NHS
North East and North Cumbria

Mental Health, Learning Disability and Neurodiversity Improvement Plan

16 September 2024

Contents

1 Purpose and Summary of this Plan

1.1 Purpose

1.1.1 This plan describes the delivery of mental health, learning disability and neurodiversity services which are the commissioning responsibility of North East North Cumbria Integrated Care Board (NENC ICB). It highlights the capacity gaps in the national quality, performance, or financial expectations.

1.1.2 This plan highlights where there is evidence that the need of people, or particular groups of people are not being satisfactorily met. It describes this separately for children and young people's mental health, adult, and older people's mental health and for people with a learning disability or who are neurodiverse.

1.1.3 The plan indicates the ICB's proposed approach to addressing gaps. The improvement approach for each service will vary depending on factors including:

- The size of the capacity gap.
- Whether the issues highlighted are ICB wide or concentrated in particular localities, or for particular groups of people.
- The connection between levels of investment and capacity gaps. In some cases, where there is not a strong correlation between levels of investment and gaps, then sharing best practice is likely to be more effective than additional financial investment.

1.1.4 The plan identifies that for some service areas there may be insufficient data, or further work is required, to understand the causes of gaps to identify which approach will be most effective in meeting the needs of our communities. Therefore, there are some instances where this plan recommends further audit, evaluation, or research to take place prior to agreeing next steps.

1.2 Summary of Improvement Approaches

1.2.1 Tables 1 - 3 summarise the proposed improvement approach for each pathway or performance metric. This analysis is primarily based on the 2024/25 Operational Plan and the NHS Long Term Plan metrics. An overview description of the improvement approaches is described in Appendix 1. The decision tree used to decide which approach is likely to be most effective is shown in Appendix 2.

Table 1 Children and Young People

Children and Young People	Proposed Approach	
Mental Health Support Teams for Schools	**A2**	Keep the current service model, but concentrate investment in places which have lower levels of investment / capacity per population than others [i.e. bid to expand to schools not yet covered]
Getting Help and Getting More Help community mental health services	**A1**	Keep the current service model, but invest in all places across the ICB to increase our capacity (may be temporary / non recurrent or permanent / recurrent)
	B1	Support incremental change and improvement across the whole ICB
	B2	Spread evidenced best practice from one place or provider to all places / providers in the ICB
	B3	Spread most efficient practice from one place to other places in the ICB
	C	Radical change, such as pathway redesign, service reconfiguration, de/re-commissioning. (e.g. commissioning around the I-Thrive framework)
Autism diagnosis	**A1**	Invest in all places across the ICB to increase our capacity *(temporary, non recurrent investment) while also commencing….*
	C	Radical change, such as pathway redesign, service reconfiguration, de/re-commissioning.
	D	Phase out interventions / activity with negative, little or no clinical value
ADHD diagnosis and treatment	**A1**	Invest in all places across the ICB to increase our capacity *(temporary, non-recurrent investment) while also commencing….*
	C	Radical change, such as pathway redesign, service reconfiguration, de/re-commissioning.
	D	Phase out interventions / activity with negative, little or no clinical value

Table 2 Adult Mental Health

Adult and Older People's mental health	Proposed Approach	
Perinatal and Maternal Mental Health	**A2**	Maintain the current service model, but concentrate investment in places which have lower levels of investment / capacity per population than others
Talking Therapies for anxiety and	**B2**	Spread evidenced best practice from one place or provider to all places / providers in the ICB

depression (TTAD) – *mix of two approaches.*	**A1**	Maintain the current service model, but invest in all places across the ICB to increase our capacity (may be temporary / non recurrent or permanent / recurrent)
Individual Placement and Support (IPS)	**A2**	Maintain the current service model, but concentrate investment in places which have lower levels of investment / capacity per population than others
Community teams and transformation *But also….* *And in time once transformation is complete….*	**A1**	invest in all places across the ICB to increase our capacity (may be temporary / non recurrent or permanent / recurrent)
	B2	Spread evidenced best practice from one place or provider to all places / providers in the ICB
	D	Phase out interventions / activity with negative, little or no clinical value (i.e. poor value for money
Dementia Diagnosis	**B2**	Spread evidenced best practice from one place, PCN or GP practice around the ICB
Crisis / Crisis Alternatives	**A2**	Maintain the current service model, but concentrate investment in places which have lower levels of investment / capacity per population than others
	E	Commission audit, evaluation, research and review type work
Section 12 doctors (MHA assessment second doctor) currently *and then either / or*	**E**	Commission audit, evaluation, research and review type work
	C	Radical change, such as pathway redesign, service reconfiguration, de/re-commissioning.
	B2	Spread evidenced best practice from one place or provider to all places / providers in the ICB
Assessment and Treatment beds (adult) – short term	**B1**	Support incremental change and improvement across the whole ICB
Assessment and Treatment beds (adult) – long term	**D**	Phase out interventions / activity with negative, little or no clinical value (i.e. poor value for money
Assessment and Treatment beds (older people)	**E**	Commission audit, evaluation, research and review type work
Rehab and Complex / Continuing Care – *Initially….* *And then either* *Or*	**E**	Commission audit, evaluation, research and review type work
	B2	Spread evidenced best practice from one place or provider to all places / providers in the ICB
	C	Radical change, such as pathway redesign, service reconfiguration, de/re-commissioning.

Table 3 Adult Learning Disability and Neurodiversity

Learning Disability and Neurodiversity	Proposed commissioning approach	
Adult Autism diagnosis	**A1**	Invest in all places across the ICB to increase our capacity *(temporary, non-recurrent investment) while also commencing….*
	C	Radical change, such as pathway redesign, service reconfiguration, de/re-commissioning.
	D	Phase out interventions / activity with negative, little or no clinical value
Adult ADHD diagnosis and treatment	**A1**	Invest in all places across the ICB to increase our capacity *(temporary, non-recurrent investment) while also commencing….*
	C	Radical change, such as pathway redesign, service reconfiguration, de/re-commissioning.
	D	Phase out interventions / activity with negative, little, or no clinical value
Health checks for people with a learning disability	**B1**	Support incremental change and improvement across the whole ICB
Support, housing, social care and inpatient / home-based health treatment for neurodiverse people and people with a learning disability with complex and continuing needs	**A1**	Invest in all places across the ICB to increase our capacity, *and*
	A2	*To some extent,* concentrate investment in places which have lower levels of investment / capacity per population than others
	C	Radical change, such as pathway redesign, service reconfiguration, de/re-commissioning.
	D	Phase out interventions / activity with negative, little or no clinical value

2 Key Strategic Issues

2.1 Performance Measures

2.1.1 The NHS Long Term Plan set a range of commitments for improving the recorded performance of mental health, learning disability and neurodiversity services. This includes the performance improvement for the total number of people accessing relevant services available at a North East and North Cumbria level.

2.1.2 Relative performance is good in meeting some of the Long Term Plan commitments. For example, we meet or nearly meet the ambitions for the number of people with a dementia diagnosis, and people on general practice registers with a learning disability or a severe and enduring mental illness accessing annual health checks.

2.1.3 However, many waiting time and access rate ambitions are not met. The planned performance in the 2024/25 North East and North Cumbria operating plan even if achieved, does not always meet the national ambition levels, for example for:

- Talking therapies: Number of people who are discharged having received at least two treatment appointments in the reporting period.
- Number of people accessing specialist community peri-natal and maternal mental health services in the reporting period.
- Number of children and young people aged under 18 supported through NHS funded mental health services receiving at least one contact.

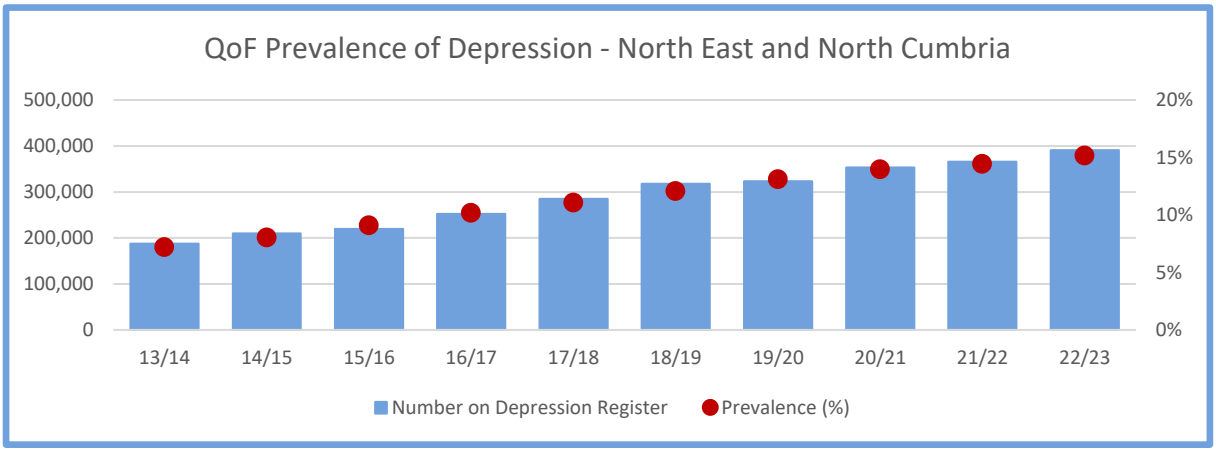
Key challenges.

