NHS
NHS West Yorkshire
Integrated Care Board

Health and Adults Social Care Scrutiny Panel

Mental Health & Wellbeing

Data & Intelligence Pack

August 2024

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Kirklees
Health & Care
Partnership

In response to the questions raised by the Health and Adults Social Care Scrutiny Panel the following slides aim to give an overview and update on previously presented information to the committee and also address specific questions that have been posed.

This is a system response from :

- Kirklees Health & Care Partnership
- Kirklees Council
- South West Yorkshire Partnership Foundation Trust

This data pack does not aim to cover:

- Children and Young People (with exception to the community PCN model)
- DOLS in relation to anything other than Mental Health Illness

Section 1

Current position in Kirklees

Current position in Kirklees

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The Kirklees Health & Wellbeing Strategy highlights the **AMBITION:**
Everyone in Kirklees achieves good mental wellbeing and has a good quality of life with purpose and fulfilment throughout their lives.

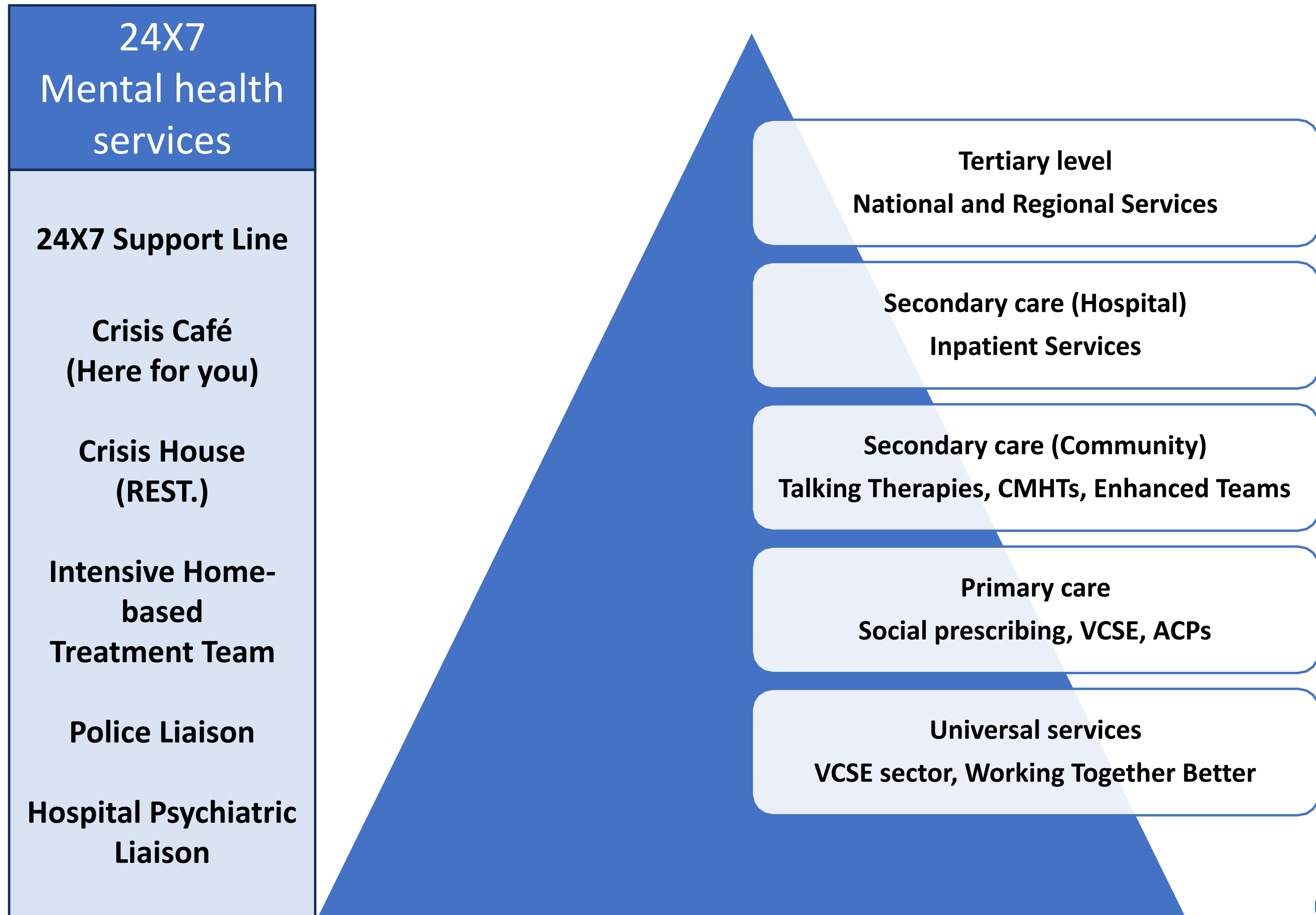
There is no health without mental health.

