need for continuous and consistent support for vulnerable groups (e.g. monitor former homeless people, probation service users)	11	0
Ensure sufficient capacity and resources to implement proposal	11	0
Concern that merged service will exclude some service users (e.g. asylum seekers and migrants)	11	1
Consider increased funding for each team instead of merging them	8	0
Consider the needs of other vulnerable groups (e.g. military veterans, people with gambling problems, victims of domestic abuse)	8	0
Consider improving other mental health services (e.g. PTSD, autism)	7	0
Disagreement with proposal	6	10
Concern that proposal will lead to removal of existing services	5	1
Consider the need for prevention and early intervention	5	0
Consider the needs of service users with learning disabilities and autism	4	0
Proposal is not good use of NHS money	4	1
Consider the need for substance misuse workers within the staffing group	3	0
Consider the needs of people with complex mental health needs	3	0
Consider provision of services for children and young people who leave home	2	0
Service should be easy to access for people experiencing homelessness	2	0
Consider improving mental health services for children and young people	2	0

Other service for vulnerable groups should be part of this joint service (e.g. children and young people, migrants)	2	0
Proposal will help to prevent crime	2	0
These teams work well separately	2	1
Concern that proposal will reduce access to support (e.g. increase waiting time, create confusion)	2	0
The service should be available 24/7	1	0
Consider provision of one-to-one support	1	0
Comment about the survey	1	0
The homeless service in Leicester works well and no improvements are required	1	0
Ensure that service reflects the needs of BAME communities	1	0
Ensure that service reflects the needs of LGBTQ community	1	0
Consider the wider publicity of this service	1	0
Homeless service should be moved into primary care	1	0
Ensure appropriate use of this service	1	0
Ensure appropriate communication with service users	1	0
Assertive Outreach services provided good quality of care	1	0
Ensure confidentiality of service users (e.g. safe space)	1	0
Consider recommendations of The Independent Review of the Mental Health Act 1983	1	0
People experiencing homelessness need permanent homes not these services	1	0
Ensure that service reflects the needs of deaf people		6

Level of support

There is strong support for the proposals – 72% agree or strongly agree. 9% disagree or strongly disagree.

Our response to the feedback

Support

We welcome the strong support for the proposals. The investment and improvements aim to improve support and access, delivering services in a more coordinated and integrated way.

Investment in staffing

We will retain the specialist roles within the integrated team. We have no plans to reduce staffing or to cut costs. Rather our proposals are to invest an additional £465,000 in these services which will increase staffing by 10.3 whole time equivalents. Our implementation plans will focus on effective collaboration between the teams coming together.

Supporting more people

The investment and integration of these teams should allow us to support a greater number of vulnerable people and address issues of people falling between the gaps with separate teams. We have no plans to exclude any vulnerable groups from accessing support.

Integrated community mental health service

The consultation proposals

Nationally there is a community framework that sets out a range of services that should be locally available to people. We believe that by implementing the services outlined in the framework across Leicester, Leicestershire and Rutland it will help to solve some of the long-term problems we have locally. It will also contribute to us meeting the guidelines for service set out by National Institute for Health and Care Excellence (NICE).

Through the proposed changes, we would reduce the excessive number of handovers between people and services, which sometimes creates added journey times for service users. We would also reduce lengthy waits into services. We would create mental health services located in local communities making them simpler to access and navigate with a strong emphasis on psychological care and treatment.

The proposed changes include:

1. Creation of eight Community Treatment and Recovery Teams focused on supporting adults and eight Community Treatment and Recovery Teams focused on older people, providing support for:
2. Improving waits to the Personality Disorder Service
3. Improving services for people of work age and older people
4. Expanding perinatal services
5. Developing a new Maternal Outreach Service
6. Streamline referrals from the Psychosis Intervention and Early Recovery Team into other services
7. Improve the Memory Service
8. Provide community rehabilitation support to help people recovery from complex psychosis

Creation of eight Community Treatment and Recovery Teams

Currently we have a number of teams working separately. There is duplications and triplication of work, overlaps and long waits due to people being excessively passed between the current teams. The teams do not work in specific geographic communities. They predominantly provide services at Leicester General Hospital.

The current teams comprise of an Assertive Outreach Support Service, Community Mental Health Teams/Outpatients and a Psychological Therapy Team including Cognitive Behavioural Therapy Service and Therapy Services for People with Personality Disorder. Also, Clinical Psychology, Employment Support Service; a Psychosis Intervention and Early Recovery Team, Perinatal Support and Community Rehabilitation.

We would integrate these teams into a Community Treatment and Recovery Team working in eight community areas. This will create a multi-disciplinary team which is a group of professionals from different areas of clinical care. They would work together to make decisions regarding the recommended treatment of individual service users and work with the service user and their family or carer to put support in place. By having this diversity of expertise, the care planning will be more thoughtful and based on a number of perspectives including the service user's. This proposed change will also provide more choice of the interventions that will benefit the recovery of service users.

The Community Treatment and Recovery Team would be geographically based teams working mainly in defined communities. They would be supported by other mental health teams within Leicestershire Partnership NHS Trust depending on the specific skills and specialist care needed.

The Community Treatment and Recovery Team would work closely with Primary Care Networks. These are groups of GP practices working together, along with other healthcare staff and organisations.

We have 25 Primary Care Networks in Leicester, Leicestershire and Rutland working with service users in specific geographic areas. This closer working will widen the expertise involved in the treatment and care of the service user.

Each of the eight Community Treatment and Recovery Teams would work with approximately three to four Primary Care Networks. Each Community Treatment and Recovery Team will offer a service seven days per week within working hours. A flexible approach will be taken to weekend cover, once need is assessed. They would offer support to service users as outpatients. They would be based in eight communities. These communities will be based broadly on district council boundaries in Leicestershire, the City Council and Rutland County Council boundary. [insert map] Their location would be in GP practices or other local buildings. They would also provide the service in the homes of services users or the place they call home. Referrals to the service would be through the Central Access Point.

In addition, where required, the Community Treatment and Recovery Team would provide more people with improved access to a range of psychological therapy services for people who are at risk or have complex needs and those with medium support needs. For example, those who are living with substance misuse needs or co-existing learning disabilities alongside mental health needs. This includes Cognitive Behavioural Therapy and Psychodynamic Treatment Service users who require these services currently have to wait a long time to access support and treatment. They currently receive the support by attending the service at the Leicester General Hospital site.

As with other services, service users will be referred through the Central Access Point. Their therapist will work as part of the multi-disciplinary team to ensure that care is built around the needs of the service user.

People who have lower-level needs will be offered support through Improving Access to Psychological Therapy Service (IAPT).

We will also recruit Recovery Workers (also known as Community Connectors). Recovery Workers would be roles largely provided by the voluntary sector or community providers. They would be able to work with the mental health service teams to connect individuals to local support services and groups in the community. They would work with service users to work out what support is out there and what would be the best fit for them.

An additional 75 Peer Support Workers, who have lived experiences of mental health conditions and the services available to support people, will also be employed and fully trained to support people with recovery.

Mental Health Services for working age and older people

Currently the community service provided for older people in Leicester, Leicestershire and Rutland is provided by six multi-disciplinary teams. They provide support for service users for older people with a functional illness. This means illnesses such as severe mental illnesses such as schizophrenia and bipolar mood disorder. They also provide support for adults of all ages with dementia.

The service is provided Monday to Friday between 9.00am and 5.00pm. The team currently manages people coming into the service and when being discharged from the system. If people are on a waiting list and their need becomes urgent, they are supported by the Unscheduled Care Team that can provide short input responsively.

The Unscheduled Care Team provide short urgent support for older people with depression, anxiety, psychosis and other similar conditions as well as organic mental health conditions such as dementia. This function will join with the expanding Crisis Team (see Crisis Team section), as part of the new Urgent and Emergency Care pathway. The urgent support currently provided for people with dementia will also join the new crisis pathway. This is currently provided by an In-reach Team that focuses on supporting people in care homes, to help them manage their dementia and stay in their current place of residence. Both of these services take referrals from a variety of sources including GPs. They don't have a set timeframe to respond, but usually respond in between one and three days.

It is proposed that the older people focused community mental health teams will increase from six to eight Community Treatment and Recovery Teams focusing specifically on older people. These will align with the geography to the eight Community Treatment and Recovery Teams focused on adults.

They will continue to support service users and their carers into and out of services for both functional (psychiatric illness other than an organic disorder) and organic (disturbances that may be caused by injury or disease affecting the brain tissue as well as chemical or hormonal abnormalities) illnesses. There will be increased support offered through the local teams that can be 'stepped up' for individuals who have escalating needs. This will help maintain continuity of experience for service users whilst being more responsive to their changing needs. This will be offered over

extended hours seven days a week. This consultation asks people to tell us about their preferences on working hours of the more routine services and their needs when accessing this service.

The alignment of the Community Treatment and Recovery Teams for adults and the teams for older adults would ensure service offers are needs focus and accessible for adults of all ages. This will also ensure that there is targeted support for individuals with needs associated with older people. Service users will be seen at the right time, in the right place and by the right clinician depending on their need, avoiding being taken into the emergency department and being admitted into hospital.

The consultation feedback

Q21A - Create eight teams each based in a local area to support adult mental health needs. They would work alongside eight teams focused on the needs of older people. Please explain why you agree or disagree with this proposal.

Support

	Standard survey online	Standard survey paper	Easy read online	Easy read paper
Strongly agree	1,987	75	114	14
Agree	1,197	61	60	24
Neither agree nor disagree	253	31	14	2
Disagree	49	4	3	0
Strongly disagree	44	8	6	0
Not applicable	16	8	1	0

Specific comments

Comment	Count survey	Count event
Agreement with proposal	71	28
Proposal improves access to mental health support locally	56	2
Concern over the removal of existing services (e.g. Assertive Outreach services, MH Integrated Team)	44	0
More details about proposal are required (e.g. capacity, type of support)	43	3
Ensure appropriate staffing (e.g. staffing levels, trained staff)	37	8
Ensure effective collaboration of these teams	35	1
Consider the need for continuous and consistent mental health support (e.g. ongoing support)	35	3
Proposal will have a negative impact on patients of Assertive Outreach services (e.g. psychotic illness)	22	0
Ensure the teams reflect the needs of vulnerable patients (e.g. elderly people)	21	0
Proposal will improve quality of care for old people	18	0
Consider improving waiting times for mental health support	16	0
Proposal will improve service efficiency	15	0
Ensure equal access to these teams (e.g. no postcode lottery)	14	0

Proposal will have a negative impact on quality of care (e.g. inconsistency, lose specialisms)	13	0
Consider extending working hours of these teams (e.g. out of hours, 24/7)	12	0
Concern over lack of capacity to support these teams (e.g. long-term funding)	11	0
Proposal helps to improve patient outcomes (e.g. save lives)	11	0
Eight teams are too many	10	0
Other	10	0
Consider improving quality of mental health care (e.g. meet patient needs, holistic approach)	9	0
Ensure that teams reflect the needs of patients with specific health conditions (e.g. eating disorders, complex physical health problems)	9	0
Consider improving mental health services for children and young people	9	0
Ensure there is sufficient funding and resources to make these changes	9	0
Consider the need to improve integration between these teams and other services (e.g. GP)	8	0
Ensure that local teams reflect the needs of the diverse community	7	0
Consider the need to reduce the stigma of asking for mental health support	6	0
Consider improving communication with service users	6	1
Proposal reduces waiting time for mental health support	6	1
More than eight teams are required (e.g. in rural area)	6	1
Consider the need to implement proposal effectively	5	1
No comment (e.g. as above, N/A)	5	1
Consider the impact of COVID-19 on mental health	4	0
Further consultation about the proposal is required (e.g. staff opinion)	3	0
Consider the need for preventive measures and early intervention	3	0
Unsure (e.g. don't know)	3	1
Concern over ineffective referral process provided by Central Access Point (e.g. too slow, allow online referral)	3	0
Proposal helps to reduce pressure on other services (e.g. hospitals)	2	1
Disagreement with the proposal	2	3
Consider provision of services for war veterans	2	0
Proposal is not good use of NHS money (e.g. increase cost)	2	0
Consider the need for more support workers	2	0
Ensure that staff are spread across eight teams according to demand of areas	2	0
Consider provision of mental health services in Leicester General Hospital	1	0
Proposal will save patients money (e.g. travel cost)	1	0
Proposal is about saving money, not improving quality of mental health care	1	0
Comment about survey	1	0
Consider recommendations of The Independent Review of the Mental Health Act 1983	1	0
Ensure adequate space and facilities for staff	1	0
Consider the need for a mother and baby unit in Leicester	1	0
More support is needed for severe depression and chronic anxiety	1	0
Consider provision of support for carers and family of mental health patients	1	0
Consider provision of drugs and alcohol services by these teams	1	0

Level of support

There is very strong support for the proposals – 89% agree or strongly agree.

Our response to the feedback

Support

The service model that was proposed in the pre-consultation business case was very strongly supported (89% of responses agreed or strongly agreed with the proposals).