- The data for some mental health metrics is either not available due to changes in the minimum mental health data set reporting in NHS England, or there is not a consistent way of recording, particularly for children and young people waiting times.
- There is persistent, entrenched, under-performance in some measures, particularly in the number of people accessing some services such as talking therapies.
- Waiting times are often exceeded and can *mask* the real scale of the performance challenge.
- Waiting times are longest in relation to neurodiversity, a national challenge experienced in nearly all ICBs.
- For some services, the relationship between performance, quality, and outcomes is not clear.
- Business as usual performance management will not be sufficient to address the performance challenges.
- The identified investment for 2024/25 and 2025/26 is not in itself sufficient to fully address the performance challenges.

2.2 Population Health: Depression, Anxiety and Trauma

2.2.1 In the North East and North Cumbria depression and anxiety are in the top five top causes of mortality. 3 in 20 adults are recorded in primary care with depression, and 1 in 5 adults have a self-reported high anxiety score. Chart 1 below shows the number and percentage of people on general practice depression registers (adjusted for changes in the population), each year since 2013/14.

Chart 1: General Practice depression registers 2013/14 – 2022/23.



***Note**: It is likely that some people included in the depression registers at one point in time have not been removed when their depression has improved. As such the number in 2022/23 may partly be a cumulative number. However, for the majority of people depression recurs, and is not a single, one of episode.*

2.2.2 The North East and North Cumbria has one of the highest suicide rates in England. Suicide is the single biggest cause of death for men aged 25 – 49.

2.2.3 We have a growing understanding of the impact of traumatic experiences on people, including the negative impacts on physical and mental wellbeing. We recognise that cumulative trauma across the lifespan is associated with multiple health consequences. There is a significant evidence base on understanding the impact of multiple adverse childhood experiences (sometimes referred to as ACEs) and similarly the recognition and incidence of trauma for adults.

Key challenges.

- There is a high prevalence of depression and anxiety, which cannot be addressed by health care services alone.
- We have not yet developed a full approach to trauma.
- We have not yet been successful in addressing the higher than England suicide rate.
- Overall, population health in relation to mental health and mental wellbeing is poor on all available metrics.

2.3 Neurodiversity and Neurodivergence

2.3.1 This improvement plan relates to autism and attention deficit and hyperactivity disorder (ADHD) in relation to neurodiversity. Estimates suggest the prevalence of autism and ADHD to be approximately:

- Under 18: Autism 1.1%, ADHD: 5%
- Adult: Autism: 1%, ADHD: 3 – 4%
- Some estimates show a much higher prevalence across all age groups.

2.3.2 Autism is not an illness, but services can make reasonable adjustments to enable autistic people to achieve better outcomes. There are effective pharmacological treatments for ADHD, but those treatments require a diagnosis and can only be initiated in secondary care by appropriately qualified clinicians. Primary care clinicians cannot diagnosis ADHD or commence/titrate pharmacological interventions but can manage stable prescriptions through shared care arrangements with secondary care providers.

2.3.4 There has been a huge rise in referrals for autism and/or ADHD assessments, summarised in table 4.

Table 4: Referrals 2019/20 – 2023/24.

Metric	April 2019	March 2024
Children and Young People (referral reason: Neurodevelopmental/Suspected Autism)		
Number of Referrals	358	1, 372
People on the waiting list	278	16,462
Adult (referral reason: Neurodevelopmental/Suspected Autism)		
Number of Referrals	246	1, 076
People on the waiting list	155	23, 956

Source: National mental health minimum dataset.

Key challenges.

- Most autistic people, and people living with ADHD, do not have a diagnosis, meaning their needs might not be appropriately met.
- Waiting times for diagnostic assessment have risen exponentially.
- Even without a diagnosis, 'needs led' services can be put in place to address presenting issues, for example sleep clinics.
- There is insufficient capacity for the initiation, titration and ongoing monitoring of ADHD pharmacological treatments.
- People with undetected neurodivergence are more likely to be misdiagnosed with other physical and/or mental health conditions.

2.4 Learning Disability

2.4.1 A learning disability is defined by the Department of Health and Social Care (DHSC) (2001) as 'a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood'.

2.4.2 A learning disability is different for everyone. The degree of disability can vary greatly, being classified as mild, moderate, severe or profound. In all cases, a learning disability is a lifelong condition and cannot be cured.

2.4.3 Prevalence estimates suggest that approximately 2.2% of adults live with a learning disability. This would suggest approximately 50, 000 adults in the North East and North Cumbria. However, primary care learning disability registers show just over 23, 500 people.

2.4.4 People with a learning disability experience significant health inequalities which are multi-factorial. Women with a learning disability have a 23 year lower life expectancy than women who do not, for men the same measure is 20.

2.4.5 The North East and North Cumbria Learning Disability Network provides leadership and coordination in seeking to improve health outcomes for people.

Key challenges.

- There is no single learning disability diagnostic pathway. Probably at least half of people with a learning disability do not have a diagnosis and most are unknown to any service (hidden population).
- People with a learning disability experience much poorer health outcomes across both physical and mental health.
- The North East and North Cumbria's use of in-patient services is significantly above the target rate set by NHS England

2.5 National Position: The Independent Investigation of the National Health Service in England.

2.5.1. The Independent Investigation of the National Health Service in England led by the Rt Hon. Professor the Lord Darzi was published in September 2024. In relation to mental health services, the report notes:

The need for mental health services has been growing rapidly. In 2016, around 2.6 million people were in contact with mental health services; by 2024, this had increased to 3.6 million people.

By April 2024, around 1 million people were waiting for mental health services. Long waits have become normalised: there were 345,00063 referrals where people are waiting more than a year for first contact with mental health services— a figure higher than the entire population of Leicester. (Section 23 and 24, page 32).

2.5.2 In relation to ADHD specifically, the report further notes:

The growth in demand for ADHD assessments has been so significant that it risks completely overwhelming the available resource. As the chart below sets out, there is a huge mismatch between demand for assessment and their availability. The result is that, at current rates, it would take an average of 8 years to clear the backlog in adult ADHD assessments – and for many trusts, at current rates, the backlog would not be cleared for decades. (Section 27, page 34).

2.5.3 The summary descriptions in the report apply as accurately to the North east and North Cumbria as they do for the whole of England.

3. NHS Long Term Plan and Better Health and Wellbeing for All

3.1 NHS Long Term Plan

3.1.1 Nationally the current NHS England long term plan for mental health is scheduled for refreshment. We expect there to be renewed direction in a 10 Year NHS Plan. This is likely to be published in the first half of 2025 and a parliamentary bill to amend the current Mental Health Act to progress through parliament. However, the core of the current mental health long term plan has been to transform community services.

3.1.2 From 2023 NHSE has also developed an Inpatient Quality Transformation Programme (IPQT), including commissioning guidance, early warning systems and a culture of care programme in response to the growth of out of area placements and high-profile instances of unacceptable service quality and culture.

3.1.3 Learning Disability priorities have been around building the right support so that fewer people with a learning disability are admitted to inpatient beds, and that they leave those beds when any mental health needs have been successfully assessed and treated. There has also been a national focus on reducing premature mortality for people with autism or a learning disability so that it more closely reflects rates in the general population. Increasing the proportion of people with a learning disability accessing annual health checks has been a core national and local target.

3.1.4 There have been similar national policy initiatives in the field of children and young people's mental health. The Future in Mind policy emphasised:

- Resilience, prevention, and early intervention
- Improving access to effective support
- Caring for the most vulnerable
- Accountancy and transparency
- Developing our workforce

3.1.4 There has been increasing recognition nationally that the prevalence of mental illness is much higher for people in the CORE20PLUS5 groups, i.e.

- People who live in the most deprived 20% of England's neighbourhoods (which is much higher than 20% of NENC's population)
- People who are members of population groups identified at greatest risk of illness or for whom there are barriers to access - these should be identified locally but are likely to be ethnic minority communities; people with a learning disability and autistic people; people with multiple long-term health conditions; other groups that share protected characteristics as defined by the Equality Act 2010; groups experiencing social exclusion, known as inclusion health groups, and also coastal communities (where there may be small areas of high deprivation hidden amongst relative affluence).

3.2 North East North Cumbria

3.2.1 The North East and North Cumbria Integrated Care Partnership Strategy, Better Health and Wellbeing for All, sets out the following strategic priorities:

1. Longer and Healthier Lives
2. Fairer outcomes
3. Better health and care services
4. Giving our children and young people the best start in life

3.2.2 The plan notes that, “Improving mental health and mental wellbeing is a key priority for our region. We know there is much more to do to improve access to psychological therapies for all our communities and diagnosis rates for people with dementia. Our key focus includes:

- Improving perinatal mental health
- Integrated care for adults with severe and common mental health issues, ensuring faster access to talking therapies and crisis support.
- Aiming to halve the difference between the suicide rate in the North East and North Cumbria and the (much lower) suicide rate in England by 2031
- Improving access to specialist mental health care for children and young people, including more school-based support teams and early intervention.
- Enhancing services for eating disorders.
- Developing a safe, personalised, and therapeutic approach to in-patient care which includes reducing the number of people treated out of the area.
- Collaborating with professionals and partners to ensure our services are trauma-informed, acknowledging the significant impact of trauma on individuals’ lives.

3.2.3 The strategy also highlights learning disabilities and neurodiversity as priority groups. It notes that “People with a learning disability and autistic people die on average at a much younger age. We will reduce the waiting times for initial assessments for suspected autism and for packages of support for people living with a learning disability and autistic people. We will also improve their access to physical health care.”

4. Children and young people.

Note: Inpatient and intensive home treatment services for children and young people are commissioned by the North East Specialist Provider Collaborative and therefore are not included in this plan.

4.1 Mental health support teams in schools (MHSTs)

4.1.1 This service has been expanded in "waves" across the country linked to the training of a new workforce and the roll out of a nationally devised model of care.