- People with good mental wellbeing are more likely to feel able to engage and contribute to their communities
- There is a reciprocal relationship between being lonely and the development of mental health problems.
- If more people in Kirklees are equipped to cope with the challenges of life; less people reach crisis point
- CLIK (Currently Living in Kirklees) survey (2021) showed that anxiety and depression are the two most common long term health conditions
  - 1 in 8 adults aged over 65 years reported experiencing anxiety or depression
  - 1 in 4 adults aged under 65 years reported experiencing anxiety or depression
- People with serious mental illness, die on average, 15 years earlier than those without serious mental illness
- Personal financial pressures increase stress and persistent stress can trigger or worsen mental wellbeing
- Financial instability and poverty can increase suicide risk

Section 2

Availability of mental health support

Pyramid of mental health support



Section 3

Community Offer

The ambition

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The original ambition was to embed mental health services within Primary Care Networks by 23/24:

- We have successfully mobilised and implemented phase one of the model and are now developing phase two for 24/25
- The diagram on the next slide demonstrates those roles already successfully implemented in green. New roles can be seen in blue
- This is a complex programme of work and celebrates partnership working with a wide range of stakeholders and ultimately delivers mental health services at a primary care level
- We are in year two of a three-year formal evaluation process across West Yorkshire and in each place

Mental Health Transformation Primary Care Network (PCN) Hub 24/25

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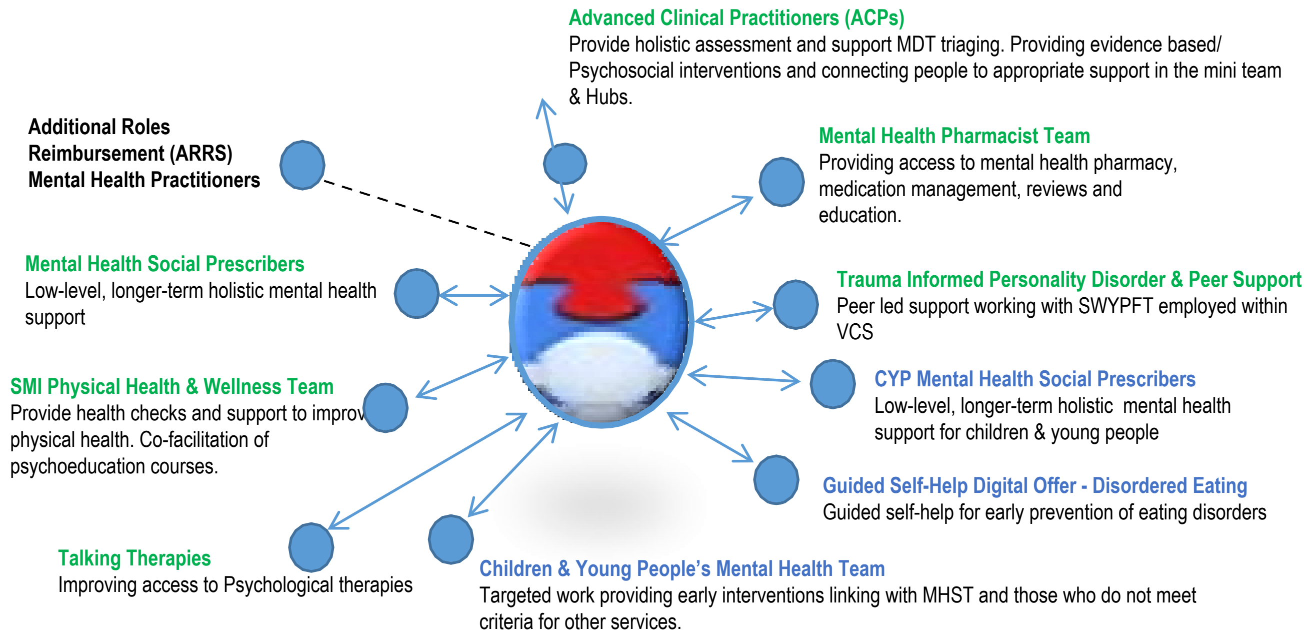

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Phase 2 - Mental Health Hub PCN model(2024)

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Implementation	
Role	**Stage**
CYP Mental Health Social Prescribers	Procurement
CYP Mental Health Team	Launch 1st September
TIPD Peer Support in Recovery College	In place
Disordered Eating guided digital self-help offer	Procurement live

Disordered Eating Guided Self-Help digital offer

- Access to psychologically informed guided self help
- Peer support and carer support
- A digital, face to face and phone offer
- Training and education offer to Primary Care colleagues
- Evaluation of gaps and need with a focus to address health inequalities and barriers

Disordered Eating Guided Self-Help digital offer

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- Consistent offer across Kirklees and Calderdale

- Available for 18+

- Review after year one to identify additional need/gaps

- Link to new roles within the transformed mental health PCN model

Children, Young People's Mental Health PCN offer

- Provide specialised mental health assessment to CYP's in primary care
- Provide low level techniques to manage first episode mental health concerns
- Support GPs in management of CYP's mental health.
- Reduce service gap
- Support new models of care putting patient first and at the centre

TIPD peer support within the Recovery College

- Provide peer to peer ‘lived experience’ support
- Enable recovery which involves a process of growth and transformation as the person moves beyond a period of acute distress (often associated with complex emotional needs)
- Develops a focus on new-found strengths enabling self-management and building resilience

Community Pathways 1

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Community services provide assessment, care management and interventions utilising a range of innovative means of communication and ensuring face to face contacts are made wherever these are clinically indicated.