Investment in our workforce

The workforce and finance plans set out in the Pre-Consultation Business Case address some of the concerns from the consultation about further information or certainty on financial investment in these teams and staffing levels.

Hours of operation

The teams will not operate 24 hours a day, seven days a week. However, the broad plan set out in the pre-consultation business case is to move to a longer 8am to 8pm day, seven days per week. We will undertake dedicated engagement in each locality to agree the working hours that best meet the need of the local population. Outside of these times, urgent and emergency support is available through the Urgent Care Hub.

Managing the transition

The implementation plans will have a focus on existing service users and managing their care during a period of transition. These will be linked to specific quality and safety triggers to be applied during the implementation phase. We will develop an implementation risk register that will focus our planning and the timing of implementation to mitigate the potential negative impact on existing service users.

We are not removing services through these changes. We are changing the way in which the services are arranged to make them more responsive to local need and to join them up in line with the national Community Mental Health Framework.

Improving flow and reducing waiting times

One of the goals of introducing the model is to improve support, flow and reduce waiting times. We will measure and publish our progress on improving waiting times. Our measures of success will be developed to include more outcome-based measures. We will also report against national standards and targets.

Personality Disorder Service

The consultation proposals

Some of the longest waits are experienced by service users who require care through the Personality Disorder Service for both assessing their needs and receiving treatment. Currently services are provided at Francis Dixon Lodge, on the site of Leicester General Hospital. The service is quite narrow in scope and does not provide care for those at highest risk. There are over a 1,000 people on the waiting list in the community and in outpatients requiring treatment and support. The current service can only manage approximately 200 people at any one time due to the intensity of the care provided, which can last 2 – 3 years. Only half the people referred actually attend their appointment. The long waits result in insufficient numbers receiving the therapeutic care they need. People often have to seek urgent and emergency care through the emergency department and urgent care centres. If admitted to an inpatient facility, it often leads to specialist treatment and long-term inpatient care, which often results in much worse outcomes for the service user.

We believe that by aligning the service with other mental health services that this will reduce waiting times and stop service users bouncing around the system and between services, still not receiving a diagnosis or treatment. The Therapy Services for People with Personality Disorder Team comprises of 17 staff that would in the future, clinically align with the Community Treatment and Recovery Team, working in partnership.

We would improve the service by recruiting 14 additional staff members to help us to implement Structured Clinical Management -which is an approach to personality disorder using three levels or tiers of care.

Support for service users through three levels or tiers would be provided through our Community Treatment and Recovery Service Team. Level or tier 1 provides a specialist structured assessment. This would then lead to tier or level 2. This would involve the development of a co-created care plan that discusses how their condition would be managed and the treatment that would be required.

Clinical evidence shows that service users with a personality disorder best respond to treatment when it is provided in a clinic rather than received through a home visit. The service user would attend a clinic in the community with one of the local Community Treatment and Recovery Service Team, which will be the tier or level 3 care. They will receive support to make decisions about their care and learn skills to help them cope, reduce risks and build up resilience. This approach does require a commitment and willingness from the service user to engage in their care and treatment. If they are not ready to commit, then a care plan will be developed, and they would be encouraged to engage with the service when they are ready, as inappropriate interventions at the wrong time can be harmful.

The service would also work with families and carers. With the permission of the service user, they would be involved in the assessment and discharge.

Support will also be provided to carers and family in the community with the local Community Treatment and Recovery Service Team. This may combine both face-to-face and virtual online meetings.

The consultation feedback

Q21B - Offer a wider range of therapies for people with personality disorders which would support the majority of individuals within the new Community Treatment and Recovery Teams. Please explain why you agree or disagree with this proposal.

Support

	Standard survey online	Standard survey paper	Easy read online	Easy read paper
Strongly agree	2,285	88	123	17
Agree	983	56	48	22
Neither agree nor disagree	191	20	13	1
Disagree	30	4	0	0
Strongly disagree	40	1	1	0
Not applicable	22	18	3	0

Specific coded comments

Comments	Count survey	Count event
Proposal will improve access to support for people with personality disorders	94	1
Agreement with proposal	67	37
Proposal will improve quality of care for people with personality disorders	42	0
Consider improving quality of care for people with personality disorders (e.g. dynamic psychotherapy, evidence-based therapy, individual approach, alternative therapies)	32	0
Ensure appropriate staffing (e.g. staffing level, proficient staff, team experienced in DBT)	23	2
Consider reducing waiting time for mental health services	22	0
No comment (e.g. as above, N/A)	20	4
Consider greater integration between mental health services and other services (e.g. police, physical health services, children's services)	14	0
Consider improving quality of diagnosis of people with personality disorders	13	0
Concern over lack of capacity and resources to meet demand for this service	13	1
Proposal will reduce quality of services (e.g. lose specialisms)	13	0
Consider the need for continuous and consistent mental health support (e.g. ongoing support)	12	0
Other	12	0
Consider provision of services for people experiencing trauma	11	1
More details about proposal are required (e.g. capacity, type of support, evidence that it's needed)	11	0
Consider that group therapy does not fit for everyone (e.g. one-to-one support is needed)	6	0
Unsure (e.g. don't know)	5	0

Concern that proposal discriminates against other people with a serious mental illness (e.g. individuals with severe mental illness, psychosis)	5	0
Ensure that proposal reflects the needs of the diverse community	4	1
Consider improving communication with service users	4	1
Disagreement with proposal	4	0
Consider the need for early intervention and prevention	3	0
Proposal will have a positive impact on family members	3	0
Consider improved provision of local services across the county	3	0
Mental health services should be available 24/7	2	0
Consider improving mental health services for children and young people	2	0
Consider the need to provide support in groups	2	0
Proposal will help to reduce pressure on other services (e.g. A&E)	2	1
Comment about the survey (e.g. question is too broad)	1	0
Consider the need to provide counselling services	1	0
Consider the need to reduce the stigma of asking for mental health support	1	0
People need to know the range of personality disorders covered	1	0
Consider recommendations of The Independent Review of the Mental Health Act 1983	1	0
Further consultation about the proposal is required (e.g. staff opinions)	1	0
Consider the need to recognise Pathological Demand Avoidance and screen adults for this condition	1	0
Consider provision of support for patients while they are waiting for treatments (e.g. online, booklets, telephone calls)	1	0
Consider the needs of deaf people		2

Headline feedback from the consultation

Very strong support for the proposals – 93% of respondents agree or strongly agree with the proposals.

Our response to the feedback

Support

The service model that was proposed in the Pre-Consultation Business Case was very strongly supported (93% of responses agreed or strongly agreed with the proposals). The specific support for improving quality and access is noted. These are key drivers of the proposals.

Increasing capacity and the range of support provided

The proposals focus on developing a more accessible and responsive structure to our services and to offer a range of therapies to support people with a Personality Disorder. The proposals do not seek to remove or dilute specialist support. They seek to bring a range of support offers together focused on the service user. Our proposals specifically focus on support to people experiencing complex trauma.

The changes to how our support offers are structured and our investment plans will create more capacity for diagnosis and a greater range of options for support to help more people.

Investment in staffing

The Pre-Consultation Business Case included more detail of the investment and workforce plans. The additional investment is made on a recurrent basis.

Improving flow and reducing waiting times

One of the goals of introducing the model is to improve support, flow and reduce waiting times. We will measure and publish our progress on improving waiting times. Our measures of success will be developed to include more outcome-based measures. We will also report against national standards and targets.

Integration with other services

The feedback on integration aligns with our plans. One of the key goals of our proposals and an aim of the national Community Mental Health Framework is to join mental health services with each other and with a wider range of local services and support in the community.

Expanding perinatal services

The consultation proposals

In line with health systems across England, we would invest in our Perinatal Service over the next two years. This would support women with moderate to severe perinatal mental health difficulties to access specialist psychological therapies in the community. This would be available for those women from pre-conception to 24 months after birth. This represents an increase in the period of care which is currently only 12 months.

This investment would increase the size of the current Perinatal Team from 17 whole time equivalent staff to 37 staff, nearly all of which will be whole time equivalent staff. This will enable more women to access the service, particularly women from the BAME community, where we know we have imbalance of women seeking treatment. This consultation will look to understand in more detail why this is in order to break down barriers.

Fathers would also have a screening assessment and be signposted to appropriate services. They would have access to online tools to assist them to support themselves, their partner and the wider family.

Access to the service would be expanded. Through this consultation we will work to understand how this expansion might look in order to meet need.

Women would also have support if appropriate from Peer Support Workers, people who have lived experienced of the service, now working within the service. Perinatal Peer Support can complement the work of specialist mental health services by offering a wider approach that goes beyond mental health. This include things like feeling heard and understood or dealing better with being unwell, rather than focusing solely on becoming well.

The consultation feedback

Support

	Standard survey online	Standard survey paper	Easy read online	Easy read paper
Strongly agree	2,336	83	115	16
Agree	938	56	63	20
Neither agree nor disagree	188	19	15	2
Disagree	28	3	1	0
Strongly disagree	13	0	1	0
Not applicable	42	24	2	2

Specific coded comments

Q21C - Increase access to perinatal services that support women with moderate to severe perinatal mental health difficulties. This would be from pre-conception to 24 months after birth (up from the current 12 months). Please explain why you agree or disagree with this proposal.

Comments	Count survey	Count event
Proposal will help to improve the mental health of service users	79	2
Agreement with proposal	47	37
Proposal will improve access to perinatal mental health support	39	2
No comment (e.g. as above, N/A)	29	4
Consider extending time for service provision after birth	21	2
Proposal will have positive impact on family members	11	2
Ensure that the service reflects the needs of the diverse community	10	3
Other	8	0
More mental health services are required	5	0
Ensure appropriate staffing (e.g. staffing levels, trained staff)	5	2
More details about proposal are required (e.g. capacity, type of support)	5	1
Perinatal services provided good quality of care	4	0
Consider greater promotion of perinatal mental health services	4	1
Disagreement with the proposal	4	0
Unsure (e.g. don't know)	4	0
Consider the need to reopen the mother and baby unit in Leicester	3	0
Mental health support should be provided 24/7	3	0
Consider improving waiting times for mental health support	3	0
The service should be a part of Community Treatment and Recovery Teams (e.g. no need for specialised service)	3	0
Consider improving mental health services for children and young people	2	0
This service should be available for all family members and carers	2	2
Consider the need to improve quality of care provided by perinatal services (e.g. up-to-date support)	2	0
Consider expanding services for other groups (e.g. support for adults with post-adoption depression, people struggling to conceive)	2	0
Consider provision of psychotherapist support	1	0
Ensure sufficient resources to implement proposal	1	0
Further consultation about the proposal is required (e.g. staff opinion)	1	1
There is no need for seven-day service	1	0
Home-Start provided good support	1	0
Consider the need to implement proposal effectively	1	0
Consider the need to improve referral process (e.g. increase staff awareness about referrals)	1	0
Consider recommendations of The Independent Review of the Mental Health Act 1983	1	0
Consider provision of support for war veterans	1	0

Ensure collaboration of this service with other services (e.g. midwives, health visitors, GPs)	1	1
Assertive Outreach team provides this support (e.g. no need for this service)	1	0
Data analysis is needed to support this proposal (e.g. percentage of people who need the service)	1	0
Consider the needs of deaf women		2

Level of support

Very strong support for the proposals – 91% of respondents agreed or strongly agreed with the proposals.

Our response to the feedback

Support for the proposal

The service model that was proposed in the Pre-Consultation Business case was very strongly supported (91% of responses agreed or strongly agreed with the proposals). The specific comments are positive on the impact of the investment and service change plans on access, support to family members and outcomes.

Support from the enhanced service

Our plans will double the period of support from 12 months to 24 months after birth.

Working with diverse communities

Our investment plans seek to increase the level of engagement from individuals from a BAME background in Leicester, Leicestershire and Rutland. We will develop specific implementation plans to reflect the diverse community and will work with relevant community groups to build awareness and access to the support on offer.

Promoting the enhanced service

We will work with partner groups to promote the expanded service and build awareness.

Maternal Outreach Clinics Service

The consultation proposals

We would develop a new service to support women who have, or are, experiencing trauma and loss in relation to their maternity experience.

Currently women have limited access to specialist care if they are suffering from Post-Traumatic Stress Disorder relating to a traumatic birth or previous experience of childbirth that has been triggered by a current pregnancy. In addition, they may be having difficulties following childbirth, or have suffered bereavement including neonatal loss, miscarriage termination or stillbirth. They may be transgender and experiencing difficulties relating to pregnancy. Preconception care may be required, or they may have Tokophobia (fear of childbirth) or Trypanophobia (extreme fear of a medical procedure involving injections of needles) or have suffered Female Genital Mutilation and are now experiencing difficulty during a pregnancy.

Women will be able to access the service at any point of their midwifery/Obstetric care, when considering a pregnancy or up to 2 years postnatal. They can be referred from primary care (GP practice) or secondary care.