4.1.2 The recommended way forward for this service is to secure further waves as NHS England funding and training places are released. The ordering for when Places are included in future waves will be based on:

1) Current coverage by place, with places with lower coverage being put forward first but also considering 2) and 3).
2) Deprivation levels: more economically and socially deprived places and neighbourhoods within places generally being put forward first, as need will be highest in these areas.
3) School system readiness: notwithstanding (1) and (2) places and their school systems must be in a state of readiness if they are to be put forward.

4.1.3 As this is a national programme, with funding released in tranches it is accepted that we will continue to have variation between places until the national roll-out is complete. We cannot "dilute" the offer in order to even it out across the ICB because NHS England will be conducting checks to make sure that services are maintaining fidelity to the national recommended model. Therefore, the most appropriate commissioning approach will be to:

A2	Keep the current service model, but concentrate investment in places which have lower levels of investment / capacity per population than others [i.e. bid to expand to schools not yet covered as new waves of funding announced]

4.1.3 By March 2025:

Operational Plan:

- A total of 56% of schools will be within the coverage of mental health school support teams by the end of 2024/25.
- The total investment in those teams will be £13.1 million.
- Expansion is resourced from the subset of service development funds (SDF) provided by NHS England to the ICB.

Planned investment:

- Additional investment is in place during 2024/25 to achieve the 56% coverage level agreed with NHS England.

4.2 Children and Young Peoples Service

4.2.1 All places have a community mental health team in place. The ICB achieves and exceeds national targets for access (appendix 2, page 15). Some Primary Care Network (PCNs) have invested in additional role reimbursement scheme (ARRS roles) but take up has been patchy due to financial and workforce supply constraints.

4.2.2 Waiting times vary between teams. This is partly due to differences in the interpretation of data definitions in terms of what constitutes “treatment” and the inclusion of people waiting for neurodevelopmental assessments who may not necessarily have a concurrent mental health need.

4.2.3 For mental health intelligence suggests that most children wait less than 1-2 months, and almost all under 6 months other than in North Cumbria, Newcastle and Gateshead, but service improvement is underway in those teams which are implementing models which are proven to work elsewhere in the country or within the region. The “official” waiting times (see appendix 2, page 22) include people waiting for ADHD and Autism assessments and so do not accurately reflect the waits for assessment and treatment of mental illness.

4.2.4 We currently do not have a fully accurate sense of which places are performing better than others. There is also no assessment of which teams offer the best value for money. This is complicated by the importance of (welcome) local authority investment into services. It will require significant work to take all resources, activity, and outcome data into account to enable the efficiency and effectiveness of different arrangements across the ICB to be compared.

4.2.5 There is evidence of unmet need and the ICB should continue to identify investment to improve services using the THRIVE framework. This includes using existing funding more optimally.

4.2.6 We underperform on national targets around children’s eating disorders (appendix 2, page 13/14). In part this is because reporting is on a rolling 12 month position. There are still data quality challenges, but we know that teams meet the target most months, with clear reasons why when they don’t (e.g. complex presentation needing a longer assessment before treatment, or family situation/choice impacting on appointment timing). The really small numbers then impact, so 1 referral in month shows as a 100% breach if the target is missed.

4.2.7 For children and young people's mental health crisis services there is national modelling guidance. The aim is to have all four of the following functions in the teams that support children and young people who are experiencing a mental health crisis:

- Single point of access through NHS 111 select mental health option' to crisis support, advice, and triage.
- Crisis biopsychosocial assessment within emergency department and/or in community settings.
- brief response with emergency department and/or in community settings, with CYP offered brief interventions in home and/or community.
- Intensive Home-Based Treatment service.

4.2.8 There are two areas where further investment is indicated to ensure all four functions are sustainably met. Children and young people's service development

funds (SDF) will be provided in 2024/25 to North Cumbria and Newcastle Gateshead to commission or enhance the final elements of the national model in those areas.

4.2.9 The ICB will also encourage the sharing of best / effective practice between places and challenge where this is not taken for unwarranted reasons. Therefore, the appropriate commissioning approach for this complex area is a mix of:

A1	Keep the current service model, but invest in all places across the ICB to increase our capacity (may be temporary / non recurrent or permanent / recurrent)
B1	Support incremental change and improvement across the whole ICB
B2	Spread evidenced best practice from one place or provider to all places / providers in the ICB
B3	Spread most efficient practice from one place to other places in the ICB
C	System transformation (e.g. commissioning around the I-Thrive framework)

4.2.10 By March 2025:

Operational Plan:

- The ICB Operational Plan is to achieve 59, 632 children and young people with at least one contact from NHS commissioned mental health services.
- To achieve the national NHS Long Term Plan trajectory, the number would need to be 60, 987.
- So even if we achieve our operational plan ambition, we would still be 1, 355 children and young people below the long term plan trajectory, a gap of 2.2%.
- We anticipate that during the Autumn of 2024 NHS England will set out ambitions for eliminating the longest waits (beginning with those over 104 weeks)
- In common with ICBs nationally, there will be a major challenge to reduce the large number of very long waits for neurodevelopmental assessment. As yet no formal ambition/trajectory has been set.

Planned investment:

- The ICB has agreed to invest up to £5.761m recurrently from April 2025/26 additional to the current committed spend.
- Some of the planned investment will be deployed to trauma informed services and neurodiversity, and therefore will not significantly improve the performance of the national long term plan trajectory for total contacts.

4.3 Trauma and needs we find complex to meet.

4.3.1 Locally and nationally, there is an increasing complexity of need. While reductions in the use of assessment and treatment inpatient beds has been achieved by the North East Specialist Provider Collaborative, there are capacity issues in the social care sector, and for young people entering the youth justice system a shortage of secure children's homes placements.

4.3.2 There has also been an increase in the use of the inherent jurisdiction to authorise the deprivation of liberty of children in placements that are unregulated and frequently unregistered. In 2022/23 there were over 1,500 of these placements across England. The Local Government Association (LGA) estimated that in 2018/19 English councils paid for approximately 120 placements costing £10,000 per week. This has contributed to budgetary pressures for the local authorities.

4.4.3 Across health and care there are various measurements that we can collect to understand and articulate the needs of this cohort of children and young people. For example, in the NENC we are aware that we have the highest rates in England for child in need, child protection plans, and children who are care experienced. Importantly across the system we are working together to improve the outcomes for children and young people with our system commitment to give every child the best start in life.

4.4.4 There are various schemes and support offers emerging around fostering, local authority housing, prevention models in maternal mental health and working together to transform children's mental health inpatient provision.

4.4.5 The golden thread of this work is recognising the impact trauma and adversity can have on our children, young people and families and skilling up society, families, and our workforce to feel confident in recognising the impact of trauma and supportively shifting our focus to ensure we are responding with trauma informed approaches consistently.

4.4.6 In three local authority areas we are testing new ways of integrated trauma informed working for children and young people known to children's social service. This evidence-based practice is linked to the national integrated care community framework, of which we are included in the national vanguard programme delivered by the children's health and justice national NHSE team. We are ambitious to share learning from our early adopter sites and consider how we can scale up this practice to all areas. We will build these approaches with intention and at a pace of change that is supportive to developing improved ways of working and supporting the wellbeing of our workforce in the North East and North Cumbria

4.4 Neurodevelopmental Diagnoses and Support services

4.4.1 This includes:

- Attention deficit and hyperactivity disorder (ADHD) assessments. A positive diagnosis can lead to medication, which must be reviewed on a regular basis.
- Autism, which is not an illness and there are no pharmacological treatments.

4.4.2 Since the Covid pandemic demand has risen exponentially and continues to rise significantly and waiting times continue to increase, as illustrated in table 5.

Table 5: Referrals and Waiting Times for Neurodevelopmental Assessment

Metric	April 2019	March 2024
Number of Referrals	358	1,372
People on the waiting list	292	22,911

4.4.2 Although there are some elements of good practice that could be spread from place to place the current service model cannot deal with the new levels of demand.

4.4.3 Financial investment on its own is unlikely to solve the problem due to limitations in the workforce supply.

4.4.4 The proposed commissioning response is therefore to bring system partners together to redesign the pathway and transform the service. In the short term there may be a case for non-recurrent investment to prevent further deterioration of waiting times. Therefore, the appropriate improvement response is to:

CYP Autism diagnosis	**A1**	Invest in all places across the ICB to increase our capacity *(temporary, non-recurrent investment) while commencing….*
	C	System transformation
	D	Phase out interventions / activity with negative, little or no clinical value
CYP ADHD diagnosis and treatment	**A1**	Invest in all places across the ICB to increase our capacity *(temporary, non- recurrent investment) while commencing….*
	C	System transformation
	D	Phase out interventions / activity with negative, little or no clinical value

5. Adult and Older People's mental health

This section addresses mental health services for people 18 years of age or over living within the NENC ICB footprint. This includes both working age people and older people but where services are commonly differentiated for these two populations, we describe them separately.

Many neurodivergent people will access mainstream mental health services. This is also increasingly true of people with a learning disability. This chapter is inclusive of those groups of people, but the next chapter deals with services that are specifically focussed on neurodivergent people or people with a learning disability.

5.1 Perinatal and maternal mental health services

5.1.1 Perinatal mental health services focus on the prevention, detection and management of mental health issues that occur during the perinatal period. This includes new onset mental health problems, as well as recurrences of previous problems and women with existing mental health problems who become pregnant. These are categorised into 3 levels low to mild, mild to moderate and moderate to severe.

