ADULT MENTAL HEALTH & DEMENTIA SYSTEM STRATEGY
2018-2023

Final v1.1
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Foreword

Mental health is everyone’s business. We have the ambition to make a significant change in the way people see and experience mental ill health and dementia. We are building on good foundations. There are many positive things to say about the progress we are making nationally and locally around mental health and dementia and associated conditions. People across the East Riding of Yorkshire have access to a range of services, dependent on their needs and there is a greater understanding of the links between mental and physical health.

There has never been a better time to look at how we can help communities to better support their own mental health and how best to support people when they need it most. We need to build and support mental resilience and wellbeing, give people the tools and information they need to help themselves, and to help each other – building resilience within people, communities and systems.

When people need treatment and support from more traditional health and care services, we plan to redesign services and systems which will co-operate and work together better across organisational boundaries.

However, significant challenges remain, particularly around finance and workforce and this strategy outlines where improvement is still required in these areas and others and what we will do about it. However, there are lots of opportunities to make things better for people; we need to focus on all the assets and resources available to us to help design and deliver new and innovative ways to provide efficient and effective person-centred responses, enabling people to be as mentally healthy as possible. Our people, places, schools, clubs, buildings, employers, charities, organisations and experts all have a vital role in helping to achieve this.

Our Vision:

'I want to enjoy good mental health, living in a community that is supportive to my, and others’ needs, if I become mentally unwell I want easy access to appropriate services with a focus on recovery and independence’

Our Outcomes:

• I will feel like I have control because my services will be personalised
• I will feel confident in my ability to manage my condition.
• I want to build positive relationships with others in my community.
• I want support to help me stay independent.
• I want my services to be sustainable and easy for people to access in the long term for me and my carer.
Introduction

Our vision in the East Riding is for local people to live healthy lifestyles, promoting overall wellness and quality of life. For people who experience mental ill health or who are living with dementia, along with their carers, to live in communities that understand and are responsive to their needs, where people feel empowered to seek help early, know where to go for support, what services to expect and how to access them.

It is also important to ensure that we promote integrated working to create an environment where individuals have access to the right care and support at the right time for them. We want to ensure that the public and professionals are well informed and that the fear and stigma associated with dementia and mental health are further decreased. It is for this reason that the 11 partners identified on the cover of this document have signed up to this joint strategy to work together to deliver better, more joined up outcomes for people living in East Riding.

We recognise the invaluable support provided by family, friends and neighbours and appreciate the importance of ensuring carers are represented well in this strategy and that they have access to the necessary information, advice and support system to help them to continue to care for as long as they are able or willing to.

Early intervention and prevention is key to avoiding any delays in access to appropriate support through the right pathway, this will in turn reduce the likelihood of admission to long term or acute care and the prevention of situations becoming difficult for people living with dementia or who have an acute episode of mental ill health.

It must be recognised that writing a strategy encompassing mental health and dementia is a challenge in itself, but there are positive benefits from doing so and having system partners signed up to the principles and actions outlined in this document is a real step forward. Whilst there are similarities in parts of some people’s journey’s, keeping the voice of those in need of help or support along with their carers is crucial, there are also some significant differences. In general for those experiencing mental ill health the focus needs to be on recovery and building resilience that helps avoid or minimise the impact on individuals and their families. For those with Dementia the focus must be on living well with their illness and ensuring that people are able to prepare and have a dignified end of life.

Good mental health helps us to thrive. Good mental health is not just the absence of illness but having the ability and resilience to deal with challenges in a way that
enables us to enjoy life and prosper or live life to fullest despite having an illness that impacts on an individual’s mental and physical functioning. That is not to say that we all need to be happy all of the time, it simply means that we are able to cope better when faced with adversity. It also doesn’t imply that we have to do this alone as we all need people around us to support us whether this is the family unit, friends and carers or a local community group.

At least one in four of us will experience mental ill health at some point in our lives – this equates to around 85,000 people in the East Riding. Nationally; around half of people experiencing mental ill health in their life course will encounter their first symptoms by the age of 14 rising to 75% by 24 years. This strategy focuses on adults, however the work we are doing locally to improve children's mental health underpins and strengthens this work. Many of the experiences referenced above will not be formally diagnosed due to a number of reasons including the stigma still associated with having mental ill health.