The Team providing the Outreach service will comprise of Consultant Psychiatrist, Clinical Psychologist, Specialist Midwife, Nursery Nurse, Mental Health Nurse, Bereavement Counsellor and other support. There will also be Peer Support Workers. The service would be provided by Leicestershire Partnership Trust, working closely with Leicester Hospitals' midwifery team. The service will be provided both in clinics and in the community. The actual locations have not been decided as yet.

The consultation feedback

Support

	Standard survey online	Standard survey paper	Easy read online	Easy read paper
Strongly agree	2,348	85	129	19
Agree	918	54	51	18
Neither agree nor disagree	192	19	13	1
Disagree	27	3	1	0
Strongly disagree	14	0	1	0
Not applicable	43	24	2	2

Specific coded comments

Q21D - Develop a new maternal outreach service to support women who are experiencing a trauma or loss in relation to their maternity experience. Also, please explain how we can ensure our perinatal services meet the cultural needs for our diverse communities across Leicester, Leicestershire and Rutland. - Please explain why you agree or disagree with this proposal.

Comments	Count survey	Count event
Proposal will improve access to mental health support	71	1
Agreement with proposal	37	38
No comment (e.g. as above, N/A)	30	1
Ensure adequate staffing (e.g. staffing levels, trained staff, recruit experts from diverse and trans communities)	11	6
Ensure that staff are aware about cultural diversity (e.g. training for staff)	10	3
Other	10	0
This service should be available for all family members and carers	8	1
Ensure close integration between maternal outreach service and other services (e.g. health visitors, GP, maternity services, schools, voluntary and community sector)	7	1
More details about proposal are required	7	1
More mental health services are required (e.g. for people with trauma)	6	0
Consider the need to research multicultural practices and incorporating them (e.g. multicultural work plan)	6	0
Ensure appropriate communication with service users (e.g. listen)	5	0
Consider the need for midwives and health visitors to provide this support	5	1
Disagreement with the proposal	5	0
Consider provision of interpreter services	5	1
Consider the need for consulting with diverse communities regarding provision of the service (e.g. ethnic minorities)	4	6
Proposal will allow service users to connect with others (e.g. lessen isolation)	3	0
Consider the need to improve mental health support for other groups (e.g. adoption, fostering and early trauma, women who cannot conceive)	3	1
Mental health support should be provided 24/7	2	0
Ensure appropriate referral process (e.g. strict timelines from referral to GP to psychiatrist)	2	0
Ensure sufficient capacity and resources to implement proposal	2	0
Consider greater promotion of this service (e.g. GP surgeries, pharmacies, supermarkets)	2	0
Proposal will help to prevent longer-term adverse effects of unprocessed trauma (e.g. improve outcomes for mothers and families)	2	1
Consider the needs of the trans community (e.g. don't use word 'mother')	2	0
Provide good grief and bereavement support to all	2	1
Unsure (e.g. don't know)	1	0
Consider provision of psychotherapy services	1	0
Ensure that the service reflects the needs of the diverse community	1	4
Further consultation about the proposal is required (e.g. staff opinion)	1	0

Concern over the removal of existing services (e.g. Assertive Outreach services, MH Integrated Team)	1	0
Consider service users' background and life experience	1	0
Consider the need for continuity and consistency of care	1	0
Consider the need to implement proposal effectively	1	0
Consider the need to improve quality of care provided by this service (e.g. up-to-date support)	1	0
Consider recommendations of The Independent Review of the Mental Health Act 1983	1	0
Consider provision of perimenopause and menopause support	1	0
Consider the need for clear service specifications (e.g. service needs to focus on priority areas)	1	0
Concern that the proposal will be implemented at expense of other services	1	0
Consider provision of group sessions	1	0
Data analysis is needed to support this proposal (e.g. percentage of people who need the service)	1	0
Consider provision of training for carers	1	0
Comment about the survey (e.g. good question)	1	0
All cultures must be treated equally	1	0
Consider that maternity loss and risk of loss is higher in the Black and Afro-Caribbean communities	1	0
Women should be seen by those of the same culture	1	0
Consider the needs of disabled women	1	5
Consider specialist grief services for provision of this support rather than mental health services	1	0
This support should be provided in wards	1	0
Consider the need for culturally appropriate location of the service		1
Ensure appropriate signposting to the service (e.g. through GPs)		1

Headline feedback from the consultation

There is very strong support for the proposals – 91% agree or strongly agree.

Our response to the feedback

Support for the proposals

The service model that was proposed in the Pre-Consultation Business Case was very strongly supported (91% of responses agreed or strongly agreed with the proposals). The specific comments are positive on the impact of the investment and service change plans of a new maternal outreach service to support women who are experiencing a trauma or loss in relation to their maternity experience.

Cultural diversity

There is positive feedback on our proposals to focus on cultural diversity in the planning and implementation of the new service. The suggestions of training on cultural diversity and incorporating multicultural practices will form part of our implementation plans.

Support to fathers and partners

Our proposals include plans to develop support services for fathers and partners.

Working with other services and partners

We plan to run the service in collaboration with a range of other services including the perinatal support service, other mental health services, wider primary care and community services. The new maternal outreach service will be developed and run in partnership with a range of partners including those suggested in the consultation feedback.

Psychosis intervention and early recovery also known as PIER

The consultation proposals

The Psychosis Intervention and Early Recovery (PIER) service works with people aged 14 - 64 years who are experiencing first symptoms of psychosis, as well as providing help to their families.

The support received from this service can help people recover from a psychotic episode. It can also help reduce the likelihood of experiencing further psychotic episodes in the future.

The service is made up of a team of professionals (including nurses, psychologists, psychiatrists, occupational therapists, support workers and social workers) who have lots of experience in working with people with psychosis.

However, most people assessed by the PIER service don't need to have treatment from the PIER team as it isn't suitable to meet their needs. They end up going to another service to be reassessed. In the future the PIER team will make it easy for service users who don't need to be treated in their service to receive the right support and treatment in another more suitable service without the need for a duplicate assessment. They will also work closely with other services, so that when the PIER team have completed supporting a service user, they can hand them over to a team who can support their recovery, independence including health, wellbeing and employment. This could include their GP practice, where they would receive medications and injections. They will also work with other teams if the service user has multiple conditions

The consultation feedback

Support

	Standard survey online	Standard survey paper	Easy read online	Easy read paper
Strongly agree	2,510	94	132	16
Agree	849	57	55	23
Neither agree nor disagree	440	16	9	1
Disagree	11	1	0	0
Strongly disagree	19	1	1	0
Not applicable	19	15	1	0

Specific coded comments

Q21E - Improve assessment for people who may need Psychosis Intervention and Early Recovery service, so they get the right support first time. Please explain why you agree or disagree with this proposal.

Comments	Count survey	Count event
Proposal will have positive impact on mental health outcomes of service users (e.g. prevent crisis, early recovery)	60	3
Agreement with proposal	54	30
Consider improving quality of care for patients with psychosis	23	0
Proposal will improve access to appropriate support	17	1
No comment (e.g. as above, N/A)	12	3
Psychosis Intervention and Early Recovery team works well (e.g. no need for changes)	10	0
Consider improving assessment of patients (e.g. avoid irrelevant questions)	9	0
Other	9	0
Consider the need for continuity and consistency of care for patients with psychosis	8	0
Consider improving waiting time for assessment and referrals	8	1
Assertive Outreach services provides better support for such patients	8	0
Consider the need for early intervention for other mental health issues (e.g. anxiety, eating disorders, suicide)	8	0
Concern over patients who do not accept the diagnosis and don't engage	8	0
Ensure adequate staffing (e.g. staffing levels, trained staff)	6	4
More details about the proposal are required	6	0
Disagreement with the proposal	6	0
Unsure (e.g. don't know)	4	1
Ensure integration of this service with other services (e.g. police, GP)	4	0
Proposal will have positive impact on family members	4	0
Consider improving mental health services for young people	3	1
More details about proposal are required	3	0
More mental health services are required	2	0
Mental health support should be provided 24/7	2	0
Ensure sufficient resources to implement this proposal	2	0
Consider greater promotion of this service	2	0
Consider improved provision of mental health services locally (e.g. Rutland)	1	0
Proposal will have a negative impact on quality of care (e.g. inconsistency, lose specialisms)	1	0
Consider the need to provide one-to-one support	1	0
Care in the community does not work	1	0
Consider recommendations of The Independent Review of the Mental Health Act 1983	1	0
Further consultation about proposal is required (e.g. staff opinions)	1	0
Consider improving service for severe and enduring mental health illness	1	0

Ensure that the service is accessible for people over 65	1	0
Consider the need to implement proposal effectively	1	0
Consider the need to look at roots of psychosis (e.g. living conditions)	1	0
Consider the need for consulting with diverse communities regarding provision of the service (e.g. ethnic minorities)		2

Level of support

There is very strong support for the proposals – 95% agree or strongly agree.

Our response to the feedback

Support for the proposals

The very strong support for the proposals is welcome and validates the proposals incorporated in the Pre-Consultation Business Case. There is strong support for this focus on the quality of care for service users with psychosis.

Goals of the investment

The investment and service improvement proposals intend to prevent crisis and support early recovery, to improve the assessment of service users and to improve waiting time for assessment and referrals. The improved service will have a focus on improving the continuity and consistency of care for service users with psychosis.

Improving access and earlier support

One of the overall themes of the Step Up to Great programme is to improve access to appropriate support. There are existing challenges with some service users who do not accept the diagnosis and do not engage with the support offering. The service changes should lead to a wider range of support offerings being made at an earlier stage. Assertive Outreach support will remain an option for relevant service users.

Investment in staffing

The Psychosis Intervention and Early Recovery team works well giving a strong basis for this investment. The PCBC confirmed the investment and new staff plans.

Memory service

The consultation proposals

The Memory Service originally introduced in November 2020, enables GPs to seek advice and guidance. GPs access this through their electronic referral system. Via the GP, the service provides a diagnostic assessment and treatment for people with dementia within a clinic setting, care home or their own home.

During the pandemic it was essential to introduce a temporary new way of providing the Memory Service that ensured that service users were kept safe and stayed physically well. It is now important to consult on this change and to understand the impact of providing more services digitally.

Where it was possible, virtual consultations were introduced to limit unnecessary exposure of vulnerable people into a hospital setting. This included video and telephone consultations. Cognitive testing would also change and we are testing a method called 'Test you Memory' which tests verbal and visual recall. If imaging and scans are needed, then a referral would be made.

Stronger joint working with GP practices has been introduced to ensure relevant information is provided as quickly as possible to reduce delays in assessing and diagnosing the service user.

The consultation feedback

Q21F - Improve the Memory Service by offering online consultations to reduce unnecessary exposure of vulnerable people to a hospital setting. Please explain why you agree or disagree with this proposal.

Support

	Standard survey online	Standard survey paper	Easy read online	Easy read paper
Strongly agree	1,940	71	119	13
Agree	996	55	57	25
Neither agree nor disagree	369	26	10	2
Disagree	135	9	3	0
Strongly disagree	64	1	7	0
Not applicable	22	16	0	0

Specific coded comments

Comments	Count survey	Count event
Concern over lack of access to technology or knowledge of how to use it	80	5
Online consultations are not suitable for users of Memory Service (e.g. face-to-face needed)	73	6
Agreement with proposal	57	29
Consider the needs of vulnerable service users (e.g. elderly, patients with dementia, deaf people)	29	8
Consider provision of memory services out of hospital (e.g. community settings)	27	1
Disagreement with proposal	18	4
Physical examination is required to provide effective care	18	2
Consider provision of assessment at patient's home	18	1
No comment, N/A (e.g. as above)	17	0
Type of support should depend on patient's needs (e.g. virtual consultation is not for everyone)	16	6
Proposal will help to reduce stress and anxiety of service users	13	0
Other	13	1
More details about the proposal are required	11	0
Proposal will improve access to services (e.g. quicker)	10	4
Consider the need for patients to choose the type of consultation	9	5
Online consultations may be suitable depending on the medical issue	9	2
Consider provision of memory Services locally	5	0
Proposal is focused on reducing cost rather than improving quality of mental health care	4	0
Consider greater integration between mental health services	4	0
Consider provision of IT support for service users who need it	4	0
Ensure sufficient capacity to implement the proposal	4	0
Proposal will increase isolation of service users	3	0
Consider the need to implement the proposal effectively	3	0
Consider expanding memory services for younger groups of population	3	1
Proposal will improve safety of care	2	0
Mental health services should be available 24/7	2	1
Ensure appropriate staffing (e.g. staffing levels, trained staff)	2	2
Ensure that the service reflects the needs of the diverse community	2	2
Proposal will have a negative impact on quality of care (e.g. inconsistency, lose specialisms)	2	0
Proposal will have positive impact on family members	2	0
Ensure appropriate referrals to other services	1	0
Further consultation about the proposal is required (e.g. staff opinions)	1	3
Virtual appointments did not work well during pandemic	1	0
Consider greater use of technology in healthcare	1	0
Consider improving waiting time for assessment and referrals	1	0
There are already numerous organisations dealing with older people and dementia	1	0

Consider recommendations of The Independent Review of the Mental Health Act 1983	1	0
Consider the need for safeguarding measures	1	0
Consider the need for regular assessment of elderly people	1	0
Community support for people with dementia is poor and requires improvement	1	0
Hospitals provided good quality of care for such patients	1	1
Consider the need to improve mental health services	1	1
Proposal will help to reduce pressure on hospitals	1	0
Initial consultation should be face-to-face		1
Video consultation is better than telephone consultation		1
Virtual appointments will help to improve service efficiency		1
Ensure that service reflects the needs of LGBT+ community		1

Level of support

There is very strong support for the proposals – 83% agree or strongly agree. 6% disagree or strongly disagree.