5.1.2 Perinatal mental health illness affects up to 27% of new and expectant mums and covers a wide range of conditions. Examples of perinatal mental illness include antenatal depression, postnatal depression, anxiety, perinatal obsessive-compulsive disorder (OCD), postpartum psychosis and post-traumatic stress disorder (PTSD). These illnesses can be mild, moderate or severe, requiring different kinds of care or treatment. If left untreated, mental health issues can have significant and long-lasting effects on the woman, the child, and the wider family.

5.1.3 Maternal mental health service development ambition is to combine maternity, reproductive health and psychological therapy for women experiencing moderate to severe or complex mental health difficulties directly arising from, or related to, their maternity experience. This may include those who experience post-traumatic stress disorder following birth trauma, perinatal loss, or severe fear of childbirth (tokophobia).

5.1.4 NHS England have set a target that ICBs should commission perinatal teams and maternal mental health services which together should reach 10% of people giving birth (or perinatal loss) and also support their partners where required and appropriate.

5.1.5 A NENC Mental Health, Learning Disability and Autism subcommittee report in March 2024 highlighted that:

- 7.2% of eligible people were accessing the service (a 2.8% percentage point gap on national expectations).
- There was significant place variation (lowest: Tees Valley 6.2%, Highest North Cumbria 9.6%).

- Not all places have a maternal mental health service however, early adopter sites have been testing integrated models.

5.1.6 The Perinatal Provider Collaborative will be strengthened an launched in Autumn 2024.

5.1.7 Therefore, NENC's commissioning approach is:

A2	**Keep the current service model, but concentrate investment in places** which have lower levels of investment / capacity per population than others

5.1.8 By March 2025:

Operational Plan:

- The NENC ICB are measured against an access target of 10% of the birth rate (2016 ONS) which is 3,176 women and birthing people accessing a maternal or perinatal service.
- The NENC operational plan for 2024/25 is 2,500 which is 21.3% lower than the national ambition.
- The targeted investment will support achievement of the national trajectory and of which the phased approach to scaling up the maternal mental health offer will be completed by March 2027, which will also support delivery of the three-year maternity plan.

Planned investment:

- To support this, the ICB has agreed to invest up to £0.84m SDF in 2024/25 and £1.5m recurrently from April 2025/26 additional to the current committed and existing spend.
- Levelling up investment for perinatal mental health and scaling the early adopter model of integrated maternal mental health to all acute trusts with consultant led maternity settings.
- Utilising learning from VCSE maternal mental health link worker roles will be key to embedding sustainable workforce models.

5.2 Talking Therapies for Anxiety and Depression (TTAD)

5.2.1 NHS Talking Therapies for Anxiety and Depression (TTAD) (previously Increasing Access to Psychological Therapies - IAPT) was launched nationally in October 2008 with an initial access target of 15% of prevalence of mild to moderate mental health problems. A focus on meeting this access target is interdependent with recovery and waiting times targets and 1st to 2nd treatment waiting times.

5.2.2 The national access target has been stretched incrementally since 2008 to meet the planned final target of 25% of expected prevalence. No service has managed to achieve this and the performance for NENC remains around 17% for the with around 3,000 potential people per month not entering therapy.

5.2.3 The reasons for this include the level of investment, workforce shortages, implications of the Covid-19 pandemic, and wider commissioning arrangements. It is also known that there is still unmet need in the client communities such as Long Term Conditions (LTC) and minority ethnic / religious communities. Existing services continue to work to engage with such communities more effectively.

5.2.4 There is an understanding that no single commissioner or provider were able to effectively overcome the barriers to achieving the Access target alone, so the NENC wide Talking Therapies Oversight and Delivery Group (TTOD) has been formed to allow commissioners and providers to collectively tackle the common issues facing them. The TTOD has been successful in bringing providers together to network, share, and implement best practice. It has developed a process that assures the system that all providers comply with essential criteria for good service provision and workforce wellbeing.

5.2.5 The achievement of the 50% reliable recovery target is currently met some months and not others, with the latest performance measured at 48.8%. There are also significantly more people waiting over 90 days for their first appointment than was the case before the Covid pandemic. The current position is 38.2% which is well above the English average of 20% and national target of 10%. In addition, reliable improvement performance at 68.8% is better than the national position (appendix 2 pages 3 - 10). There are difficulties in comparing places against each other due to differences in specifications, income levels and integration with other services. Therefore, we intend to continue the current approach as a variant of:

B2	**Spread evidenced best practice from one place or provider to all places / providers in the ICB**

5.2.6 This includes developing a common service specification, which individual services across the ICB will move onto over time.

5.2.7 We will also invest £1.2m into TTAD in 25/26 (MHIS funding). This is an example of the commissioning approach below.

A1	**Keep the current service model, but invest in all places across the ICB to increase our capacity** (may be temporary / non recurrent or permanent / recurrent)

Operational Plan:

- The NENC plan for the number of people who are discharged having received at least two treatment appointments is 35,000 for 2024/25.
- The national ambition is 40,517, so if we achieve our planned target this will be 14% lower than the national ambition.
- The NENC plan for reliable improvement was developed at our baseline of 68% for 2024/25 with the national ambition being lower at 67%.
- The NENC plan for reliable recovery was developed at our baseline of 50% for 2024/25 with the national ambition being lower at 48%.
- Criteria to access the Autumn statement 100% salary support for trainees requires the ICB's trainee baseline requests to be made, as such the NENC cannot access the Autumn statement salary support in 2024/25 as the required baseline has not been met.
- Achievement of the overall trajectories is a national challenge including a collective challenge of increasing waiting times particularly for step 3 (high intensity interventions).

Planned investment:

- To support this, the ICB has agreed to invest up to £1.2m recurrently from April 2025/26 additional to the current committed and existing spend.
- The detail of where this investment will be utilised will be developed in the transformation programme which will focus on:
    - Developing a standard service specification.
    - Reviewing pathways for psychological support, to ensure people get to the right services when they need them.
    - Developing a contracting and procurement plan.
    - Developing an interlinked commissioning and workforce transformation plan for 2025/26 moving forwards with focus on seeking to access Autumn statement funding approved until 2027/28.

5.3 Individual Placement and Support (IPS)

5.3.1 IPS is an employment support service integrated within community mental health teams, designed for individuals experiencing severe mental health conditions. For service users, employment offers numerous benefits, including a stable income, a stronger sense of purpose, and enhanced wellbeing. From the perspective of the health system, IPS contributes to overall efficiency and cost savings by reducing the use of primary and secondary mental health services. There is evidence from Durham and Tees Valley that the majority of people who complete 26 weeks in work can be discharged from secondary care caseloads.

5.3.2 Part of the further development of the service is to focus on IPS in general practice, to ensure that service users who are not engaged with community care teams do not mis the opportunity of IPS.

5.3.3 The ICB is aware of differences in performance between places in the north of the ICB and Durham / Tees Valley. These are correlated to investment levels (as there is a national operational model which all teams follow). Therefore, the ICB is not allocating the earmarked NHSE funding on a per-population basis but instead flowing investment 50% (2024/25) and 60% (2025/26) towards Durham Tees Valley. This commissioning approach fits the following category:

A2	**Keep the current service model, but concentrate investment in places** which have lower levels of investment / capacity per population than others

Operational Plan:

- The ICB Operational Plan aims to achieve combined access targets of 2,388 for 2024/25 and 2,985 for 2025/26.
- The combined baseline access targets are 1,769 for both 2024/25 and 2025/26. The combined expansion access targets are 619 for 2024/25 and 1,216 for 2025/26.
- Both trusts will ensure their IPS services begin reporting data to the IPS Growth Reporting Tool by the start of Q4, or at least demonstrate progress towards this goal.
- The expansion funding for 2024/25 will be allocated to increasing the workforce within IPS teams, with a focus on areas that require levelling up.

Planned investment:

- To support this, the ICB has agreed to invest up to £0.6m SDF in 2024/25 and £0.9m recurrently from April 2025/26 additional to the current committed and existing spend.

5.4 Annual Health Check

5.4.1 There is evidence to show that people with long term, serious and enduring mental conditions such as schizophrenia often experience premature mortality. One factor behind this is the impact of some mental health medications on physical health. There is therefore a national target that at least 60% of this group, "working towards 75%" should receive an annual health check. NENC ICB is currently achieving these standards, having seen significant improvement since 2022 (see appendix 2, page 17).

5.5 Community Mental Health Transformation

5.5.1 Waiting times data (appendix 2, page 23) shows that community teams are under pressure, with high demand leading to increasing waiting times. However, some of these waits are for autism / ADHD assessments which arguably skew these figures (see next chapter for discussion of this issue). NHSE are due to introduce new waiting time measures which take community transformation into account.

5.5.2 Community Transformation is an approach based on integrating secondary care mental health community teams with primary care, voluntary and community sector assets and local authority services at place / sub-place level. This generally leads to the development of physical or virtual hubs. Progress towards this is at variable rates across the ICB, with Stockton, Hartlepool, and Cruddas Park (Newcastle) among the places that have gone furthest on this journey.

5.5.3 The principle is that integration will enable more effective early intervention and reduce "failure demand" where people become more ill than they would have been had effective and co-ordinated early intervention taken place. It is still early days but there are some indications from Tees Valley and County Durham that some of these initiatives are leading to a reduction of referrals into secondary care community mental health teams.

5.5.4 There is a clear need for the ICB to adopt more secure, flexible, and long term contracting arrangements with voluntary, community and social enterprise (VCSE) sector organisations which are critical in delivering community services.

5.5.5 Community transformation has rightly been seen as a task for place-based commissioners and delivery partners to interpret and work through the national model together so that the local model reflects the assets of that place – the argument recognises that, for example, that Workington is very different to Whitley Bay and so local stakeholders must interpret the national model and tailor it to local circumstances.