Work continues in front line services to adopt collaborative approaches to care planning, build community resilience, and to offer care at home. This includes providing robust gatekeeping, trauma informed care and effective intensive home treatment. Teams are working closely with the acute pathway to tackle barriers to discharge, reduce the demand for out of area placements and to ensure purposeful admissions and timely returns to the community.

We continue to work in collaboration with our places to implement the community mental health transformation. We are looking at the core and enhanced pathways in terms of local place and the trust offer, to ensure we optimise our opportunities for innovation, effectiveness and partnership working and that we achieve the best model possible for our service users and carers.

Kirklees Health & Care Partnership

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Community Transformation in Kirklees

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SWYPFT have been working closely with the Kirklees partnership to help design, recruit and support roles that form part of the new community transformation model.

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By 2023/24 the programme will ensure that each Primary Care Network will benefit from a co-located, mini-mental health team, working together to provide a seamless service with interventions of varying intensity, appropriate to the individual level of need – with integrated pathways to the core specialist hub

Phased transformation & Integration of current mental health service:
Core/enhanced SWYPFT service (into PCN mini teams & Hubs)
Recovery College & services
VCS contracted services

Mental Health Social Prescribers
To provide mental health knowledge /expertise

Physical Health Coaches – (New Role)
Provide health checks and support to improve physical health. Co-facilitation of psychoeducation courses.

Mental Health Peer support Workers
Workers within teams – individuals with lived experience

Advanced Community Practitioners (ACPs)
Provide holistic assessment and support MDT triaging. Providing evidence based/ Psychosocial interventions and connecting people to appropriate support in the mini team & Hubs.

Mental Health Pharmacist – (New Role)
Providing access to mental health pharmacy, medication management, reviews and education.

Community Connectors (New Role)
Employed within VCS – to reflect community demographics, these roles are more focused on the specific needs of people with serious mental illness and complex needs.
Navigating through a range of activities to support wellbeing, connecting people with their community and supporting the transfer of stable individuals out of Recovery and Older Adults Teams enabling them to engage with and receive community support.

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Community pathways (2)

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Community teams are experiencing significant workforce challenges, we currently have higher than usual levels of vacancies in community teams for qualified practitioners and proactive attempts to fill these have had limited success. We have action plans in place for teams where there are particular challenges and continue to be proactive and innovative in our approaches to recruitment for example the introduction of Trainee Nurse Associate roles in Kirklees following new investment by commissioners.

We are experiencing challenges after a period of sustained increased demand. This has lead to pressures in Single Point of Access (SPA) necessitating the use of additional staff and sessions for assessment slots. Workforce challenges are continuing to compound these problems. SPA is prioritising risk screening of all referrals to ensure any urgent demand is met within 24 hours, but routine triage and assessment is at some risk of being delayed. The situation is being kept under close review by General Managers and teams and all possible mitigations are in place.

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Section 4

How can people access services

Access of mental health support

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Access for all via:

- Doctor's Surgery
- Voluntary Sector
- Digital programmes
- Recovery College
- 111
- A&E onward referral
- Self help

These can be accessed via the web, telephone or in person.

Specialist access:

- Secondary care
- Tertiary services such as chronic fatigue

These can be accessed by referral from GP or another route such as IFR.

Partnership working

Working Together Better Partnership -VCSE update

What mental health support in the community via the partnership?

- WomenCentre
- Richmond Fellowship project
- Support 2 Recovery (S2R), including The Great outdoors (TGO)
- Hoot
- Cloverleaf Kirklees Advocacy
- Carers Count
- CLEAR
- Active for Life (via Wellness service)
- Brain in Hand app

Working Together Better Partnership -VCSE update

What type of mental health/wellbeing support is available in communities via the partnership?

- Indoor and outdoor activity
- Employment support
- Specialist and creative women's services
- Peer support
- Volunteer support/access to volunteering
- Creative writing, singing, visual art, music and digital music across Kirklees
- Growing projects and nature based wellbeing
- Statutory mental health advocacy (IMHA) for people detained under the Mental Health Act
- Non-Statutory community mental health advocacy for people who have mental health and struggling with access to services

Working Together Better Partnership -VCSE update

How do the community access the support they need?

- By attending groups at centres or out in the community
- Online via: interactive groups, YouTube how to, Facebook, Twitter etc, What's App /Zoom support groups.
- Signposting
- Via self or professional referral
- Drop ins and welcome sessions

Are there any gaps which the partnership encounters, in the support you're able to give?