Our response to the feedback

Support

The very strong support for the proposals is welcome. We will take forward the specific comments in our implementation planning.

Digital as an option

We recognise that there will be access challenges for some potential service users and will therefore offer digitally based support as an option rather than the only route to Memory Services. Virtual consultations will not work for everyone and will therefore be an option but not the only route to access care. The service users will be able to choose.

Face-to-face support

If required, physical examinations will still take place. We have developed the service so that it can now be accessed in care homes. Where appropriate, the service could be made available in other community care settings and in the service user's home.

Accessible information

We are developing the range of support to service users with different language and access needs in line with the Accessible Information Standards.

Enhanced Recovery (community rehabilitation) for people with complex psychosis

The consultation proposals

In Leicester, Leicestershire and Rutland we currently do not offer enhanced recovery also known as community rehabilitation for people with complex psychosis and other severe and enduring mental health difficulties. This support has historically been delivered by admitting a service user to an inpatient bed.

We want to better support people who are struggling to live independently and people who are in supported independent placements by offering them community support delivered in a less restrictive environment and preferably in their own home. We would coordinate a person's care and hold overall clinical responsibility for the person's mental health while they are living in the community, preventing a hospital admission.

During the pandemic, we temporarily introduced a community team to try to support rehabilitation in the community, for those people that could benefit. If a person cannot be supported in a community setting, then they would still be managed as an inpatient for as long as it was necessary. But when appropriate they would be discharged under the care of the Community Treatment and Recovery Team.

We now propose to expand this service. Enhanced recovery would be provided through a Community Enhanced Recovery 'Hub' Team. This team would comprise of specialists in psychology, nursing, occupational therapy and medical specialties working together to discuss and provide care for the service user. They would work with the Community Treatment and Recovery Team offering consultation and support.

The Enhanced Recovery Team would also work with GPs, who take responsibility for an individual's physical health needs. They would focus on promoting healthy living including smoking cessation support, healthy eating advice, physical activity, links to neighbourhood groups and activities to decrease social isolation. The team would also work with social services and local housing providers to support people with serious mental health illness to access and maintain accommodation that is safe and secure. They would form a relationship with accommodation providers or social care landlords to increase the service user's ability to maintain their tenancy. In addition, they would also work with employment specialists to support people into stable and rewarding employment, where appropriate.

We know that in an inpatient setting black and minority ethnic individuals are over-represented. We want to reduce this inequality by working with the BAME community to understand way and identify the barriers they experience in accessing more care in the community.

The consultation feedback

Support

	Standard survey online	Standard survey paper	Easy read online	Easy read paper
Strongly agree	2,189	88	128	16
Agree	1,019	55	53	23
Neither agree nor disagree	228	16	13	1
Disagree	40	3	1	0
Strongly disagree	31	11	2	0
Not applicable	21	10	1	0

Specific comments

Q21G - Provide community rehabilitation support to help people recover from complex psychosis. Please explain why you agree or disagree with this proposal.

Comments	Count survey	Count event
Agreement with proposal	94	26
The service is already being provided (e.g. Assertive Outreach team, has been renamed)	36	0
Proposal improves access to mental health support (e.g. local, reduced waiting times)	23	0
No comment (e.g. as above, N/A)	14	5
Ensure appropriate staffing (e.g. trained staff, staffing levels)	14	5
Other	14	1
Consider the need to implement proposal effectively	12	1
Proposal will provide preventative services for mental health issues	12	0
More details about proposal are required	11	3
Concern over the removal of existing services (e.g. out of community care)	11	0
Ensure continuity of care (e.g. regular support)	11	0
Ensure there is sufficient funding and resources to make these changes	10	0
Consider the safety of caring for those with complex psychosis within the community	10	0
Further promotion of community rehabilitation is required (e.g. leaflets, GP surgeries)	7	0
Consider the needs of those with substance addiction	7	0
Disagreement with the proposal	7	0
Consider the need to provide easy access to the service	6	0
Ensure that the service reflects the needs of the diverse community	6	3
Proposal is focused on reducing cost rather than improving quality of mental health care	5	0
Concern over patients who do not accept the diagnosis	5	0
Consider provision of assessment at patient's home	5	0

Proposal will allow family and friends to support when needed	4	0
Consider extending working hours of these teams (e.g. out of hours, 24/7)	4	0
Consider the need to integrate with local organisations	3	0
Proposal will have a negative impact on quality of care (e.g. inconsistency, lose specialisms)	2	0
Consider provision of training for staff	2	0
Ensure that there are appropriate facilities to hospitalise if needed	2	0
A seven-day service is not required	1	0
Proposal could impact families negatively (e.g. pressured to keep family member at home)	1	0
Further consultation about the proposal is required (e.g. staff and service users' opinion)	1	0
Consider the need for preventive measures and early intervention	1	0
Proposal will increase isolation of service users	1	0
Consider expanding services for younger age groups	1	0
Proposal helps to reduce pressure on other services (e.g. hospitals)	1	0
Consider provision of assessment at patient's home	1	0
Ensure appropriate referral process	1	0
Consider recommendations of The Independent Review of the Mental Health Act 1983	1	0
Consider the need for greater community engagement for anyone living with a mental illness	1	0
Consider improving mental health support for children	1	0

Level of support

There is very strong support for the proposals – 90% agree or strongly agree.

Our response to the feedback

Support for the proposals

There is very strong support for the proposals set out in the Pre-Consultation Business Case. There is agreement and support for our plans to improve access to mental health support and reduce waiting times. The focus on earlier intervention and prevention is also supported.

Investment in staffing to improve access

Some of the comments highlight the need for appropriate funding, resources, staffing and training. These were set out in the Pre-Consultation Business Case and will be detailed in our implementation plans. Many of the elements of our future service plans are already delivered by LPT. The service improvement focuses on new investment, the coordination of our support offers and the settings in which they are offered. The existing range of services will not be withdrawn.

Continuity of care and the safe provision of care are key drivers of our service improvement plans and the on-going service provision.

Telephone and video support

The consultation feedback

Q23

We propose to introduce the choice of having appointments by telephone or video call. This could reduce: the stress of attending a consultation in person, the need to travel to appointments, the possible spread of infection and increase access to support to enable people to self-care. Please explain why you agree or disagree with this proposal.

Support

	Standard survey online	Standard survey paper	Easy read online	Easy read paper
Strongly agree	1501	52	81	7
Agree	1026	50	53	25
Neither agree nor disagree	540	33	40	4
Disagree	301	26	10	3
Strongly disagree	234	25	19	1
Not applicable	7	3	0	0

Specific coded comments

Comments	Count	Event
Consider the need for the patient, not the clinician to choose the type of appointment (e.g. face-to-face, telephone, video)	231	5
Virtual appointments may be suitable depending on patient's needs (e.g. medical issues)	143	6
Face-to-face assessment is required to provide effective care (e.g. potential for misdiagnosis)	130	10
Concern over lack of access to digital technology	123	5
Virtual appointments are not suitable for mental health patients (e.g. need human interaction)	118	3
Virtual appointments should be in addition to face-to-face appointments (e.g. not replace them or be default option)	118	8
Agreement with proposal	116	16
Virtual appointments do not allow to pick up non-verbal and environmental cues (e.g. body language)	103	5
Virtual appointments will benefit some patients (e.g. with social anxiety)	89	8
Virtual appointments are impersonal (e.g. adds to isolation and loneliness)	87	4
Technology improves access to services (e.g. reduce travel, reduce waiting time)	81	8
Concern over patients who require face-to-face appointments (e.g. hearing problems, elderly)	67	14

Concern over lack of knowledge how to use technology	66	6
Disagreement with proposal	37	16
Virtual appointments could have negative impact on patient health (e.g. increased suicides, stress)	33	4
Video consultation is better than telephone consultation	24	3
Consider lack of patient confidentiality (e.g. no space at home for private conversation)	23	1
Virtual appointments will help to improve service efficiency (e.g. allow more patients to be seen)	19	0
Other	18	1
Virtual appointments worked well during pandemic	17	1
Virtual appointments help to reduce infection transmission	17	1
Proposal is focused on reducing cost rather than improving quality of mental health care	15	1
Concern over negative impact of virtual appointments on quality of care	15	0
Concern that proposal will reduce availability of face-to-face appointments	13	1
Consider provision of IT support for patients who need it	11	2
Ensure that service reflects the needs of the diverse communities (e.g. languages)	10	2
Virtual appointments did not work well during pandemic	10	0
Consider improving booking of virtual appointments (e.g. book call time)	9	1
Consider the need for home visits (e.g. for those with deteriorating mental health)	9	0
Virtual appointments are suitable only during the pandemic	8	1
Consider provision of online messaging service (e.g. text services)	8	0
No comment (e.g. as above)	6	0
Concern that proposal will increase health inequalities (e.g. not inclusive)	6	0
Consider training for staff on how to conduct virtual appointments	5	0
Initial appointment should be face-to-face	5	1
Consider the need for continuous and consistent care	5	0
Concern over reliability of technology (e.g. poor signal, frozen screen)	5	3
Ensure sufficient duration of virtual appointments	4	0
Proposal will help to save patients money	4	0
More details about proposal are required	4	1
Comment about the survey (e.g. question unclear)	3	0
Ensure appropriate staffing (e.g. trained staff)	3	0
Technology allows observation of patients in their home environment (e.g. patients are relaxed at home)	3	2
Quality of care is more important than the type of appointment	3	0
Direct and regular contact from Assertive Outreach services is required for service users	3	0
Safeguarding measures must be put in place	3	0
Concern over poor NHS IT infrastructure to provide virtual appointments	2	0
Consider opinions and suggestions of family members	2	1
Telephone consultation is not suitable for young people	2	0
Consider improving access to GP appointments	2	0
Consider improving access to local services	1	0

Appointments via technology only suitable for initial consultation	1	0
Use recognised telephone number for telephone appointments	1	0
Consider informal environment for mental health appointments (e.g. parks, coffee shops)	1	0
Consider improving access to mental health services (e.g. waiting time)	1	0
Consider greater integration between mental health and other services (e.g. charities)	1	0
Consider more investment in Leicester Deaf Centre to support deaf people		1
Further consultation about the proposal is required (e.g. with Deaf Forum)		2

Level of support

There is strong support for the proposals – 70% agree or strongly agree. 15% of responses disagree or strongly disagree.

Our response to the feedback

Support

We are pleased that 70% of respondents agree or strongly agree with the proposal but recognise the potential concerns raised in some of the comments.

An additional choice

We agree that the use of telephone and video as a vehicle to interact with service users will bring benefits but needs to be offered a choice and will not be the preference of all service users. We agree that the service users rather than the clinician should determine whether to use virtual appointments.

There may be some issues with access to technology although this is offering an alternative, often telephone based, to face-to-face appointments. No service users will miss out on interaction with our services due to technology access issues.

Improving services using technology

The use of telephone and video technology will support a reduction in waiting times and therefore, improve access. We will continue to invest in technology and support to book virtual appointments.

Under the self-care programme of work, we plan to trial open access to IT in a confidential setting for service users. We have developed protocols to support confidentiality when using telephone and video-based technology.

We will also feed this into our wider system work on digital poverty and increasing access to digital technology.

General

The information below is captured in response to question 24 – other comments on the proposed changes.

The consultation feedback

Q24

If you have any other specific comments about the proposed changes to the Mental Health Services, please use this space to tell us what they are.