5.5.6 Inevitably this creates variation between places, some of which will be warranted and some unwarranted. Therefore as well as "Transformation" (including investing the SDF allocated for this purpose) the appropriate commissioning response

is also to facilitate learning between places and neighbourhoods. So the commissioning approach is a mixture of:

B2	Spread evidenced best practice from one place or provider to all places / providers in the ICB

C	Radical change, such as pathway redesign, service reconfiguration, de/re-commissioning.

5.5.7 By March 2025:

Operational Plan:

- The plan for access to transformed community mental health services for adults and older adults with severe mental illnesses in 2024/25 is 30,000 which is above the national ambition of 23,586.

Planned investment:

- The ICB has agreed to invest up to £1.9M SDF in 2024/25 and £3M recurrently from April 2025/26 additional to the current committed and existing spend.
- Focus to ensure our community services are transformed and accurate reflective data is flowing the MHSDS.
- Local plans to invest the allocated shares of community mental health transformation SDF will cover a range of schemes which demonstrates the warranted local variation and the varied sequencing of the mandated focus areas of 1) adult eating disorders, 2) personality disorder and 3) mental health rehabilitation that each local area developed.

5.6 Psychiatric Liaison, Crisis and "Alternative to Crisis" services

5.6.1 Psychiatric Liaison services, mostly designed around the "CORE24" standard were introduced at acute hospitals during the 2010s. They ensure that people who enter an acute hospital ward or emergency department who have mental health needs are identified and supported. These services cover the whole ICB but there are some local variations, especially around hospitals that do not require Core 24 levels of cover.

5.6.2 Outside acute hospitals, NHS crisis teams have traditionally been both provided home based intensive treatment and identified patients who require inpatient treatment. In recent years, crisis alternatives services have also developed. In 2022/23 for NENC identified the following resources currently available in NENC, some of which are provided by the VCSE sector (see table 6). Commissioning such services can be via local authorities as well as the NHS.

Table 5: Alternatives to Admission Provision

Type of provision	Units in place across NENC in 2022/23
Crisis cafes / community drop in	7
Haven / Sanctuary	3
NHS 24/7 crisis line / Single Point of access	7
VCSE helpline	4
Crisis houses	3
24/7 walk in / crisis assessment centre	3
Acute Day care units	0
Other	5

5.6.3 A safe haven recently opened in Ashington (Northumberland) and was visited by the Chief Executive of NHSE on 22 March 2024. A new safe haven in Newcastle has also recently opened. There are currently no safe havens in North Tyneside, County Durham, or Tees Valley.

5.6.4 However, there is considerable variation across the ICB in terms of access to alternatives to admission. This may be one of the factors driving significant variation in rates of admission to adult assessment and treatment beds (although counter to this hypothesis, North Tyneside has very low admission rates).

5.6.5 The commissioning approach adopted by the ICB is therefore:

A2	**Keep the current service model, but concentrate investment in places** which have lower levels of investment / capacity per population than others

5.6.6 We are investing £850k SDF in 2024/25 and £1.453m in 25/26 recurrently. Some of the inpatient quality transformation investment may also be invested into this element of the urgent care pathway.

5.6.7 In addition the ICB is investing £300k (2024/25) and £600k (2025/26) to support the expansion of liaison services in North Cumbria and Newcastle's Royal Victoria Infirmary.

5.6.8 This is an area with a fast-developing evidence base, which will be added to by the experience gained in Whitehaven through the operation of their 24/7 Open Access community pilot (and similar schemes in York which involves TEWV and elsewhere across England). Therefore, part of the commissioning approach will also be to:

E	**Commission audit, evaluation, research and review type work**

5.6.9 By March 2025:

Operational Plan:

- The ICB Operational Plan is to achieve an equitable offer of alternatives to crisis/admission across the NENC footprint.

Planned investment:

- The ICB has agreed to invest up to £0.84m SDF in 2024/25 and £1.5m recurrently from April 2025/26 additional to the current committed and existing spend.
- To develop our plans to target investment appropriately, there is a need to review our bed and citizen census by the end of Q3 2024/25 and set long-term trajectories for a reduction in admission rates, appreciating that there may be no immediate impact on these until robust and equitable alternatives to admission are established.

5.7 Section 12 Doctors

5.7.1 The current Mental Health Act requires assessments of patients under the act to be carried out by two doctors and an approved Mental Health Professional (AMPH). Section 12 of the Act stipulates that one of these doctors should have some independence from the clinical team currently managing that patient.

5.7.2 Delays in obtaining a second "section 12" doctor for an assessment are not only distressing for patients, but also significantly constrain the capacity of AMPHs who have to stay with a patient awaiting an assessment.

5.7.3 There is significant variation in the arrangements for obtaining and paying section 12 doctors across the ICB. A working group is currently looking at the issue i.e. commissioning approach E:

E	**Commission audit, evaluation, research and review type work**

5.7.4 However, it is likely that the outcome of this work will be either:

B2	**Spread evidenced best practice from one place or provider to all places / providers in the ICB**

5.7.5 Or, in conjunction with wider work on crisis and admissions (and taking forthcoming changes to the Mental Health Act into account)

C	**Radical change, such as pathway redesign, service reconfiguration, de/re-commissioning.**

5.8 Inpatient provision

5.8.1 There are separate services for:

- Working aged people (generally up to age 64)
- Older People: these beds are either focused on:
    - Functional illnesses (essentially the same affective and psychotic illnesses which the working age population also suffer from, but the service takes account of old age based physical frailty)
    - Organic illnesses (e.g. dementia / Alzheimer's) which with the exception of "early onset dementia" mostly impact on older people.

5.8.2 NHSE's inpatient pathway commissioning guidance makes clear crisis / alternatives to admission, purposeful admission and discharge planning / support are inter-related. The ICB's planned SDF investment Transformation will be utilised on admission avoidance or discharge services as well as directly on inpatient provision. Local authority are key partners and have made investments to support discharge.

Adult Beds

5.8.3 As the chart on page 11 of appendix 3 shows, there have been significant pressures on the adult bed base in recent years, and instances where CNTW, and more frequently TEWV have had to utilise private sector PICU and Assessment and Treatment beds, some of which have been located outside NENC's geography. The position has improved over recent months.

5.8.4 The recent bed census carried out as part of NENC's inpatient quality transformation plan identified that:

- There is very little variation in adult A&T and PICU beds per population in different parts of the region (taking into account that some places are served by beds located in a neighbouring place) and the number of beds per population is relatively low compared to UK wide benchmark data.
- There are significant differences in admission rates per population (highest in parts of Tees Valley and Durham, and low in Northumberland, North Tyneside, Newcastle, Gateshead and Sunderland. These low admission rates are some of the lowest in the country.
- There are variations in availability of crisis alternatives such as safe havens (see previous section) and some correlation between high admission rates and lack of such facilities.
- The use of "out of area" beds for admissions seen during 2023, and in Durham Tees Valley into 2024 have largely been eliminated, but bed occupancy rates remain high and well above the Royal College of Psychiatrists recommended level of 85%.

- There are significant numbers of people who are clinically ready for discharge but who cannot be discharged due to housing and care capacity issues.
- Care is sometimes over-focussed on risk management and bureaucratic tasks, at the expense of time to work therapeutically with patients.
- Although there are a high number of independent sector beds located within the region, these largely "import" patients from elsewhere in Britain with only around 5% of beds filled with patients from NENC.

5.8.5 There is a consensus that the addition of additional assessment and treatment beds is not necessarily the right way forward. Instead, both commissioners and providers are focussed on providing more effective early and crisis / home treatment interventions and on discharge support. Both NHS providers and the two eligible private sector groups with beds in the ICB area are also playing an active part in the national culture of care programme.

B1	**Support incremental change and improvement across the whole ICB**

5.8.6 However, we recognise that improvements in alternatives to crisis/admission, discharge support and the Culture of Care may reduce the need for bed-based provision in the medium to long-term.

D	**Phase out interventions / activity with negative, little or no clinical value (i.e. poor value for money)**

Older People's Beds

5.8.7 There are currently 4 NHS providers across the ICB and broadly two very different service models:

1) Close integration with acute hospital services for older people.
2) Stand along mental health Trust-based services, where links are closer with Adult mental health wards.

5.8.8 At present those Places with model (1) have significantly more beds per population than those operating model (2). What is not fully known is the costs and benefits of the two very different models. Therefore, in the ICB's IPQT plan the need for an analysis of this has been identified. The commissioning approach is therefore currently:

E	**Commission audit, evaluation, research and review type work**

5.8.9 This work can also examine the potential impact of new treatments for dementia and whether these will significantly change the demand for organic beds in the long term (or fit better with either of the current service models).

Operational Plan:

- Reduce the use of out of area placements to zero by the end of 27/28.
- As of July 2024, CNTW had 2 out of area placements and TEWV had 0. CNTW prior to July had a 10-month period of 0 placements and TEWV have had a significantly improved trend since February 2024 to an achieved trajectory position in July 2024.
- As part of the identified Inpatient Quality Transformation Programme, we will also seek to:
    - Support implementation of and seek assurances for Culture of Care programme with view to improving measures of patient and staff satisfaction.
    - Evaluate models of mental health care for older adults.
    - Collaborate with foundation trusts to establish performance metrics and set trajectories for long-term reductions in admissions to hospital.

Planned investment:

- To support this, the ICB has agreed to invest up to £1.2 million SDF in 2024/25 and £**2.243 million** recurrently from April 2025/26 additional to the current committed and existing spend.

5.9 Rehabilitation

5.9.1 The issuing of rehabilitation pathway guidance by NHSE earlier in 2024 poses some challenges to current models of provision in NENC.