- People wanting more out of hours support
- Increased demand for befriending
- Waiting lists for carer's breaks
- Demand for counselling

Our Approach to Commissioning with VCSE Partners

The VCSE sector in Kirklees is an integral part of the Kirklees H&C Partnership.

This is reflected in:
The Health & Care Plan:
The role of the VCSE is integral to the delivery.
The plan also explicitly includes the identified risks to the sustainability of the VCSE sector.
Our ways of working,
VCSE having strong representation on ICB Committee, H&C Partnership Forum, Delivery Collaborative, Workforce Steering Group, Mental Health Collaborative, and Communications and Involvement Network.
Our Kirklees VCSE Investment Strategy
has been signed up to by the H&C Partnership, in line with the 7 agreed actions.
Delivery of the Strategy is supported by the Kirklees Third sector leaders Infrastructure Alliance

Our Inclusive Communities Framework,
developed in conjunction with the VSCE, sets out our ambitions for working with the VCSE and communities.
Our work with the sector
to work better with communities through our Community Voices and Community Champion programmes [which includes infrastructure & scheme financial support]
Recognising and supporting the VCSE as partners:
to commission and deliver services. For example via our Mental Health Collaborative and increasingly through the ongoing development of our Well Programmes

Our Approach to Commissioning with VCSE Partners

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we recognise the financial challenges facing our VSCE sector, and that the challenging financial position of both the ICB and LA will impact on this both in terms of commissioned services and infrastructure support. With this in mind, we used our Kirklees ICB Committee Development Session in Oct 2023 to focus on how we work with our VSCE including future challenges and opportunities. In addition we have established relationships at a senior level with Third Sector Leaders Kirklees and an ongoing dialogue around this.

So recognising that this is not easy, steps we are taking include:

- through the disinvestment protocol we have explicit reference to consider the impact on VCSE – including proportionality principles.
- Being open, honest, and transparent with each other so that we are having meaningful, if sometimes difficult, conversations
- Mapping current spend with the VCSE. (high level info attached). - The existing mapping has already identified some areas where we can make improvements, for example around simplifying payment arrangements.
- Prioritising key areas of work to help to ensure financial stability. For example, our Community Champions moving from a non-recurrent funding.
- Working with system partners to maximise the total value of local funding and minimise duplication.
- In line with our H&C Plan, maximise the input of community and VCSE organisations where they can add most value to our priorities. For example with the work we are doing with Sport England, where they have a vital role in working with communities.

Developing other ways to support the sector ,that may not be explicitly about direct funding. This includes:

- by supporting our staff to develop closer links with the sector. A number of organisations in our H&C Partnership have staff volunteering schemes which allows their employees to support VCSE organisations.
- working with our Power of Communities Programme to help to develop a scheme for the ICB and are looking to pilot this in Kirklees [subject to this being approved]
- The objectives of Keep it Local are very similar to those already across the Kirklees Health and Care Partnership. So this is about where it can help us move forward with these, rather than separate areas of work.

Working Together Better – Q4 referral sources

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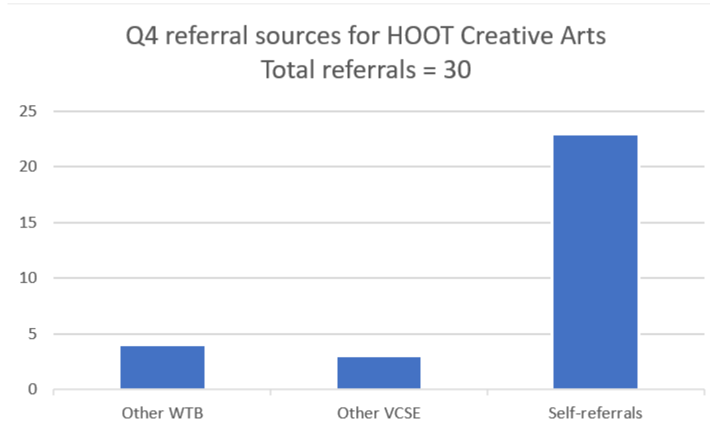