Comments	Count survey	Count event
Consider improving waiting time for mental health service (e.g. waiting time threshold)	161	5
Ensure appropriate staffing (e.g. staffing level, diverse staff, qualified staff, culturally representative workforce)	152	10
Agreement with proposals	146	13
Consider improving quality of mental health care (e.g. meet patient needs, alternative therapies, reduce drug dependency)	142	6
Consider the need to improve mental health services for children and young people (e.g. CAMHS, transition to adult services)	84	5
Virtual appointments are not suitable for mental health patients (e.g. impersonal, risk of misdiagnosis)	83	0
Consider the need for continuous and consistent mental health support (e.g. after crisis support, follow-up)	79	3
Consider improving integration between mental health providers and other services (e.g. social care, GP, substance misuse, voluntary sector, housing)	77	11
Consider improving access to mental health services (e.g. home visits, easier pathway, accessible locations, more services)	75	5
Consider greater promotion of available mental health services and support	71	8
Consider increased provision of mental health services locally (e.g. in primary care settings, rural areas)	61	4
Ensure sufficient capacity and funding to implement proposals	57	2
Consider improving communication with patients and their families (e.g. keep informed, listen)	56	6
Proposals improve access to mental health services and support	56	3
Consider the need to implement proposals effectively (e.g. regular audit and scrutiny)	56	4
Consider the need for preventive measures and early intervention	52	2
No comment (e.g. as above)	48	1
Virtual appointments should be an option (e.g. not replace face-to-face, depends on patient's needs)	47	2
Consider the needs of vulnerable patients (e.g. complex needs, homeless people, asylum seekers and refugees, elderly people)	39	2
More details about proposals are required	37	8

Concern over removing existing services (e.g. Assertive Outreach services, MH Integrated Team, psycho oncology service)	37	0
Other	35	2
Consider increased support for carers and families of mental health patients	32	8
Consider the need to improve referral process to mental health services (e.g. criteria to be referred, self-referral online, referrals to counselling)	29	1
Assertive Outreach services provide essential care (e.g. lack of the service will have negative impact on patients)	29	0
More investment in mental health services is required	25	1
Concern over lack of access to technology or knowledge of how to use it	24	1
Consider provision of training for staff in mental health (e.g. new therapies, training for GPs)	22	0
Consider improving services provided by mental health urgent care hub (e.g. Bradgate Unit provided poor service, poor access to service)	20	0
Concern that proposals are focused on reducing cost rather than improving quality of mental health care	20	0
Consider improving triage and navigation of mental health patients	20	1
Consider the needs of patients with autism and ADHD (e.g. clear pathway is needed, better assessment)	19	1
Consider provision of social support groups (e.g. more social prescribing services, wellness groups, peer support)	18	1
Ensure that proposals reflect the needs of the diverse community (e.g. language, cultural sensitivity, staff from community)	16	12
Consider extending working hours for all mental health services (e.g. 24/7)	16	0
Consider the need for reducing stigma of asking for mental help	16	10
Consider increased provision of face-to-face support	16	0
Consider the need to raise awareness about mental health (e.g. starting in school)	14	5
Virtual appointments benefit some patients (e.g. with social anxiety)	13	0
Comment about the survey (e.g. good survey, poorly designed)	13	1
Proposals will reduce quality of mental health services (e.g. lose specialisms)	11	0
Consider improving services for patients with personality disorders	11	1
Consider improving working conditions for staff (e.g. staff recognition)	10	0
Proposals will help to improve quality of mental health care	10	0
Consider the need to use NHS money appropriately (e.g. evaluate spending)	10	0
Consider increasing service provision for women after birth (e.g. parenting support)	10	0
Consider increasing provision of services for patients with mild and moderate mental health difficulties	10	0
Further consultation about the proposals is required (e.g. with frontline staff)	9	2
Consider improving services for patients with depression and anxiety	9	0
Consider provision of online services (e.g. by email, online chat, online therapy)	9	0
Consider involving of ex-service users and volunteers in development and running of mental health services (e.g. Crisis Cafés)	8	1
Virtual appointments improve access to services (e.g. save time)	8	0

Consider improving facilities for mental health patients (e.g. in hospitals, clinic rooms, hospital food, separate area in A&E)	8	0
Consider the needs of deaf people (e.g. BSL videos and interpreters)	8	0
Consider improving services provided by Central Access Point services (e.g. call queue system)	7	1
Consider the needs of different local areas in provision of mental health services (e.g. south and south east of Leicestershire)	7	0
The crisis team is not fit for purpose	7	0
Consider the impact of COVID-19 on mental health	7	1
Consider improving addiction services (e.g. lack of crisis help)	7	0
Disagreement with proposals	6	0
Ensure equal access to mental health services (e.g. no postcode lottery)	6	1
Proposal will improve service efficiency (e.g. reduce pressure on other services)	6	0
Crisis Cafés are a good idea	6	0
Consider improving access for crisis team (e.g. waiting time, response for phone call)	6	0
Consider improving services for PTSD and trauma	6	2
Concern that mental health patients will not contact the services (e.g. staff should be proactive)	6	0
Consider the need for family, carers or public to refer mental health patients (e.g. without their consent)	6	0
Mental health services should be free	5	1
Consider improving psychodynamic service	5	0
Consider the need for an Information Sharing Protocol between organisations and teams	5	2
Consider the need to reinstate work of some mental health services (e.g. as before COVID, FDL, psycho oncology service)	5	0
Consider the need to improve service for menopausal women	4	0
Maternal outreach service should be available for all family members who lost a baby	4	0
Consider the need for outreach system for schools to support children before they present with mental health problems	4	0
More hospital beds for mental health patients are required	4	0
Mental health needs to be treated the same as physical health	4	0
Consider the need for provision support with life issues (e.g. debt, employment)	4	0
Concern that proposals will increase pressure on staff	4	0
Consider provision of service for patients who suffer from psychosis	4	0
Provide information about commonly used medications and managing mental health problems	3	0
Consider the need for simple phone number to access mental health support (e.g. free number)	3	1
Consider improving services for victims of abuse (e.g. domestic abuse, sexual abuse)	3	0
Crisis Cafés are not for everyone	3	0
Consider the needs of armed forces veterans	3	2
Consider improving support for patients with eating disorders	3	0

Police are not suitable to deal with mental health patients (e.g. lack of training)	3	0
Consider improving prescriptions process (e.g. electronic prescription)	2	0
Consider improving access to other services (e.g. GP)	2	1
Comment about the consultation	2	0
Consider provision of support for patients while they are waiting for treatment	2	0
Consider improving discharge process (e.g. discharge is too fast)	2	0
Concern over lack of support for patients with schizophrenia and bipolar disorder	2	0
Consider provision of support for people at risk of suicide (e.g. other potential harmful behaviour to self or others)	2	0
Video consultation is better than telephone consultation	2	0
Consider recommendations of The Independent Review of the Mental Health Act 1983	2	0
Concern over privatisation of NHS	2	0
Consider provision of self-diagnosis (e.g. self-assessment form)	1	0
Ensure adequate IT infrastructure to provide online consultations	1	0
Consider provision of mental health support for patients with life-long illness	1	0
Consider the needs of LGBT+ groups	1	3
Self-help guidance is useful only as a supplementary tool (e.g. should not replace professional help)	1	0
Consider the needs of street-based sex workers	1	0
Consider the needs of patients with neurological disorders	1	0
Ensure that NHS services are used appropriately	1	0
Consider provision of support for people with gender dysphoria	1	0
Concern over negative impacts of these proposals on acute patients	1	0
The CAP provides good quality of services	1	0
More research is needed on mental health problems	1	0
Consider providing support for different groups separately (e.g. women-only and men-only days, different age groups)		1
A&E is not a suitable place for mental health patients		1
Concern over access to Glenfield Hospital (e.g. poor public transport, too far)		1
Consider greater support of voluntary sector and community groups by NHS		2
Consider the need for consulting with diverse communities regarding provision of the service (e.g. ethnic minorities)		4
Consider changing the name of Crisis Cafés (e.g. negative associations of crisis)		1
Concern over lack of mental health support in prison		1
Consider provision mental health and bereavement support for people who have experienced deaths due to COVID-19		1
Consider the needs of trans people		2
Consider provision of BSL helpline		1
Consider lack of patient confidentiality		2
Consider provision of interpreter services		1
Concern that mental health patients will not use the service (e.g. don't recognise problem)		1

Consider visits to workplaces to get to those hard to reach		1
Consider the need to discuss men's mental health		1

Our response to the feedback

Support

We welcome the strong support through the consultation for our proposals. We will address the majority of comments on how to implement via our implementation plans once the Decision-Making Business Case is approved.

There are a very wide range of comments, many were also raised under one of the specific service change proposals. The comments are mainly supportive of the proposals set out through the consultation with most focusing on how to implement the proposals set out in the consultation document while supporting the overall models.

Improving waiting times and outcomes

The highest volume of comments focused on the need to improving waiting time for mental health services, ensure appropriate staffing, agreement with proposals and the need to improve the quality of mental health care.

We strongly agree with the feedback on the need to improve waiting times for mental health services, ensuring appropriate staffing and the need to improve the quality of mental health care. These comments support some of the key drivers of this investment and the related service improvement plans.

Comments on other services

There are some comments outside of the scope of the programme that focus on the need to improve mental health services for children and young people. We will share these with the leads for children and young people's services.

Digital as an option

We have addressed the comments, positive and negative, about telephone and video-based services under the digital consultation question. The comments here are consistent with the comments made in response to that more specific question.

Implementation planning and integration

We will develop implementation plans for these service changes and are developing further plans relating to inpatient and neighbourhood mental health services. As part of our implementation planning, we will consider the comments relating to the need for continuous and consistent mental

health support, improving integration between mental health providers and other services and improving access to mental health services.

We will apply the specific comments on implementation to the relevant service improvement implementation plans. We have set funding aside to support transition and for team building.

Communicating with service users, carers and families

We will develop plans to improve communication with service users, their families and carers and communities that the Urgent and Emergency Care pathway and the Community Treatment and Recovery Teams are intended to support. A second related strand of work will focus on the promotion and awareness raising of the enhanced services.

Recurrent investment in mental health staffing

This is the most significant recurrent increase in mental health investment in Leicester, Leicestershire and Rutland in the last decade. We have restated our investment and recruitment plans in the Decision-Making Business Case. None of our proposals reduce staffing. We are seeking to enhance the services and to invest in additional resources. The specific scale of investment is set out in the finance and workforce chapter. Our plans seek to increase the hours of many of our services. We will review the opportunities to go further as resources are made available.

Earlier support

We are pleased to receive the positive feedback on delivering a greater shift to focus on preventive measures, early intervention and the needs of vulnerable service users.

Service specific comments

The specific feedback included here will be applied to the relevant service development implementation plan, including comments about the environment at the Bradgate Unit.

Our specific implementation plans will include offering different models in different parts of the health system to reflect the needs of the diverse community.

Building engagement and improving communication

As we move from consultation to delivery of the planned improvements, our communications and engagement plan will continue to involve as many people as possible in our work, enabling us to develop services that meet the needs of the whole population. In our plan we will:

- Use many different communication channels to make sure that people are aware of the outputs of the consultation and the progress that we are making. This will include continuing to use the dedicated Step up to Great Mental Health website

- Continue the investment we have made in our partners, particularly in the voluntary and community sector, to help provide insights and help us hear from the diverse local communities of LLR to shape and deliver our plans
- Invest in promotional materials so that all audiences know what is available to them. This will include both online and hard copy, printed materials.

Working with the VCS

We intend to build on the strong alliances that have been formed with the voluntary sector, that empower communities to make decisions jointly and co-design services that improve their health and wellbeing.

The VCS has played a central role through the engagement, equality impact assessment and consultation processes. We will continue to seek support from the VCS to help understand what local communities need in future design and implementation of mental health services from this process and in future development work.

Through the phase two work around neighbourhoods, we are looking to invest in VCS to help deliver targeted offers to support mental health in local communities, in conjunction with the statutory organisations. We also require their help in education and strengthening of communities in relation to mental health.

Working with families and carers

We have a strong commitment to recognise the role of family carers and other people supporting service users to access care and support their treatment and recovery. This army of individuals work tirelessly and are often unrecognised. We will work to involve carers in the recovery process of their loved ones, also recognising their mental health needs. We will also develop strong relationships with voluntary and community groups acting as advocates of carers to ensure that improvements align with carer needs and services are co-produced with their support.

The importance of co-design and co-production

We have a strong commitment to co-produce services with services users, carers, local people and communities. Co-production will acknowledge that people with 'lived experience' and their carers are often best placed to advise on what support and services will make a positive difference to their lives. Co-production will help to ground discussions and shape services in reality, and to maintain a person-centred perspective.

Principles post consultation to the communities in Leicester, Leicestershire, and Rutland

The Step up to Great Mental Health Consultation Report of Findings presents the common themes emerging from the consultation with service users, staff, stakeholders and the public.

The Clinical Commissioning Groups in Leicester, Leicestershire and Rutland and Leicestershire Partnership NHS Trust recognise the importance of the contribution that people made to the consultation sharing their observations, ideas and what matters most to them.

All the feedback received throughout the consultation has been carefully considered. A number of general principles have been developed that address what we heard during the consultation. In addition, we have created principles for each of the sixteen proposals, that address the key themes and ideas supporting the co-production of improvements, over the coming weeks and months.

General principles which the NHS in Leicester, Leicestershire and Rutland will adhere to when implementing change

ACCESSIBILITY

- Services will be designed that are convenient for people to access with adequate transport networks, parking facilities and are easy to enter.
- Information will be made available in a variety of languages and distributed through various mechanisms.
- Services will be easily accessible to all including people with disabilities.

APPROPRIATE SELF-HELP AND GUIDANCE

- Self-help guidance will cover a wide range of conditions and how to manage them and will be accessible through various mechanisms.

RESPONSE TIME AND THRESHOLD

- Services will be delivered in a timely manner and response time thresholds will be established.