5.9.2 Our inpatient quality transformation (IPQT) census work tells us that:

- There are significant differences in the use of private sector and NHS beds between the south and north of the ICB (significant use versus low use).
- There are significant numbers of beds in the north of the ICB which have a function somewhere between assessment and treatment and rehab.
- Non bedded community rehab services are not at the same level in all places.
- There are shortages of supported housing and care packages that impact on people with severe and enduring mental illnesses (see neurodiversity and learning disability chapter).
- There has been an identified system goal to move towards decommissioning of all locked rehabilitation by the end of 27/28.

5.9.3 The most appropriate commissioning approach in this context is initially:

E	**Commission audit, evaluation, research and review type work**

5.9.4 However, it is likely that the outcome of this work will be either:

B2	**Spread evidenced best practice from one place or provider to all places / providers in the ICB**

5.9.5 Or potentially, in conjunction with significant investment into community (non-bed) rehab and supported housing (see next chapter)

C	**Radical change, such as pathway redesign, service reconfiguration, de/re-commissioning.**

5.10 Dementia Diagnosis

5.10.1 Achieving the dementia diagnosis target is not the only aim. The key is to ensure that people receive can access appropriate support post diagnosis.

5.10.2 National targets are developed based on the expected prevalence and population in each place. NENC is currently achieving the national target but underperforming against the target that the ICB has set itself. Variation can be found at PCN / GP practice level.

5.10.3 At present the commissioning approach is therefore:

B2	Spread evidenced best practice from one place, PCN or GP practice around the ICB

5.10.4 By March 2025:

Operational Plan:

- The NENC ICB operational plan is to maintain the current dementia diagnosis rate of 68% at March 2024 as this exceeds the national ambition of 66.7% by March 2025.

6. Adult Neurodiversity and Learning Disability

Autism and ADHD

Autism and Attention Deficit Hyperactivity Disorder (ADHD) are different types of neurodiversity. In this plan they are frequently grouped together, which can be misleading. However, there are lots of common challenges across autism and ADHD, including:

- Autistic people and people with living with ADHD are more likely to experience poor mental health compared to the general population.
- Autistic people and people living with AHD may also require reasonable adjustments to effectively access and benefit from mental health services.

However, there are also some very clear differences:

- Autism is not an illness, although autistic people may need different types of reasonable adjustments to support them, they do not need 'treatment'.
- ADHD is different. There are pharmacological interventions for ADHD that can improve outcomes in education, work, and other aspects of life.

Learning Disability

The NHS defines learning disability as a “significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood.” Learning disabilities can be classified as mild, moderate, severe, or profound, based on a person's IQ, language skills, practical abilities, and capacity for self-care.

People with a learning disability may also experience associated conditions such as behaviours that challenge, physical and mental health complications, and may also face social stigma and discrimination.

There is a significant difference in early mortality rates between people with a learning disability and autistic people and the general population. The 2022/23 North East and North Cumbria learning from deaths reports notes that the factors underlying early mortality for people with a learning disability and autistic people.[1]

This chapter focusses first on diagnosis and initial interventions and support, and then moves to treatment and care for people with a serious mental illness who are also neurodiverse or have a learning disability.

[1] item-10-1b-easy_read_annual_report.pdf (northeastnorthcumbria.nhs.uk)

6.1 Autism and ADHD diagnosis

6.1.0 Since the pandemic, there has been a significant and rapid increase in the volume of referrals for autism and / or ADHD diagnosis, far exceeding the system's capacity. As a result, there are substantial waiting lists across the entire ICB, with some regional variations. In certain areas, the wait time for adult autism or ADHD diagnostic services can exceed 5 years.

6.1.1 CNTW and TEWV have implemented “keeping in touch” processes to ensure that individuals at high risk of immediate harm are identified and supported. However, this approach is resource-intensive, and its overall benefits remain uncertain. People waiting can exercise their “right to choose” and seek diagnosis from independent sector providers with an NHS contract. Recently, there have been national supply issues with medications commonly prescribed for ADHD treatment.

6.1.2 There is a growing consensus that the best way forward is to involve system partners (such as primary care) and stakeholder groups in a comprehensive redesign of the care pathway. This effort will draw on similar transformational work happening elsewhere in England. However, while this long-term redesign is underway, there may be a need for short-term, non-recurrent investments to reduce waiting lists. Such investments are likely to focus on the non-NHS sector, as TEWV and CNTW currently lack additional capacity. In summary the commissioning approach will be:

1) Immediate / short-term

A1	Keep the current service model, but invest in all places across the ICB to increase our capacity on a temporary / non recurrent basis utilising the non NHS sector

2) In parallel, commence

C	Radical change, such as pathway redesign, service reconfiguration, de/re-commissioning.

3) Which may lead to

D	Phase out interventions / activity with negative, little or no clinical value (links to investment in housing and care below)

6.1.3 By March 2025:

Operational Plan:

- Increase temporary capacity: expand capacity to address the surge in referrals.
- Enhance "Keeping in Touch" Processes: ensure high risk individuals receive timely support.
- Redesign Pathways: develop a more efficient diagnostic and treatment pathway, aligning our "right to choose" ICB accreditation process with our redesign work.
- Service Model Review and Reconfiguration: assess the effectiveness of the new care pathways, consider radical changes such as reconfiguration, decommissioning, or recommissioning services based on performance and outcomes.
- Phasing Out Ineffective Interventions: review and phase out interventions or activities that offer little or no clinical benefit, redirect resources to more effective and high-impact areas.

Planned investment:

The proposal is to invest £1.734 million in 2024/25, rising £3.861 million recurrently in 2025/26. The focus of investment is across all of the services described below in this chapter, but in particular:

- Non-recurrent deployment to address the cost pressures in complex care, which in 2025/26 will be reversed to insure investment in complex care on a recurrent basis.
- Addressing the current challenges in access for adult ADHD and autism assessment, diagnosis, and support.
- Locality investments in building the right support.

6.2 Health Checks

6.2.1 The provision of Learning Disability Annual Health Checks (AHCs) is a crucial component in reducing premature mortality. These enhanced services are delivered within primary care, with the ICB's objective and NHS England's KPI being to ensure that 75% of people aged 14 and over on a GP learning disability register receive an annual health check.

6.2.2 The NENC ICB has successfully met this target over the past two years (post-COVID) and is on track to do so again in 2024/25. The ICB's Learning Disability Network provides strategic leadership to improve both the quantity and quality of

annual heath checks, such as recently introducing prompt sheets to help individuals prepare for their checks.

6.2.3 However, there are disparities in service delivery across different areas, Primary Care Networks, and general practices.

6.2.4 Annual health check provision for autistic people is inconsistent across the ICB.

6.2.5 Given these challenges, the commissioning focus should prioritise improving the quality of AHCs. Quality improvement schemes have been effective in the past, but it is important to consider the significant pressures currently facing general practice. Clinical involvement will be crucial in designing any future AHC quality initiatives. The appropriate commissioning approach is to:

B1	Support incremental change and improvement across the whole ICB

Operational Plan:

- **ICB Operational Plan Goal:** Ensure that 75% of people with a learning disability aged 14 and over on GP registers receive an annual health check. The ICB is on track to meet this target in 2024/25.
- **Current Variation:** While some areas within the region have the capacity to support individuals in attending their annual health checks, this service is not consistently available across the ICB footprint, which will be investigated.
- **Future Aim:** The ICB aims to enhance assurance regarding the quality of annual health checks to ensure they effectively identify health problems early, allowing individuals with learning disabilities to receive timely treatment and maintain their health.
- **Expansion to Autistic People:** The NHS Long Term Plan seeks to extend annual health checks to include autistic people. Some regions are already implementing this, there are gaps in others which needs further investigation.
- **Planning for 2025/26:** We are developing strategies to ensure equitable access to annual health checks for autistic people, pending formal guidance and funding confirmation from NHS England.

6.3 Learning from lives and deaths

6.3.1 People with learning disabilities often face poorer physical and mental health and encounter barriers to accessing necessary care. As a result, they frequently die earlier than expected from conditions that could have been treated or prevented.

6.3.2 The Learning from Deaths, People with Learning Disabilities and Autistic People (LeDeR) programme was established to improve services by investigating the

causes of these premature deaths. The programme aims to identify the factors contributing to these deaths and implement changes both locally and nationally to improve health outcomes and reduce inequalities for people with learning disabilities and autism. By analysing these cases, we can determine what needs to change to make a meaningful difference in their lives.

6.3.3 The ICB is working to have a consistent model for LeDeR reviews fully embedded by March 2025.

6.3.4 The NENC LeDeR panel and Learning into Action Group are currently being co-designed with experts by experience and are set to commence in September 2024.

6.3.5 The LeDeR annual report for 2023 will include insights from approximately 200 deaths. Once approved, this report will be published on the website.

6.4 Community based services, supported living / care and urgent care

6.4.1 Consistent access to clinically led, community-based care, combined with high-quality housing and appropriate health and social care support, is vital for neurodiverse individuals and those with learning disabilities who also have a mental illness. These elements are crucial not only for facilitating hospital discharge but also for preventing mental health crises that might lead to hospital admissions or readmissions.

6.4.2 After the mistreatment scandal at Winterbourne View in 2011, the NHS set targets under the Transforming Care Programme and the "Building the Right Support" initiative to reduce reliance on mental health inpatient care for people with learning disabilities and autistic individuals. The targets were set at no more than 30 adults and 12-15 under-18s per 1 million population in inpatient settings, excluding short-term assessments and treatments. These targets have since expanded to include autistic individuals and both learning disability and mainstream adult mental health beds. High-profile cases of poor-quality services have reinforced this policy. Recent NHS England guidance now directs Integrated Care Boards (ICBs) to cease commissioning "locked rehab" beds.