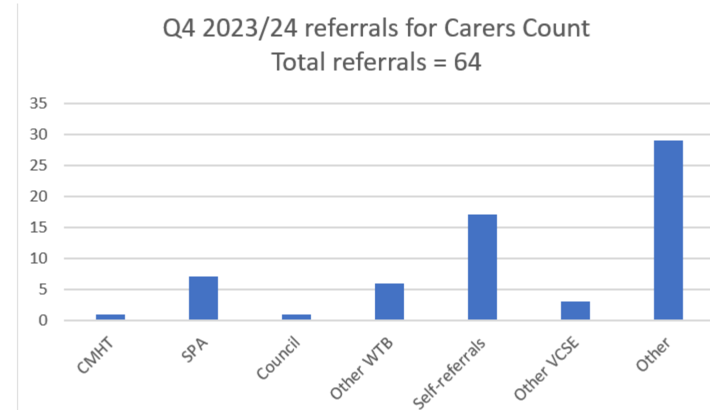

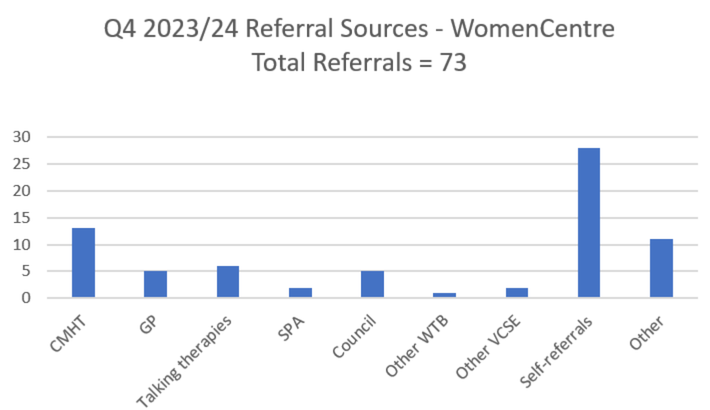

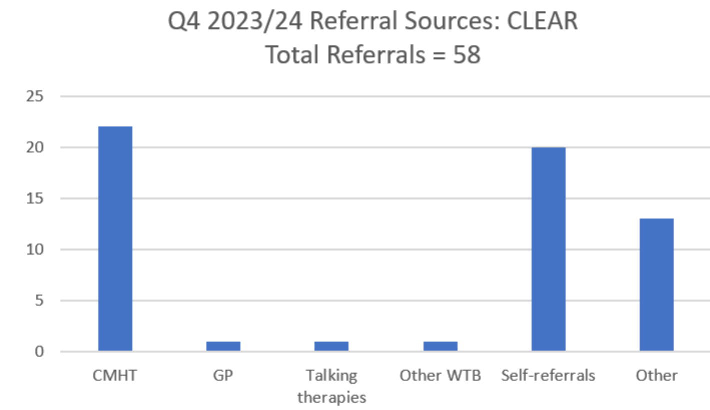

Partnership working

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- Bringing together the skills and expertise of the workforce enhancing the quality and consistency of services across Gateway / SPA, Core, Enhanced and the Social Care Hub.
- Clearly defined roles and responsibilities across to promote a clear social care identity and true multi-disciplinary working.
- Strong focus on Care Act 2014 compliance within the comprehensive Mental Health Assessment, quality improvement and awareness of safeguarding and self-neglect pathways.
- Reduced duplication of work and 'hand offs' for service users, preventing unnecessary movement around a complex system, and avoidable hospital admissions and reducing patient waits.
- Delivery of strength-based approaches and practice.
- Improved managerial authorisation processes to ensure the most appropriate use of resources.
- Development and nurturing of a skilled work force with a training package suitable to their needs, ensuring accountability and recording on council systems.
- Provision of a system by which cases can be discharged from secondary mental health, but still reviewed regularly to ensure care and support needs were being met.
- Reduced use of inappropriate residential placements.

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Section 5

Talking Therapies

Talking Therapies

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- 100% of people who are referred into IAPT wait less than 6 weeks for their first assessment, which is over the national wait time target of 75%
- Within IAPT there are 2 main treatment options
    1. Low intensity cognitive behavioural therapy (CBT) - Guided self-help / Computerised CBT/ groups
    2. High intensity – CBT, counselling for depression, EMDR, couples therapy for depression and interpersonal therapy.
- There are no wait times for low intensity - with people accessing treatment immediately following assessment

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Talking Therapies pathways (2)

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- Wait times for high intensity are grouped together - the performance target is that less than 10% of people should wait for more than 90 days to start treatment.

Q1 performance

Measure	Target	Quarter 1
Access treatment within 90 days (2nd contact)	90%	70.74%

- People accessing high intensity treatment are waiting longer due to workforce pressures and difficulties in recruiting to qualified therapist positions – this is a national challenge and not specific to Kirklees
- Some people wait longer because they have specific choices for example – a male therapist or a particular location.
- Everybody waiting for therapy has had an assessment of their risk and are offered psychoeducational material.

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Access and assessments

Access to services

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Routine access within 14 days is being managed well across the teams with performance currently averaging 81% (430 average) for referrals seen within that time, despite some challenges in SPA in terms of capacity and managing demand. The service continues with business continuity measures and a quality improvement plan.

Access into treatment in 6 weeks has been 89% (190 average) This is following an improving trajectory of performance, due to high demand in SPA, challenges within enhanced teams and pressures in arranging timely outpatient appointments.