GREATER PROMOTION OF SERVICES

- Services will be promoted using a variety of strategies to ensure a broad reach.

APPROPRIATE AND PROFICIENT STAFF

- Services will be provided by a diverse group of people with a range of skills.
- There will be an adequate number of staff to meet the population's needs.

SIGNPOST AND REFERRAL TO OTHER SERVICES

- Awareness of available services will be raised to ensure health care providers refer people to the appropriate service and there will be adequate signposting to these services.

INCREASED PROVISION IN EMERGENCY

- More care will be accessible to meet the needs of people when it is urgent or in an emergency.

REFLECT THE NEEDS OF DIVERSE COMMUNITIES

- Services will be patient-centred and designed to meet the needs of diverse populations

DO NOT FORGET FAMILY CARER AND WIDER SUPPORT NETWORKS AND PEOPLE

- Support will be provided to both service users, family carers and all support networks e.g. neighbours, friends

INTEGRATE SERVICES ACROSS MENTAL HEALTH SERVICES AND OTHER SERVICES

- Healthcare services will be provided based on a holistic approach to meet mental, physical, emotional needs

CONTINUITY OF CARE

- Care will be seamless and coordinated across the wider health care system

PATIENT CHOICE

- Care will be provided in ways appropriate to service users and their family that are most conducive to improving their health ensuring they can live the best life possible

DIGITAL CARE NEEDS TO BE APPROPRIATE TO THE PERSON AND CONDITION

- Digital care will be part of the future offer but will only be provided when appropriate and acceptable to the service user

EMPOWER PEOPLE AND COMMUNITIES AND SEEK COMMUNITY BASED SOLUTIONS

- Stronger alliances will be created with the voluntary sector, empowering communities to make decisions jointly and co-design services that improve their health and wellbeing

A set of 16 principles which align with individual proposals which the NHS in Leicester, Leicestershire and Rutland will adhere to when implementing change.

1. BUILDING SELF-HELP GUIDANCE AND SUPPORT

- Self-help information will be accessible for everyone (e.g. hard copies at GP surgeries, libraries, British Sign Language (BSL) videos and online resources)
- Self-help guidance will be used as an adjunct to professional mental health care (e.g., back up to professional help)
- Self-help guidance will reflect the diverse community needs
- Self-help guidance will assist people in getting the appropriate information, support, and services

2. STRENGTHENING THE ROLE OF CRISIS CAFES

- Crises Cafés will be stigma free- implementing multiple approaches to reduce stigma
- Crisis Cafés will be easily accessible, located in local areas and community settings (e.g., community centres, libraries, shopping centres, high streets, faith centres)
- Crisis Cafés will offer a wide range of services
- Crisis Cafés will have a name that makes clear to the local community what is on offer and would be something that they would use if needed
- Confidentiality of services provided at Crisis Cafés will be respected

3. INTRODUCING A CENTRAL ACCESS POINT

- The Central Access Point will provide quality services (safe, timely, effective, efficient, equity and patient-centred)
- The Central Access Point will be promoted and communicated widely
- The Central Access Point will be adequately staffed (number, skill mix, diversity, staff who speak different languages, specialist BSL)

4. IMPROVING THE CRISIS SERVICE

- Crisis services will be of high quality (safe, timely, effective, efficient, equity and patient-centred)
- Crisis services will be adequately staffed
- Crisis services will meet the needs of a diverse population (e.g., deaf population, ethnic minorities)
- Crisis services will be promoted, and we will raise awareness of services
- GPs will be involved in the mental health patient pathway
- The crisis services will be extended to support carers and families

5. EXPANDING THE USE OF THE TRIAGE CAR

- The Triage Car service will meet the needs of vulnerable people
- The Triage Care services will have trained mental health staff in all triage vehicles

6. MENTAL HEALTH URGENT CARE HUB

- Communication between service providers and service users will be improved (e.g., simplify complex terms, ensure needs of those with language barriers are met)
- A hospital bed will be available to those who need it.

7. IMPROVING AN ACUTE MENTAL HEALTH LIASION SERVICE

- The needs of the older population and vulnerable population will be met
- The service will be available 24/7

8. JOINING UP SUPPORT FOR VULNERABLE GROUPS

- There will be partnerships with voluntary community sectors
- Awareness of services will be raised and adequate signposting to these services will be ensured

9. WORKING WITH THE COMMUNITY TO PROVIDE MORE MENTAL HEALTH SERVICES LOCALLY

- Existing services will be strengthened (e.g. Assertive outreach offer, MH Integrated Team)

10. OFFER A WIDER RANGE OF THERAPIES FOR PEOPLE WITH PERSONALITY DISORDERS

- Capacity and resources (e.g., staff level, skill mix, diversity) will be sufficient to meet demand
- Services will be offered to improve the quality of care of people with personality disorders (e.g., psychotherapy, individualised approach, alternative therapies)

11. INCREASE ACCESS TO PERINATAL SERVICES

- Services will be broadened to include the postnatal period
- Service will meet the diverse needs of the population

12. DEVELOP A NEW MATERNAL OUTREACH SERVICE

- Adequate staffing level will be maintained
- We will collaborate with voluntary community sectors in designing services

13. IMPROVE ASSESSMENT FOR PEOPLE WHO MAY NEED PSYCHOSIS INTERVENTION AND EARLY RECOVERY SERVICE

- Staff will be trained to meet the needs of the population

14. IMPROVE THE MEMORY SERVICE BY OFFERING ONLINE CONSULTATIONS

- Care will be provided in ways appropriate to service users and their family in ways that would be most conducive to improving their health ensuring they can live the best life possible

15. PROVIDE COMMUNITY REHABILITATION SUPPORT

- Staff will be well trained to meet the needs of the population

16, TELEPHONE AND VIDEO CALL APPOINTMENTS

- Patients will have the choice to decide on the type of appointment they prefer (e.g., face to face or online)

8. Finance, investment and workforce

Financial under-pinning

The financial under-pinning of these service changes is very simple. Many of the changes are to the way in which we as a system work and the coordination of our offer to service users. The majority of these changes are cost neutral aside from the one-off costs of team building and communications. All of the other changes that we propose making are funded through recurrent investment in mental health services, many funded through the Mental Health Investment Standard. The LLR system has protected the MHIS and sought to link new investment to new posts in order to create additional capacity.

This is a programme of investment, growth and improvement. There are no unfunded workforce commitments in these plans. We have no plans to make staff redundant as part of this programme and have therefore not aside any funds for that purpose.

Breakdown of investment

Area	Investment	Recurrent / non-recurrent	Source of funds
Delivery support	£110,000	Non-recurrent	LPT investment
Central Access Point	£2,000,000	Recurrent	MHIS baseline growth and LPT investment
New Vulnerability Pathway	£465,000	Recurrent	NHSE contract award (liaison and diversion) and MHIS baseline growth (Vulnerable people investment)
Crisis home treatment	£972,000	Recurrent	MHIS baseline growth
Crisis Café investment	£145,000	Recurrent	Transformation funds (year on year funding for next three years and then expected to become recurrent)
Core 24	£532,000	Recurrent	MHIS baseline growth funding
Mental Health urgent care hub	£1,142,000	Recurrent	MHIS baseline growth and LPT investment
Personality Disorder (tier 2)	£600,000	Recurrent	MHIS
Peer support worker	£394,000	Recurrent	MHIS
ADHD	£399,000	Recurrent	MHIS

Area	Investment	Recurrent / non-recurrent	Source of funds
Enhanced recovery hub and spoke	£777,000	Recurrent	LPT investment
Perinatal Hub and spoke	£1,000,000	Recurrent	MHIS
PIER	£184,000	Recurrent	MHIS
Summary non-recurrent	£110,000		
Summary Recurrent	£8,610,000		
Total summary	£8,720,000		

Summary of intended efficiency / value for money improvements

There are a range of benefits expected from the proposed changes. Many of these will improve system efficiency and value for money improvements in delivery. Any realised benefit in the mental health system is reinvested back into the mental health system in line with national and local expectations (thus this is describing an investment plan).

The efficiencies that will be delivered are not expected to be realised in the form of an explicit savings plan and therefore this is not provided in numerical terms. The themes of efficiency/value for money improvements include:

Improved effectiveness of services through the integrated community model

- Reduced duplication in contacts and assessments
- More effective treatment choices (thus reducing ineffective treatments / contacts) through whole team MDT working and formulation driven assessments
- Reduced unnecessary appointments through improved recovery work and improved MDT working
- Reduced acute episodes through improved support in integrated community team and reduced waits (reducing contact with other mental health services and wider urgent care services)
- Improved community support reducing requirement for inpatient care allowing avoidance of out of area placements and additional system cost
- Reduced burden on specialist out of area placements and inpatient stays through improvements to personality disorder pathway and enhanced recovery service.

Improvements in urgent and community mental health provision positively impacting on wider system partners

- Reduced time and number of service users accessing emergency department through urgent care pathway (acute liaison support in emergency department, alternative to emergency department support through MH urgent care hub and improved on-site support of triage cars)
- Reduced length of stay for individuals in acute hospital beds (through enhanced and timelier acute liaison support in inpatient wards)
- Reduced burden on GP and primary care through direct access using Central Access Point, crisis cafés enhanced crisis service and the urgent care hub

Non recurrent costs of change

Our implementation workshops and plans focus on some areas that will require additional external support, notably in recruitment, team building and communications. We have set aside the following sums for those non-recurrent costs.

Non-recurrent support	**Budget**
Recruitment campaign support	£30,000
Team building, training and external supervision support	£50,000
Communications with service users, staff and stakeholders	£30,000
Total	£110,000

Urgent and Emergency Care workforce

In Urgent and Emergency Care we plan to draw a range of services together and to invest in them to create a coherent pathway. We will use MHIS investment to enhance the resource and offerings. We will develop posts that rotate across the UEC pathway, adding interest and resilience to these teams.

The new models of integrated community care and urgent and emergency care have been co-designed with hundreds of staff alongside service users and stakeholders. The designs have derived from co-designed workshops and then been taken forward in clear workstreams with mixture of clinical, managerial and support staff. All staff are being engaged in the transformation programme with a plan for front-line staff to be actively leading on the implementation of changes supported by clinical and operational leaders. This is all been designed to maintain engagement and involvement of workforce in change.

The level of engagement and motivation of staff has been demonstrated in the recent initiatives put in place during the COVID-19 incident of the Central Access Point, Mental Health Urgent Care Hub and Community rehabilitation offer. Each of these were put in place very quickly with staff organising themselves to work in different areas and settings to get these services started and making them work.

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

We have established a first cohort of Peer Support Workers to work in community teams to support service user's recovery and support transition out of services. A framework and development process has been established with the recovery focused ImROC (an organisation specialising in developing recovery principle in organisations) this had three stages:

1. Prepare people with lived experience with skills, knowledge and confidence to be in a position to potentially apply for peer support worker roles
2. Recruitment to peer support worker roles (or guidance into alternative opportunities)
3. Ongoing coaching and preceptorship within role

This will be continued to recruit additional peer support workers as part of the new investment within community mental health services. These roles will support people through community and into neighbourhoods (or vice versa) to help people's recovery and for them to live as independently as possible.

The tables below show the existing and new staff investment set out in the Pre Consultation Business Case. We will refresh the workforce modelling for each service as we develop our implementation plans and move on to deliver the investment and service changes.

Central Access Point

	Crisis line	Crisis triage	Investment (£2m)	New team
Medical			0.5	0.5
Psychological			0.1	0.1
Nursing		10.0	26.00	36.0
AHP			0	0
Support	6.0	1.0	18.0	24.0

New Vulnerability Pathway

	Liaison Diversion	Homeless	PAVE	Liaison Diversion investment (£326,000)	Vulnerable people investment (£139,000)	New Vulnerability pathway
Medical	0	0	0	0	0.1	0.1
Psychological	0	0	0	0.5	0	0.5
Nursing	9.0	2.0	0	0.6	2.0	13.6
AHP	0	1.0	0	0.5	0	1.5
Support	2.6	7.53	0	6.6	0	16.73

Emergency Triage Car service

	Existing team	New team
Medical		
Psychological		
Nursing	4.0	4.0
AHP		
Support		

Crisis Home Treatment investment

	Existing team	Investment (£972,000)	New team
Medical	4.0	0	4.0
Psychological	0	0	0
Nursing	54.58	12.5	67.08
AHP	1.0	0	1.0
Support	7.2	13.7	20.9

Crisis Cafés investment in 20/21

	Existing team	Investment (£145,000)	New team
Medical	0	0	0
Psychological	0	0	0
Nursing	0	0	0
AHP	0	0	0
Support	5.4	12.84	18.24

There will be further investment to expand the number of Crisis Cafés over the next three years, over and above this funding.