6.4.3 The 2015 guidance, published by NHS England, the Local Government Association (LGA), and the Association of Directors of Adult Social Services (ADASS) as part of the Transforming Care Programme, aimed to reduce inpatient care for people with learning disabilities and autistic individuals by enhancing community-based alternatives. The model focuses on providing high-quality, personalised support to prevent avoidable admissions. Emphasising early intervention, continuous support, and person-centred care, it seeks to deliver appropriate care in community settings, empowering individuals, improving their quality of life, and reducing the human and financial costs of preventable hospitalisations, while fostering independence and community participation.

6.4.4 Despite these efforts, the North East and North Cumbria (NENC) region has consistently exceeded the expected reduction in inpatient bed usage. There has been

no significant decrease, and many individuals with learning disabilities or autism remain in inpatient units while waiting for suitable housing and support packages. This prolonged stay can lead to increased distress, behavioural challenges, deteriorated mental health, and additional trauma.

6.4.5 A recent report to the ICB's mental health, learning disability and autism sub-committee highlighted the following concerns:

- Up to 40% of individuals with learning disabilities and autism ready for discharge from mental health inpatient services are delayed due to a lack of suitable housing and support.
- Some children and young people require complex care in residential settings, either unnecessarily or requiring transition upon reaching adulthood, including those in unregulated placements.
- There is a shortage of accessible, adaptable, and affordable housing that supports independent living, placing pressure on families and the health and social care system.
- Feedback from housing and social care providers indicates that investment is hindered by unclear or unsustainable funding, short-term commissioning decisions, and the absence of a clear long-term strategy for housing and support needs.

6.4.6 Data from local authority and health partners across North East and North Cumbria shows:

- 326 people (121 children and young people, and 205 adults) on Dynamic Support Registers.
- 139 adults with learning disabilities or autism in inpatient settings, including secure facilities.
- 1,355 adults with learning disabilities and autism in care homes.
- 1,372 adults with mental health conditions in care homes.
- 38 patients funded by the NENC ICB in independent sector hospitals, 14 of whom are outside the ICB, including 6 with learning disabilities.

Additionally, there are other indicators of need, for example a significant number of adults who are currently cared for at home with elderly parents/carers which in time will not be sustainable.

6.4.7 Stakeholder insights suggest that annually:

- 25% of those on Dynamic Support Registers may need housing, with or without care or support, including some young people approaching adulthood.
- 10% of individuals in care homes could transition to supported housing.
- 20% of people with learning disabilities and autism in inpatient settings will need housing with care and/or support upon discharge.

6.4.8 To address these needs, there is an annual requirement to find or develop 350 homes across the region that include access to care and/or support for individuals needing complex care. A detailed action plan, developed through collaboration between the NHS, local authorities, and other partners, is now being implemented to meet this demand.

6.4.9 This plan encompasses a combination of long-term strategy and policy development, provider market shaping, and shorter-term pathway and service development, and will include:

A1	Invest in all places across the ICB to increase our capacity
B1	Support incremental change and improvement across the whole ICB
B2	Spread evidenced best practice from one place or provider to all places / providers in the ICB
C	Radical change, such as pathway redesign, service reconfiguration, de/re-commissioning.

Operational Plan:

- **ICB Operational Plan:** Our 2024/25 target is to reduce the use of mental health inpatient beds for adults with learning disabilities and autistic adults to 64.8 per million adults. While this remains above the national target of 30 per million, it is a significant reduction.
- **Housing with Support:** We will prioritise the development of housing with support for individuals ready to leave hospital, focusing on areas with the greatest challenges.
- **Long-Term Strategy:** We will collaborate with system partners and individuals with lived experience to develop a comprehensive long-term strategy for complex care.
- **Standards and Pathway Redesign:** We will work with our community of practice to establish standards and guidelines for housing with support, and to redesign pathways that enhance information, advice, and access to quality housing.
- **Enhanced Community Models of Care:** We will identify areas for improvement within our Enhanced Community Models of Care, aiming to reconfigure, re-commission, or strategically invest in these services for 2025/26.

Planned investment:

- In 2024/25 we will expand our capacity to deliver proactive community support, focusing on reducing the need for both admissions and readmissions.

6.5 Care Treatment Reviews (CTRs)

6.5.1 Care (Education) and Treatment Reviews (C(E)TRs) are a key part of NHS England's commitment to transforming services for people with learning disabilities and autistic individuals. C(E)TRs are conducted for those who have been admitted to a mental health hospital or are at risk of admission. Their primary purpose is to ensure that hospital admission is only used when absolutely necessary and for the shortest time possible. Care and Treatment Reviews (CTRs) focus on adults, while C(E)TRs are specifically for children and young people.

6.5.2 CTRs aim to reduce hospital admissions by improving the quality of care and treatment through key questions and recommendations that enhance safety and care. They work to minimise the time people spend in hospital and bring together key stakeholders to resolve issues that might prolong a hospital stay. This process also aids in better current and future care planning, including discharge plans.

6.5.3 The C(E)TR policy was last updated in January 2023, with implementation beginning in May 2023. It now includes the Dynamic Support Register (DSR), which ensures a collaborative approach to reviewing the needs of individuals on the register. The DSR helps systems identify adults, children, and young people with increasing or complex health and care needs who may require additional support in the community as a safe and effective alternative to mental health hospital admission.

7. Enablers

This section will be developed over time for future iterations of this plan. It is intended to develop a description for each of the following enablers:

- Working Together at Place and in Neighbourhoods
- Involving People to Co-produce the Best Solutions
- Best use of Resources and Protecting the Environment
- Financial Plan.
- Protecting the Environment.
- Innovating with Improved Technology, Equipment and Estates
- Research and Innovation.
- Estates.
- Digital, Data and Technology.

Alongside the enablers identified in the Better Health and Wellbeing for All strategy, we will also develop a clearer plan for **trauma informed care**. We think that trauma informed approaches should be a clear, underpinning enabler, to all of our transformation and improvement approaches.

8. Provider Market

This section will be developed over time for future iterations of this plan. In this section we will set out our collective vision more clearly for the role of each of:

- NHS Primary, Secondary Care and Tertiary Care

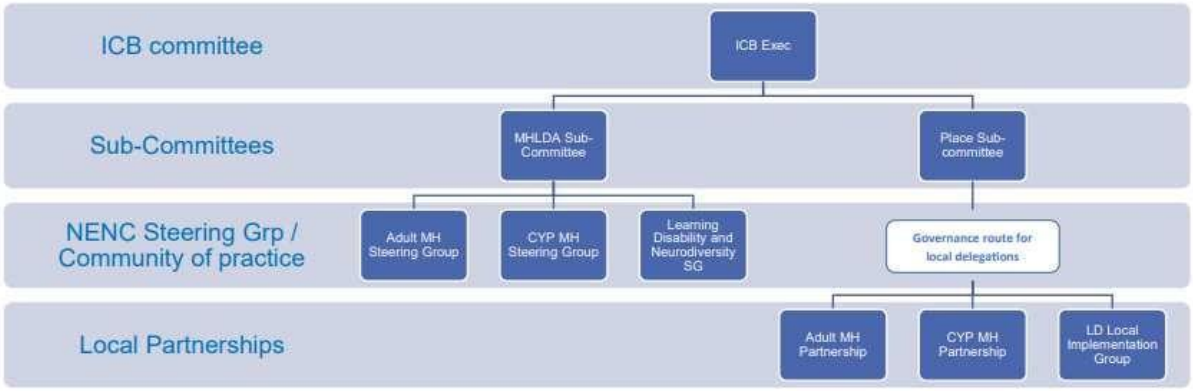
- The voluntary, community and social enterprise sector
- The independent sector
- The joint or aligned work between the NHS and Local Authorities, across social care and public health.

This will also include areas where we collectively agree that provider organisations, particularly including the NHS Trusts that provide secondary care, may be most appropriate to lead particular parts of this emerging plan.

9. Governance and Partnership Working

Over time we will continue to review and improve our governance structures, focussed on strong stakeholder engagement and clarity of decision making.

The diagram below outlines the revised ICB governance structure for the mental health, learning disabilities and autism sub-committee, though this is only one part of our partnership structures.



10. Next Steps

The following are summary next steps for the delivery of this plan.

1) To develop a more detailed recovery plan for each of the operational plan and/or NHS Long term plan ambitions.
2) To develop the key enablers referenced in chapter 7, including specifically to develop a longer term financial/investment plan and the involvement of people with lived experience, clinicians, practitioners and stakeholders.
3) More clearly develop our collective partnership working governance.
4) To ensure clear oversight from the ICB Board and respective Committees and support equivalent arrangements in NHS and partner organisations.
5) To ensure a clear, transparent, and reliable assessment of current performance and performance trends. This will be through an effective set of business intelligence dashboards.

11. Glossary

There are some acronyms in common use in mental health, learning disability and neurodiversity services that may not be well understood in the wider community. There are also some words such as “recovery” or “organic” that have a different meaning in our context to their general use. The table below is intended to be a handy guide which explains what any acronyms and specialised words mean in every day, “plain” English.