We are currently following a 6-step quality improvement approach guided by data and community insight that aims to improve waiting times and improve access:

- Develop guiding principles for waiting well waiting fair
- Use learning from improvement projects - Reduce waits through service QI activity such as LEAN processes, managing DNAs
- Improve support whilst waiting (waiting well) and consolidate operational innovations
- Gain understanding of the wider determinants and what we can do to reduce inequalities (waiting fairly)

Number of referrals received into the Kirklees SPA (23/24)

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Referrals to SPA Split by Month - Kirklees Place

Year	Month	Referrals
2023	Apr	635
2023	May	496
2023	Jun	1096
2023	Jul	686
2023	Aug	756
2023	Sep	788
2023	Oct	957
2023	Nov	763
2023	Dec	692
2024	Jan	868
2024	Feb	782
2024	Mar	748

Breakdown of referrals by source 23/24

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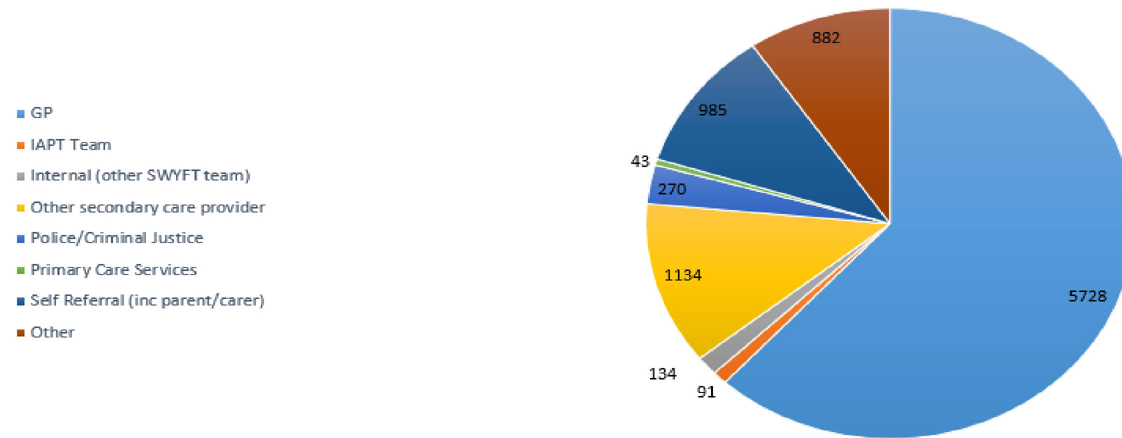

Over the Last 12 Months

61.8%

of referrals were from GPs

and

10.6%

were self referrals

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Section 6

Self-referrals and referrals from GP for mental health assessments

Section 7

NHS and other providers

Independent Sector

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- Tertiary services such as chronic fatigue in Leeds, specialist eating disorders in Leeds
- Accommodation services
- Mental health secondary care services are subject to choice
- Boundaries for example those living in Scissett choose South Yorkshire services
- Reasons behind choice can include:
  - Longer waiting times
  - Peer support (ADHD/ASD)
  - Boundaries
- We receive very little through the Individual Funding Request (IFR) process

Section 8

DOLS

Section 9

Crisis referrals, access & workload

Crisis referrals

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IHBT and Mental Health Liaison are 24/7 services working with the most vulnerable service users and those most at risk: ensuring safe and effective care at home for those people who would otherwise need admission to hospital.

MHLT work in acute hospitals offering assessment and interventions with service users presenting with mental health challenges in Accident and Emergency departments and inpatient wards

IHBT undertake a gatekeeping function for all inpatient beds.

The teams consistently meet the key performance requirements.

They continue to experience a high level of demand:
Kirklees IHBT referrals - average per month; 2022/23 = 125 2023/24 = 101 2024/25 = 94
Kirklees MHLT referrals: average per month; 2022/23 = 289 2023/24 = 293, 2024/25 = 307

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Intensive home based treatment team update

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- The intensive home-based treatment team works with the most vulnerable service users and those most at risk, ensuring safe and effective care at home for those people who would otherwise need admission to hospital.
- They provide a 24/7 service.
- They undertake a gatekeeping function for all inpatient beds.
- The teams consistently meet the key performance requirements, which include time to contact – 4hr to assessment for crisis referrals and follow-up with 72hrs of people leaving a mental health ward.
- The team average 106 referrals a month and provide on average 615 contacts with service users per month. (three-year data)
- The team have recently increased its consultant psychiatrist establishment to two WTE which is supporting the needs of service users and the team.

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Crisis pathways: partnership working in Kirklees

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NHS Foundation Trust

Collaborative working - residents of Kirklees are able to access a 24/7 mental health support line when they need support. Provided as part of a West Yorkshire ICB initiative the support line offers support when needed or signposting to an appropriate local service. Additionally, there is a separate Bereavement line (previously known as the West Yorkshire Grief and Loss line) which operates between 8am and 8pm, and this was established as part of the health and care response to Covid.

Mental health teams from across the Kirklees Health and Care Partnership and the 3rd sector have worked together to establish a crisis house which acts as a short term (up to 7 days) residential placement when the individual is unable to remain at their home but, following an assessment by the Intensive Home-based Treatment Team, requires a level of support which can safely be provided at the crisis house rather than a hospital setting.

Residents of Kirklees have access to the Here For You service which is run by Touchstone. It's a phone and place-based service which currently operates 6pm to midnight 7 nights a week. It helps people in person or on the phone with their crisis. The team follow-up with their guests on the next working day to check in with people and help with signposting or ongoing support to maintain wellness.