Core 24 investment

	Existing team	Investment (£532,000)	New team
Medical	2.5	0.5	3.0
Psychological	1.2	0	1.2
Nursing	21.0	5.9	26.9
AHP	1.0	0	1.0
Support	7.4	0	7.4

Mental Health Urgent Care Hub

	Investment in new team (£1,142,000)
Medical	0
Psychological	0.1
Nursing	13.2
AHP	3.1
Support	11.53

Bringing our Community Treatment and Recovery Teams together

The eight Community Treatment and Recovery Teams will bring together siloed teams and further strengthen them with additional investment and integration with wider neighbourhood teams. We will ensure there is a rich MDT team of medical, nursing, advanced practitioners, occupational therapists, psychologists, assistant psychologists and support workers within each team complimented by PCN MH practitioners and local VCS. Our proposal is to use whole team approach across whole networks to support individuals care and recovery all underpinned by a strong formulation coproduced needs assessments and well supervised psychologically informed practice.

The staff will be drawn together into the new models and the augmented with investment in additional staff. The investment will be a mixture of traditional professional roles such as psychological workers, nursing and less traditional peer support workers.

The model to date has been developed through co-design with staff, service users, carers and stakeholders over several years with extensive ongoing engagement which will continue through the transformation.

Wide reaching development and training will be undertaken across all partners for the new model. This will build on existing OD programmes (e.g. PCN OD) and specialist training to provide a mixture of external and local training, team building, education, supervision and pathway leadership (e.g. PD, complex trauma, rehab, psychosis) and focus on:

- structured clinical management approaches (personality disorder pathway)
- multi-modal psychological approaches
- peer support workers (training approach developed across last two years for first cohort will be used to train and recruit c.75 by 2023/24)
- new team working in each local area
- embedding recovery and co-production principles (supported by organisations like ImROC)

This framework will be delivered across the system and tailored in local areas in line with local development plans. These plans will promote recruitment and education to meet the local population diversity and targeted needs.

The tables below show the existing and new staff investment set out in the Pre Consultation Business Case. We will refresh the workforce modelling for each service as we develop our implementation plans and move on to deliver the investment and service changes.

Existing teams being brought together – Integrated Community Teams

	Assertive Outreach	CMHT	CBT	Psycho-Dynamic
Medical	5.1	19.28	1.70	0
Psychological	1.5	8.0	7.80	10.61
Nursing	24.25	65.67	0	0
AHP	0	10.39	0	0
Support	13.1	7.93	0.75	0

Investment in Integrated Community Teams

	Tier 2 Personality Disorder (£600,000)	Enhancing support workers and Peer Support workers (£394,000)
Medical		
Psychological		
Nursing	14.00	
AHP		
Support		16.00

New Integrated Community Teams

	New Integrated Community Teams
Medical	26.08
Psychological	27.91
Nursing	103.92
AHP	10.39
Support	37.69

ADHD

	Existing team	Investment (£399,000)	New team
Medical	2.0		2.0
Psychological			
Nursing	2.0	3.0	5.0
AHP			
Support	4.0	3.8	7.8

Personality Disorders hub and spoke

	Existing team	New hub and spoke team
Medical		
Psychological	16.98	16.98
Nursing		
AHP		
Support		

Enhanced Recovery hub and spoke

	Investment in new team (£777,000)
Medical	1.0
Psychological	3.0
Nursing	4.0
AHP	2.0
Support	6.0

Perinatal hub and spoke

	Existing team	Investment (£1,000,000)	New hub and spoke team
Medical	2.3	1.8	4.1
Psychological	1.85	3.2	5.05
Nursing	8.0	5.1	13.1
AHP	1.0	1.0	2.0
Support	8.0	10.1	18.1

PIER

	Existing team	Investment (£184,000)	New team
Medical	3.8		3.8
Psychological	2.6	1.6	4.2
Nursing	20.8		20.8
AHP	2.9		2.9
Support	10.91	1.0	11.91

Mental Health services for Older People

	Existing team	New team
Medical	8.91	8.91
Psychological	5.6	5.6
Nursing	40.12	40.12
AHP	13.0	13.0
Support	36.28	36.28

Memory Services

	Existing team	New team
Medical	3.55	3.55
Psychological	0	0
Nursing	10.8	10.8
AHP	0	0
Support	12.0	12.0

Apprenticeships and developing our own staff

LPT has an established apprentice framework within the organisation, which has been running for a number of years. The Mental Health Directorate has committed and continues to run first entrance apprenticeship programmes in clinical nursing, therapy and business and administration. This is an annual recruitment process with apprentices being appointed for an 18-month programme.

We work closely with local education providers, we are able to attract young people into mental health services with opportunities to work and learn in key clinical areas such as inpatient nursing, occupational therapy, physiotherapy and in administration roles in clinical and corporate services. On completion of this programme applications are offered opportunities to apply for Level 3 apprentice roles within the service to gain further qualifications.

Apprentice routes to degree qualifications in nursing, occupational therapy, physiotherapy and speech and language therapy are being developed with partners in the university sector. Using this grow your own approach is helping to secure and retain a workforce for our services that meets the changes needs of our population.

This approach is continued into newly qualified staff who, will be recruited to the urgent care pathway and be part of a rotation across the different settings (e.g. Emergency department, Urgent Care hub, central access point, crisis community, crisis cafés). This is intended to increase knowledge, confidence and skills of the workforce and a greater level of consistency across the pathway. It is also to minimise burn out associated with working in intense and high-risk settings / teams.

Education and training requirements

Our proposals include widening the psychological underpinning of our community services and freeing expert clinicians to undertake different roles including training, development and supervising of the wider Community Treatment and Recovery Teams to increase psychologically informed practice.

The main service changes are focused on how teams are organised, who they work with, how they work together and how we invest the additional funds available to increase our workforce. To deliver the changed model we will be running a programme to develop new skills based on:

- Strong and standardised formulation-based assessments
- Whole team working and collaborative care planning
- Recovery approaches as part of focused and strength focused treatment offers
- New pathway approaches

We will be developing a communications approach and joint development sessions to help partners such as EMAS staff, A&E staff, social care to understand our enhanced service offering.

As outlined in the summary of planned changes to wider therapy services, we plan to free more Therapist time to build capacity and resilience in the wider Community Treatment and Recovery Teams, rather than only focusing on therapy interventions. This will support our drive towards more Psychologically informed services delivered by a wider range of staff in the community.

With the changes to the hub and spoke personality disorder pathway and model there will be extensive training and education. Including:

- Structured Clinical Management for community staff
- New tier 3 treatment offers
- Overall pathway principles and awareness training for all system partners, community and inpatient staff (this will be focused on ensuring that system partners provide a consistent management approach with individuals with personality disorder and reinforce engagement in planned service offer)

Part of the Mental Health Investment will be used to support training staff on structured clinical management.

9. Equality Impact Assessment

Post consultation EIA

Leicester, Leicestershire, and Rutland Clinical Commissioning Groups (CCGs) commissioned an Equality Impact Assessment in relation to Step up to Great Mental Health consultation process. The EIA review is a follow up to the original Equality Impact Assessment [EIA] also undertaken in January 2021 by North of England Commissioning Support Unit [NECS].

The assessment is a requirement to assure key decision makers and the population of Leicester, Leicestershire, and Rutland that providers' legal obligations concerning their duties under the NHS Act 2006 and subsequent Equality Act 2010 are satisfied.

The Equality Act 2010 protects people against discrimination, harassment, or victimisation in employment, and as users of private and public services based on nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

The NHS Act 2006 determines that health inequalities must be properly, and seriously considered and respective Clinical Commissioning Groups must have regard to the need to reduce inequalities between patients in their access to health services as well as the outcomes achieved for them by the provision of such health services.

As part of this multifactorial assessment by the CCG, it has a duty to balance all such legal duties and make conscious effort to mitigate any potential negative impacts upon those from protected groups.

The original EIA conducted by NECS was seen by external independent parties as a good foundation from which to build the formal public consultation some months later. The public consultation was aimed particularly at reaching diverse communities and to understand equalities/inequalities issues. It was undertaken during a long-term pandemic and extensive mechanisms were put in place to reach out to communities and inform them of the proposals and how to offer their views.

Midlands and Lancashire CSU [MLCSU] were commissioned to support the public consultation and this helped to ensure learning was taken from another major programme of development concerning Acute and Maternity services. The CSU produced a comprehensive report of findings encapsulating a full analysis of responses from the diverse communities within Leicester, Leicestershire, and Rutland.

The follow up assessment was undertaken by the same subject matter expert as the original EIA from North of England CSU [NECS] to aid continuity from the original recommendations.

The findings endorse the recommendations of the earlier assessment and applaud the CCGs and the Trust's ongoing efforts to further reach out to, and take into consideration, the diverse population of Leicester, Leicestershire, and Rutland. It is acknowledged that these efforts are ongoing and are expected to develop further over coming weeks, months and years throughout the design and delivery phase of the programme.

Opportunities will arise to capitalise on successes to date and purposefully engage with Leicester, Leicestershire, and Rutland's population, in designing services that attracts inward investment and are 'owned' by its communities.

Whilst recognising and respecting difference of opinion and geographical variation, the EIA review concludes that the proposals attracted significant endorsement and have ably considered most of the population's needs. There is also clear evidence of a desire to continue to work with the community and partner organisations.

Conclusions

The findings of this reassessment conclude that:

1. LLR CCG and LPT have both demonstrated significant respect and understanding in their discharge of their Equality Duty and the wider duties to reduce inequalities conferred on the CCG under the NHS Act 2006.
2. The efforts throughout what was a challenging period for a consultation, have been immense and creative. This generated significantly valuable feedback and there is clear evidence this is being actively used to inform continued collaboration.
3. Analysis suggests respondents appear to reasonably represent the demographic profile of the county and are in the main, supportive of the proposals.
4. Engaging subject matter experts in the design of processes to enhance engagement and use today's technology to its full potential, is to be commended.
5. Engagement with diverse communities that has now commenced, is appropriately regarded as a steppingstone, is ongoing, and yet to grow to its full potential. The opportunity is there to build upon successes and enhance this further.
6. The value of material arising from the views of the local and diverse population of Leicester, Leicestershire and Rutland is potentially rich, and to be capitalised upon. Feedback will inform decisions over many years to come. Those decisions are based upon the belief that service providers are accountable to the population they serve in promoting equality, reducing inequalities, determining resource allocation in modernised, cost effective and efficient ways.

Recommendations

The independent EIA review recommends the following:

1. The intelligence and guidance achieved to date is a rich learning opportunity for the future; it is acknowledged that the results of the consultation are being shared widely and whilst doing so, recommends communities are formally thanked for their contribution.
2. Build upon the relationships and alliances that have already established through the consultation, by enhancing the current arrangements to create genuine and sustainable partnership arrangement with the voluntary and community sector. Where mutually agreeable, partnering during the co-design, implementation phase; post-project evaluation and beyond to find lasting solutions to issues on an ongoing mutual basis.
3. Empower communities and capitalising on front line NHS staff being members of such communities, maintaining an understanding and support of protected groups through long term collaboration.
4. Apply the same rigour of focus, devoted to the communities served, to staff and the organisations ways of working.
5. Ensure the Trusts staff education and training programme is inclusive of understanding beliefs and values of different communities and of a broad cultural education.

6. Persevere, to engage under-represented groups in co-design and implementation phases.
7. Develop a plan for digital enablement and health literacy, to appropriately support the delivery of treatment and use of digital tools across communities.
8. Aspire to be an exemplar system for health inequality through collaboration with communities.

We are recommending that the CCG Board accept all the above EIA recommendations with a particular focus on travellers in recommendation 6.

10. Implementation plans

The next phase of the programme will be to coproduce implementation plans with service users, carers, local communities, staff and stakeholders. The consultation process has given us a rich set of comments to feed into the implementation planning stage.

Some of the UEC MH pathway changes have already been made under national direction, on a temporary basis, as a response to Covid.

Themed challenges

There are a number of themed challenges that fall out of the consultation that will need to be addressed in the implementation planning and delivery stages. These are summarised below.

Workforce supply

Increasing the workforce is a component of the proposals. There is a national shortage of professional mental health roles, with all systems describing significant recruitment challenges. This poses a risk to the delivery and the timeliness of the proposed changes. The risk is intended to be ameliorated through a system-wide mental health workforce planning and development group as part of the new Integrated Care System. It will focus on strong recruitment campaigns based on national best practice, streamlining recruitment processes, introduction of new alternative roles that are being nationally developed and new 'grow your own' schemes across professional groups. We have set aside an initial £30,000 to support this work with the potential of increasing funding as required.

Adopting new ways of working Team building and wider OD

Delivery of the proposal will require new teams to come together and operate differently to current services. This includes working to a greater degree with local communities and services that they support. There is a risk that these changes will not be fully realised without adequate development of both staff in the changing services and the staff currently operating in local areas such as GPs. This risk is intended to be mitigated through a structured programme of organisational development for all relevant staff (both those directly affected by the change and staff that interact with the changed service). We have set aside £50,000 to set up and run this structured programme.