Term or acronym used in this document	**Plain English or full words version**
ACEs	adverse childhood experiences
A&T	Assessment and Treatment
CNTW	Cumbria Northumberland Tyne and Wear Foundation Trust
CYP	Children and Young People
functional	See *organic* entry below
GP	General Practice
ICB	Integrated Care Board
IPS	Individual Placement and Support (a service which helps people with a serious mental illness find paid work to assist with their recovery)
MHA	Mental Health Act 1983
MHSOP	Mental Health services for older people (“older” is generally 65 or more years old)
MHST	Mental health support team (for schools)
NENC	North East North Cumbria
Neurodiverse / neurodiversity	Neurodiversity is a concept that recognises that there are a variety of ways in which people’s brains process information, function and present behaviourally. People who differ from the average or “norm” in how their brain processes information have a higher risk of mental illness. Attention Deficit Hyperactive Disorder (ADHD), Autism, Dyspraxia, and Dyslexia all fall within the spectrum of “Neurodiversity” and are all neurodiverse conditions.
NHSE	NHS England
organic	A mental illness caused by degeneration of brain structures (such as Alzheimer’s). In older people’s services this is contrasted with *functional* illnesses which are not caused by changes in brain structures and which are similar to illnesses that younger people may develop.
PICU	Psychiatric Intensive Care Unit
Place	In this plan “place” either means individual or groupings of local authority areas which commissioning teams are organised around by NENC ICB.

Primary Care	Primary care services provide the first point of contact in the healthcare system, acting as the 'front door' of the NHS. Primary care includes general practice, community pharmacy, and *Talking Therapies for Anxiety and Depression (TTAD)*
SDF	Service Development Fund
Secondary Care	Secondary care services are those provided by medical specialists, who in general only treat patients who are referred to them by primary care. This includes community mental health teams, and most mental health inpatient bed based services
SENCO	Special Educational Needs Coordinator
Stakeholder	A person, group of people or organisation that have an interest or “stake” in how a service is delivered now or in the future
Tertiary Care	Tertiary care refers to highly specialised treatment such as neurosurgery, transplants and secure forensic mental health services. In mental health such services are commissioned by specialist provider collaboratives on behalf of NHS England and so are not featured in this version of this plan.
TEWV	Tees, Esk and Wear Valleys Foundation Trust
TTAD	Talking Therapies for Anxiety and Depression
VCSE	Voluntary, Community and Social Enterprise sector

Appendix 1 Indicators of Need

A1 1.1 Indicators of Need: Children and Young People

Source: The data under children and young people is all taken from Children and young people's mental health in 2023 | National Centre for Social Research (natcen.ac.uk). The definitions and metrics are explained in that source document.

Prevalence
In 2023, about **1 in 5** children and young people aged 8 to 25 years had a probable mental disorder: • 20.3% of 8 to 16 year olds • 23.3% of 17 to 19 year olds • 21.7% of 20 to 25 year olds. After a rise in prevalence between 2017 and 2020, rates of probable mental disorder remained stable in all age groups between 2022 and 2023.

Socio-Economic
In 2023, more than 1 in 4 children aged 8 to 16 years (26.8%) with a probable mental disorder had a parent who could not afford for their child to take part in activities outside school or college, compared with 1 in 10 (10.3%) of those unlikely to have a mental disorder. 17 to 25 year olds with a probable mental disorder were 3 times more likely to not be able to afford to take part in activities such as sports, days out, or socialising with friends, compared with those unlikely to have a mental disorder (26.1% compared with 8.3%). As North East North Cumbria has much higher deprivation levels than the English norm it is likely that prevalence of child and young person in this ICB area is higher than the national average (see bullet 4 above).

Female and Male
In 2023, among 8 to 16 year olds, rates of probable mental disorder were similar for boys and girls. For 17 to 25 year olds, rates were twice as high for young women than young men. Eating disorders were identified in 12.5% of 17 to 19 year olds, with rates 4 times higher in young women (20.8%) than young men (5.1%). 2.6% of 11 to 16 year olds were identified with eating disorders, with rates 4 times higher in girls (4.3%) than boys (1.0%) and 5.9% of 20 to 25 year olds, were identified with eating disorders with no difference in rates evident between women and men.

A1 1.2 Adult Mental Illness Prevalence

The 2014 survey of Mental Health and Wellbeing in England found that 1 in 6 people aged 16+ had experienced symptoms of a common mental health problem, such as depression or anxiety, in the past week. Women were more likely than men to be experiencing common mental disorders. Prevalence has increased since 1993.

Prevalence
• Nationally, 1 in 6 people experience common mental health problems like anxiety and depression, and 1 in 8 people have a mixed anxiety and depression diagnosis. • In the North East and North Cumbria (NENC), 20.3% of our population have an anxiety disorder, and 14.8% have depression. • 348, 264 people are prescribed antidepressants, including 1,213 individuals under 18. The area has one of the highest rates of antidepressant prescriptions and costs in England. • 2% of survey respondents had ever experienced bipolar disorder, while 0.7% had experienced psychotic disorder in the past year. • 4.4% of respondents screened positive for post-traumatic stress disorder. • Just over 5% of survey respondents reported having had suicidal thoughts in the past year.[2]

Socio- Economic Factors
• 28% of our population lives in the 20% most deprived areas in England. • 45.1% of those with a severe mental illness reside in these areas. • While anxiety and depression can affect people in wealthier areas, poverty, deprivation, unemployment, and economic hardship disproportionately impact communities in more deprived regions.

Health Related Behaviours
• People with anxiety disorders, depression, or severe mental illness are 1.3 times more likely to be overweight and 1.6 times more likely to be obese. Nicotine dependency (smoking rates) are 1.7 times higher, and the prevalence of substance misuse is 2.0 times higher. • 34.7% of those with a record of substance misuse also having a diagnosis of anxiety, depression, or severe mental illness. • People living with a common long term condition, for example a chronic obstructive pulmonary disease (COPD) are much more likely to have poorer mental wellbeing.

[2] Mental health statistics: prevalence, services and funding in England - House of Commons Library (parliament.uk)

Suicide
• In 2021, there were 5,219 suicides registered in England, equivalent to a rate of 10.4 deaths per 100,000 people. • In NENC, the rate was significantly higher at 13.4 deaths per 100,000 people (2019-2021). • The rate is highest in parts of North Cumbria, Tees Valley and Durham. • Around three-quarters of suicides in England were males (3,852; 73.8%), with a rate of 15.8 deaths per 100,000, compared to 5.5 deaths per 100,000 for females. • These trends are similar in NENC, with the highest proportion of male mortality occurring in the 18-25 age range, contributing to significant health inequalities in the region.

A1 1.3 Learning Disability and Neurodiversity

Learning Disability and Neurodiversity
Prevalence estimates suggest that approximately 2.2% of adults live with a learning disability, with a higher prevalence amongst people who live in neighbourhoods with higher socio-economic deprivation. This would suggest approximately 50, 000 adults in the North East and North Cumbria. However, primary care learning disability registers show just over 23, 500 people. Estimates suggest the prevalence of autism and ADHD to be approximately: • Under 18: Autism 1.1%, ADHD: 5% • Adult: Autism: 1%, ADHD: 3 – 4% This equates to approximately 7,000 autistic children and 30,500 with ADHD across NENC ICB. For adults this equates to around 25,000 autistic adults and 100,000 adults with ADHD across NENC ICB.

Appendix 2 Integrated Delivery Report - Mental Health, Learning Disability and Autism

(See separate document)

Appendix 3 Commissioning / Improvement Approaches

	Narrative		Implementation Lever	What would indicate this is the right response?
A	We need to do more of what we currently do by adding capacity	A1	**Keep the current service model, but invest in all places across the ICB to increase our capacity** (may be temporary / non recurrent or permanent / recurrent)	Access, performance or quality gap between where we are and where we should be is relatively small and relatively similar across all places. We are sure that our service model is the most appropriate / nationally recommended / mandated one. If capacity is matched to demand but waits are excessive, this indicates non recurrent investment. If capacity is below demand and gap is growing recurrent investment indicated.
		A2	**Keep the current service model, but concentrate investment in places** which have lower levels of investment / capacity per population than others	Access, performance or quality gap between where we are and where we should be is concentrated in one / a few places and correlated with level of resources invested and / or workforce capacity [i.e. we are sure that inefficiency is not causing the problem]
B	We need to improve what we do by incrementally changing the way we do things	B1	**Support incremental change and improvement across the whole ICB**	There is an ICB-wide access, performance or quality gap between where we are and where we want to be, and there is evidence either of "waste" in our systems and / or evidence that other places in the UK that invest similar amounts of money in this service are performing better. We are not tied to a national mandated model (or if there is one, we are not following it)
		B2	**Spread evidenced best practice from one place or provider to all places / providers in the ICB**	There are significant differences in service models between different places in the ICB despite similar levels of investment, and no reasons why the practice in our "best" performing place(s) can't spread across whole of ICB
		B3	**Spread most efficient practice from one place to other places in the ICB**	There is evidence that different places achieve similar levels of performance / access / quality despite very different levels of investment. Share and spread of the most efficient ways of working to be encouraged to free up investment for either doing more (A1 / A2) or transformation (C)
C	We need to transform what we do	C	**Radical change, such as pathway redesign, service reconfiguration, de/re-commissioning.**	ICB wide significant quality/access issues + workforce, clinical and financial restraints rule out investing in current model OR a change in available technology OR national policy require radical change or setting up new services.
D	We need to do less of what we currently do	D	**Phase out interventions / activity with negative, little or no clinical value (i.e. poor value for money)**	There is quantitative or qualitative data / research which shows that a service or aspect of a service that we are providing produces little, no or negative clinical outcomes and is clearly poor value for money
E	We need to understand more	E	**Commission audit, evaluation, research and review type work**	We do not really understand either if or why our services do not meet national expectations or the needs of NENC's people so we cannot work out what the right response is yet

Appendix 4: Decision Making Tree to determine the appropriate commissioning/improvement approach