We have introduced of a call response pathway where YAS can refer people with a mental health need can be directly referred into to a SWYPFT crisis response where this may be clinically indicated.

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Crisis pathways
Access, contacts, responses & outcomes

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Adult Crisis Pathway - main

ACCESS	CONTACT POINTS	RESPONSES	OUTCOMES
WEB/ Digital	111 --- Online referral	24hr advice & guidance; Assessment; Help to speak to a MH professional	UTC / A&E; OOH GP; Advice & Guidance; Urgent / crisis MH specialist support
	Social Care --- Online referral	Telephone Gateway to Care (in normal working hours)	Advice & guidance; Referral for assessment
	SWYPFT: Current service users →	Contact usual team	Signpost; Refer / make appt with appropriate team
	SWYPFT: New service users →	999; GP	Refer to 111 Outcomes
	GP	111; 999; GP OOH	WiC; 111; 999
	ICB	Together We Can	24/7 helpline; 111; 999
	VCSE/Other	Responses and outcomes dependant on VCSE website accessed but similar to above	
PHONE	111 (MH Option) WY MH Support Line	Talk and listen; Advice & guidance; Signpost	De-escalate; Next day follow – up / agree plan; Escalate to crisis / emergency service
	Crisis Cafe	Advice & guidance; Invite for face to face	De-escalate; Escalate to crisis / emergency service
PERSON	WY Police	S136; Police Liaison Team; A&E; Crisis Cafe	Home; Admission
	YAS	A&E; GP OOH; Crisis Cafe	Home; Escalate to WYP; Escalate to SPA; Escalate to IHBTT; Referral to Crisis House
	A&E	Psychiatric Liaison Team; Usual support team	Discharged with follow-up; Admission to Acute Trust; Care of relatives; Discharged NFA; MHA
	GP	Urgent appointment; 24/7 support line	Usual support team; Crisis Cafe; SPA referral; MH social prescribers
	Community and Primary Care Workers		

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Alternatives to crisis – telephone support

- 24hours X 7 days a week mental health support line
- Commissioned by NHS West Yorkshire Integrated Care Board
- Provided by Nottingham Community Housing Association
- Table below shows
  - number of calls identified as being from Kirklees and total calls
  - number of calls from area 'unknown'
  - number of calls to 111 routed to local support

Area	April	May	June
Kirklees calls	403	493	435
Unknown	3179	2319	1795
Total	5608	6959	6532
Diverts from 111		2115	2616

Alternatives to crisis – Here For You service

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- Here For You service (previously known as Well-bean Crisis Café)
- Commissioned by NHS West Yorkshire Integrated Care Board
- Provided by Touchstone 7 nights per week at Trinity Street, Batley Carr
  - ✓ 387 support interventions provided during Q1 of 2024/25
  - ✓ 35 individual supported during the quarter
  - ✓ 15 new individuals referred (5 self-referred, 3 from IHTT, YAS & others)
- People signposted to other alternative services, dependent on need.

Service user feedback

"I used to use A&E twice a week for self-harm. For last 3 months, since coming here, I have not been once."

"I tried to take my own life and saw your poster and haven't made another attempt since coming here."

Alternatives to crisis – REST. Service

- REST. service (previously known as Crisis House)
- Commissioned by NHS West Yorkshire Integrated Care Board
- Provided by Community Links 24X7 at Trinity Street, Batley Carr
  - ✓ 25 people accepted into service for a short residential stay
  - ✓ Referrals accepted from Enhanced Team (17), IHTT (6) and KOT (2)
  - ✓ Average length of stay is 5.4 nights

Service user feedback

> "I just want to thank every single person that is involved in the care and treatment making REST. such a welcoming and lovely place."

REST. service user activity with other services

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Patient A – Several previous admissions to an acute ward ranging in length from a few weeks to a few months in 2022 -2023. No noted benefit to the admissions from an objective view, appears to have created a dependence on admission when stressors increased and following each discharge requesting re-admission within days. REST utilised in 2023 and found it helpful specifically interventions from staff focusing on coping skills, safety planning and demonstrating compassion and validation. From IHBT view, REST encourage autonomy and increased independence. Following first admission, co-created a care plan where REST to be given consideration before looking at hospital which has largely been successful. Also encourage working with IHBT but has used REST on a further 2 occasions. 10/07/24 – Referred for Gatekeeping, admission to hospital agreed – notes do not state if REST explored

Patient B – Had been with IHBT for 2 weeks, minimal improvement. Long history of formal and informal admissions to acute wards, primarily for the purpose of risk management and not for therapeutic value. Admission to hospital also shown to increase risks to self. REST utilised which the patient found this helpful from a respite aspect and also reduced feelings of shame they associated with hospital admission. No further referral to REST, hospital or IHBT since.