Co-production

A consistent theme of feedback from the consultation engagement related to the diversity and differences in the various communities within Leicester City, Leicestershire as an overall and in Rutland. There is a risk that application of any proposed changes would not work for, or be accessed by, all communities unless it is designed and developed with those communities. The risk is intended to be mitigated through ongoing investment in voluntary sector to support co-design of the

changes as they are put into practice within each local area. We have set aside an additional £50,000 to support this.

Maintaining safety care of existing service users and individuals waiting for services

Delivery of the proposal will involve bringing together teams and the organisation of services. There is a risk of a disruption to existing service user care. To mitigate this risk, existing service users and those currently waiting for services will be actively tracked and monitored using go-live triggers. These triggers will be markers of safety, quality and purposeful activity for those individuals. They will be used to promptly identify and mitigate any safety concerns that arise. These will be overseen by established quality and safety forums for each service area.

11. National reconfiguration tests and governance

National reconfiguration tests

The government's four tests of service change are:

- Strong public and patient engagement.
- Consistency with current and prospective need for patient choice.
- Clear, clinical evidence base.
- Support for proposals from clinical commissioners

The fifth test introduced in April 2017 that relates to significant bed reductions is not applicable for these service changes which focus on UEC and integrated community provision. We are developed other plans to replace dormitory accommodation with single rooms, but they are subject to a separate bidding process to NHS England and the changes in this DMBC are not reliant on those changes.

Strong public and patient engagement

We are able to demonstrate that this test has been met. The national guidance focuses on three areas to address to demonstrate that this test is met:

- Consultation and communication plan
- Consultation document
- Support from the joint Health Overview and Scrutiny Committee (HOSC)

Chapter four sets out the engagement that was undertaken over the last three years to develop our plans. The Clinical Senate paid credit to the system for the collaborative co-production approach to developing our plans. The joint HOSC also noted our approach.

We involved a number of local VCS groups focused on equality in the Equality Impact Assessment process.

We received an excellent response to the consultation with over 6,500 responses. This was compromised of 3,635 completed online main questionnaires, 212 completed postal questionnaires, 205 completed online easy read questionnaires, 41 completed postal questionnaires, 41 correspondence (letters and emails). There were also 2,516 participants/focus groups and one-to-one interviews across 164 events.

Consistency with current and prospective need for patient choice

The national service reconfiguration guidance focuses on two areas to confirm that this test has been passed:

- Impact on patient choice considered
- Equality Impact Assessment completed

Our plans seek to improve the options open to service users, to make a shift between services easier and quicker, and to replace poor and inappropriate routes of access. Our plans also seek to remove

long waits for the services that we agree to provide to service users. We have set out our plans to work with a broader range of community partners to expand the treatment and recovery options available to the population we serve.

As part of our implementation plans, we will review the treatment offer for all service users facing a long wait and confirm with them whether to move to an appropriate alternative or to continue to wait for a service. We have committed to honouring previous service users' choices for treatment.

We have set out in chapter nine the post-consultation Equality Impact Assessment review undertaken on the consultation process which includes the positive conclusions from the CSU and a set of recommendations for future work. We have recommended in chapter 12 that the EIA future recommendations are all agreed by the CCG Boards.

Clear clinical evidence base

Chapter three sets out the case for change including detailed references to the national policy, guidance and best practice that our plans will deliver in the LLR system. We have had a successful Senate review that noted the clear link that our proposals have with relevant national strategies and investment plans. We included the Senate report as an appendix to the Pre-Consultation Business Case.

Support for proposals from clinical commissioners

The Step Up to Great mental health programme is the CCG and ICS system plan to improve mental health provision in Leicester, Leicestershire and Rutland. We have presented updates and draft documents to the CCG Board, and they are strongly supportive of these investment and improvement plans.

We have strong support from GPs to implement the national Integrated Community Mental Health framework taking services closer to communities. We have strong support to develop a more integrated Urgent and Emergency Mental Health pathway that focuses on earlier intervention, self-referral and support outside of A&E and the criminal justice system, while at the same time improving the experience for people who do enter the system through A&E or through contact with the police.

The CCG Board reviewed the final draft version of the Pre Consultation Business Case, the consultation plan and document at their Board meeting on 9 March and supported the move to NHS England assurance.

The NHS England assurance review took place on 31 March 2021. A set of submissions were made to NHS England. Four follow up questions were answered. The additional information provided to NHS England has been incorporated into the final DMBC.

A team led by Angela Hillery, LPT CEO, and Andy Williams, CCG AO and ICS AO, met with NHS England on 31 March for an assurance panel. The feedback on the day and subsequently was very positive. The written material and coherence of the plans was described as exemplary. The panel Chair noted that he had no concerns, that the LLR system had come across well in articulating coherent plans and that the programme met all of the Government's reconfiguration tests.

An updated Pre Consultation Business Case and final consultation documentation and plan were approved by the LLR CCG Board on 10 May.

The CCG Board have received regular updates on the consultation process. The CCG Board will review the CSU Report of Findings, the updated Equality Impact Assessment and this Decision-Making Business Case at their December 2021 meeting.

Governance - Step Up to Great Mental Health

Step Up to Great Mental Health is the Leicester, Leicestershire and Rutland (LLR) ICS programme designed to improve mental health services in the region. The Step Up to Great programme is led by the LLR ICS through their Mental Health Partnership Delivery Board which is chaired by the Chief Executive of Leicestershire Partnership NHS Trust.

The Leicestershire ICS has established a Mental Health Partnership Delivery Board. A key deliverable for that ICS Board is to progress a programme of service model changes to the provision of adult mental health in Leicestershire.

To progress the work on the clinical and operational models, a business case, engagement, communication, consultation and the required assurance, the All Age Mental Health Design Group established a Steering Group.

This joint commissioner and provider Steering Group meets monthly and provides progress updates to the ICS Mental Health Partnership Board. The Steering Group makes recommendations for key decision to the ICS Mental Health Partnership Board, Trust and CCG Board.

12. Recommended decisions

Decisions relating to the consultation

The CCG Board is asked to take the following recommended decisions:

	Service we consulted on	Recommended decision
1	Provide an additional comprehensive suite of self-help guidance and tools	a) Agree to provide a comprehensive suite of self-help guidance and tools in one place online, while making the material available in printable format. b) Agree to address the feedback on the type and simplicity of the information, and access routes to the information with the support of a service user advisory group and wider engagement as we develop and implement our plans. c) Agree to provide support to find and understand the information via the Mental Health Central Access Point for people unable to navigate or understand the information on the website. d) Agree to share a QR code on posters and business cards in a wide range of settings including GP practices. e) Agree to pilot the use of publicly accessible IT terminals to access the self-care guidance.
2	Introduction of a Central Access Point	a) Agree to make the Central Access Point permanent. b) Agree to address the consultation feedback on promotion and awareness of the CAP, access routes for vulnerable groups, interpreter and BSL support, improving responsiveness and performance standards as part of the implementation and further development phase. c) Agree to develop the service to provide support to families and carers. To support this, the CAP and the Urgent and Emergency Care Steering Group will be expanded to include family and carer representatives to develop and test material. d) Agree to undertake a review of demand, capacity and workforce models alongside the potential use of technology to improve the support offer. The review of capacity will include modelling the workforce required to introduce a call-back service and a text access route.
3	Expand the number of Crisis Cafés	a) Agree to open a further 22 crisis cafés in community locations in Leicester, Leicestershire and Rutland. b) Agree to work with local communities and voluntary and community groups to identify suitable locations, to co-design appropriate support offers considering diversity and

	Service we consulted on	Recommended decision
		ethnicity, co-location of other services and to link with wider community assets. Developing an appropriate local offer in each neighbourhood. c) Agree to work with local communities and service user groups to inform the names of the Cafés to identify a different term or terms for the cafés.
4	Improve and expand the Crisis Service	a) Agree to improve and expand the Crisis Service in Leicester, Leicestershire and Rutland as set out in the Pre Consultation Business Case. b) Agree to promote the range of Urgent and Emergency Care (UEC) services and build awareness of the support available across the pathway. c) Agree to work with the UEC service user group to consider options to improve communication with service users and their families as part of our implementation and on-going review processes.
5	Introduce an Acute Mental Health Liaison Service	a) Agree to create an Acute Mental Health Liaison Service by joining together the existing teams and basing them at Leicester Royal Infirmary close to the emergency department. b) Agree to address the feedback on promoting the service to UHL staff and building awareness of all wards and departments through implementation. c) Agree to provide support and development training to acute hospital colleagues including to A&E staff in mental health awareness.
6	Establish a Mental Health Urgent Care Hub	a) Agree to make the Urgent Care Hub permanent and to undertake an options appraisal on whether to maintain the Hub at the Bradgate Unit in the longer term. b) Agree to include staff training in customer care to strengthen the nature of the welcome at the Urgent Care Hub.
7	Expand the hours that the Triage car is provided	a) Agree to expand the hours of the Triage car service and to expand the joint working with East Midlands Ambulance Service. b) Agree to develop further mental health awareness training alongside the police and ambulance services.
8	Intensive support to vulnerable groups	a) Agree to implement the investment and recruitment plans set out in the consultation, focusing our implementation plans on effective collaboration between the teams coming together.

	Service we consulted on	Recommended decision
9	Create eight Community Treatment and Recovery Teams focused on adults and eight Community Treatment and Recovery Teams focused on older people	a) Agree to move eight Community Treatment and Recovery Teams for adult mental health with eight dedicated teams for Older People's mental health operating on the same geographic footprints. b) Agree to undertake dedicated engagement in each locality to agree the working hours that best meet the need of the local population. c) Agree to focus implementation plans on existing service users and managing their care during the period of transition. These plans will be linked to specific quality and safety triggers to be applied during the implementation phase.
10	Dramatically cut waiting times to access Personality Disorder Services	a) Agree to the investment and expansion to the Personality Disorder service set out in the Pre-Consultation Business Case focusing on integration with other services.
11	Expand the service available for perinatal women from pre-conception to 24 months after birth	a) Agree to the investment and expansion of the perinatal service including doubling the period of support from 12 months to 24 months after birth. b) Agree to develop specific implementation plans to reflect the diverse community and work with relevant community groups to build awareness and access to the support on offer.
12	Improve the support for women who are experiencing trauma and loss in relation to maternity experience	a) Agree to the investment and expansion of the maternal outreach service including the development of support services for fathers and partners. b) Agree to address the suggestions of training on cultural diversity and incorporating multicultural practices through the implementation plans.
13	Improve psychosis intervention and early recovery service	a) Agree to support the investment and service change plans to improve psychosis intervention and early recovery, set out in the Pre-Consultation Business Case.
14	Enhance the memory service introducing different ways of providing the service	a) Agree to the investment and improvement proposals relating to the Memory Service, set out in the Pre-Consultation Business Case. b) Agree that provision via digital means will be an option rather than the only route to Memory Services and that service users will be able to choose the vehicle that suits them best.

	Service we consulted on	Recommended decision
15	Establish an Enhanced Recovery Hub team	a) Agree to establish an Enhanced Recovery Hub team and to develop the services, as set out in the Pre-Consultation Business Case.
16	Telephone and video-based services	a) Agree to continue to offer and develop telephone and video-based services as an option for service delivery. b) Agree that the use of telephone and video as a vehicle to interact with service users will be offered a choice determined by the service user. c) Agree to pilot the use of publicly accessible IT terminals to access the self-care guidance.

Decisions relating to overall consultation feedback themes

1	Working with local communities, voluntary and community sector	Agree to apply the principles set out in chapter 7 on the role of the VCS in implementation planning, co-production, making the service changes and in the on-going delivery of these services.
2	Working with carers	Agree to apply the principles set out in chapter 7 in our work with carers and with VCS groups acting as advocates of carers to ensure that the service improvements align with carer needs and are co-produced with their support.

Decisions relating to the Equality Impact Assessment

The CCG Board is asked to take the following recommended decisions:

	EIA recommendation	Recommended response
1	The intelligence and guidance achieved to date is a rich learning opportunity for the future; it is acknowledged that the results of the consultation are being shared widely and whilst doing so, recommends communities are formally thanked for their contribution.	Agree
2	Build upon the relationships and alliances that have already established through the consultation, by enhancing the current arrangements to create genuine and sustainable partnership arrangement with the voluntary and community sector. Where mutually agreeable, partnering during the co-	Agree

	design, implementation phase; post-project evaluation and beyond to find lasting solutions to issues on an ongoing mutual basis.	
3	Empower communities and capitalising on front line NHS staff being members of such communities, maintaining an understanding and support of protected groups through long term collaboration.	Agree
4	Apply the same rigour of focus, devoted to the communities served, to staff and the organisations' ways of working.	Agree
5	Ensure the Trust's staff education and training programme is inclusive of understanding beliefs and values of different communities and of a broad cultural education.	Agree
6	Persevere, to engage under-represented groups in co-design and implementation phases.	Agree
7	Develop a plan for digital enablement and health literacy, to appropriately support the delivery of treatment and use of digital tools across communities.	Agree
8	Aspire to be an exemplar system for health inequality through collaboration with communities.	Agree

Appendices

1. CSU Report of Findings
2. Equality Impact Assessment report

Version 12

06/12/2021

THE END