Patient C – Was referred to REST whilst awaiting admission to hospital in A&E at the request of Senior Management. There were concerns by IHBT this was initially not appropriate use of REST (i.e. when someone has been assessed as needing hospital admission). However, they engaged well with REST and IHBT, and before hospital bed identified, admission stood down. Both patient and IHBT staff found the REST service to be of more therapeutic value for the person and the stay enabled further period of risk assessment (patient previously unknown to MH services). No referrals to REST, hospital or IHBT since.

Patient D – Under care of IHBT for approximately 6 days before referral made to REST. Main purpose of referral was to support patient engaging in a robust safety plan and allow for respite from home environment. Reported 1:1 time provided to practice coping skills very helpful. No referrals to REST, hospital or IHBT since.

Patient E – Referred by KIHBTT, stayed full 7 days. Patient reported time staff spent with her practicing coping skills helpful. Allowed family respite and more comprehensive assessment of presentation for IHBT practitioners. Returned home and further period with IHBT before discharge back to Core team.

Mental Health Response Vehicles

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Programme Objectives

Reduced ED conveyance rate

Increased confidence of frontline staff to support patients in MH crisis

Reduce the number of mental health incidents requiring 'at-scene' response

Improve patient satisfaction levels

Releasing ambulance resources for higher acuity calls

- Investment in YAS MHRVs
- Roll-out across the region
- Piloted in Hull, Rotherham and Wakefield
- Wakefield MHRV covers Kirklees too
- Calderdale & Kirklees now have an additional MHRV
- Specially trained workforce

Additional Resources

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- ✓ 24X7 mental health crisis support line (Freephone or access via 111)
- ✓ 24X7 psychiatric liaison team covering general hospitals DDH, HRI, etc
- ✓ Additional screening and triage resource in Emergency Departments
- ✓ Additional support for people with MH conditions staying in hospital
- ✓ MH ED steering groups covering CHFT and MYTHT
- ✓ Additional resource for West Yorkshire Police – street triage & control
- ✓ Section 136 suites at The Dales (Halifax) and Fieldhead (Wakefield)
- ✓ Alternatives to Crisis – Crisis House REST. service (Community Links)
- ✓ Alternatives to Crisis – Crisis Café Here for you service (Touchstone)

Suicide Prevention

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- Reducing suicide rates is one of the ten West Yorkshire ambitions.
- New suicide audit findings for years 2019-2021 inclusive, with executive summary report and recommendations available here: Help for somebody with suicidal thoughts | Kirklees Council
- Updated/revised mental health support card for Kirklees communities and service providers is available. Approximately 23,000 have been distributed already since April 2024.
- New service Stepping Stones commissioned across Calderdale, Kirklees and Wakefield, to help reduce pressure within crisis services, and respond to those at greater risk of suicide.
- Delivery of a self-harm workshop in July 2024 with stakeholders and system partners to raise awareness of self-harm and better understand how to respond. Self-harm is a key risk factor for suicide.
- Campaign work with Huddersfield Town foundation and Huddersfield Giants to reach young to middle aged men who connect with sporting clubs in Kirklees.
- Commissioned family postvention worker for families and young people bereaved of suicide in Kirklees
- Commissioned suicide prevention training across Kirklees, reaching those who are most likely to come into contact with those at risk of suicide.
- Working within the council, but also with system partners to work towards becoming a trauma informed organisation. Some of our more vulnerable communities are more likely to have experienced trauma, which in turn leads to some long term heath conditions and mental health conditions.

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Section 10

What are the gaps in mental health services

Gaps identified and work underway to address them

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1. One of the identified gaps in mental health services was the provision for people with eating disorders whose needs did not meet the criteria for the West Yorkshire CONNECT service.
**A newly commissioned service will provide early access and psychological interventions for people with a range of disordered eating concerns.*

2. Transitions from child to adult services for people aged between 18-25 is an area which would benefit from system wide development, as would ADHD ASD waits and access.

**West Yorkshire steering group; place-based work; digital solutions; pathway redesign; transitions – Starting Well Programme and Kirklees Keep in Mind.*

Gaps identified and work underway to address them

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3. Kirklees community mental health pathways have continued to see a high rate of referrals and demand for services following Covid, which has led to longer waits for people requiring specific psychological therapies. National shortages of suitably qualified clinical psychological therapists has added to the challenge.

***SWYPFT and Kirklees ICB have worked together to provide additional mental health resource within the PCN's providing earlier and simpler access to mental health professionals to help manage the demand for services in a local and accessible way.**

** System workforce group; International recruitment programme; reviewing recruitment processes*

Gaps identified and work underway to address them

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4. Public and colleague awareness over the range of services, how to access them and managing public expectations

**Systems partners working together to ensure consistent and directional information is available on websites and in places the public would seek help from, such as the 'Z' card of mental health support. Regular briefings and updates for colleagues in partner organisations to update them on system and pathway changes.*

5. Data and data systems integration

**There is a need for systems partners to continue to work together to ensure data captured is useful and subject to robust analysis to address health inequalities, as well as the improved alignment of information systems beyond organisational boundaries to improve health and care outcomes.*