The prevalence of diagnosed severe mental illness is much lower however; people diagnosed with severe mental illness die up to 20 years younger than their peers in the UK, predominantly due to higher rates of poor physical health.

Whilst we know that people in the care of Mental Health Services are at higher risk of suicide than the general population, three quarters of suicides occur in people not in contact with Mental Health Services in the previous 12 months. It is therefore crucial that a broad, community-based approach is taken to suicide prevention. Further details on our response to suicide and suicide prevention will be made available in the forthcoming East Riding Suicide Prevention Plan and are not covered in detail in this strategy.

As of January 2017, circa 903,000 people in the UK were living with dementia. By 2023, the end of this strategy, this is predicted to increase to over 1 million people. There remains considerable stigma around dementia and many people have a negative view of the disease which can make some that are affected feel worthless and lack purpose. People with learning disabilities are at increased risk of developing dementia particularly people with Down’s syndrome: a third of people with Down's syndrome develop dementia in their 50s. Many people also worry about how they or their families will cope as support and care can be seen as

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1 Five Year Forward View for Mental Health, 2016
4 https://www.alzheimers.org.uk/
of particular concern is the number of carers supporting people with dementia and their needs and the volume of people in care homes and hospital beds with diagnosed / undiagnosed dementia. Figure 1 provides some useful feedback from people with dementia and their families and carers.

Figure 1: Feedback from People with Dementia, their Families and Carers

There are things, however, that we can all do to help prevent mental ill health and dementia; things that offer a protective benefit. Prevention is a critical theme within this strategy – as important as supporting and treating people who are ill. In contrast, there are also things that can lead to dementia or mental ill health (Figure 2 and 3).

Figure 2: Preventative actions for mental ill health and dementia

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5 Turning Up the Volume: Unheard Voices of People with Dementia, 2017
6 Turning Up the Volume: Unheard Voices of People with Dementia, 2017
7 https://www.nhs.uk/conditions/stress-anxiety-depression/improve-mental-wellbeing/?#five-steps-to-mental-wellbeing
Figure 3: Risk factors for mental ill health and dementia

<table>
<thead>
<tr>
<th>Mental Health</th>
<th>Dementia⁸:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Poverty / deprivation</td>
<td>• Age</td>
</tr>
<tr>
<td>• Drug / alcohol misuse</td>
<td>• Genetics</td>
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<tr>
<td>• Unemployment / debt</td>
<td>• Cardiovascular</td>
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<tr>
<td>• Work related stress</td>
<td>• Diabetes,</td>
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<td>• Long term physical conditions</td>
<td>• Head trauma</td>
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<td>• Social isolation</td>
<td>• Depression and anxiety</td>
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<tr>
<td>• Traumatic experiences</td>
<td>• Smoking</td>
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<tr>
<td>• Brain injury</td>
<td>• Alcohol consumption</td>
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<tr>
<td>• Adverse life events</td>
<td>• Inactivity</td>
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<tr>
<td>o Relationship breakdown</td>
<td>• Poor diet</td>
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<tr>
<td>o Job loss</td>
<td>• Social isolation</td>
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<tr>
<td>o Bereavement</td>
<td>• People with a learning</td>
</tr>
<tr>
<td>• Domestic violence</td>
<td>disability, particularly</td>
</tr>
<tr>
<td>• Adverse Childhood Experiences (ACE)⁹</td>
<td>Down’s syndrome</td>
</tr>
</tbody>
</table>

What we want to achieve

We have listened carefully during the formulation of this strategy. We have met with people who use services, their families and carers, as well as professionals and volunteers from various health and social care organisations in the East Riding as well as other services and organisations, such as Housing, the Police and the Fire and Rescue Service. Our local people have told us what they would like to see from this strategy that will make their lives better and we have used this to create the following vision statement.

'I want to enjoy good mental health, living in a community that is supportive to my, and others’ needs, if I become mentally unwell I want easy access to appropriate services with a focus on recovery and independence'

We aim to raise the standard of health and wellbeing services across the East Riding by addressing all aspects of need under a common framework. This is to support the development and building of the Resilience Framework: Personal Resilience, Community Resilience and System Resilience.


⁹ The response to ACEs is captured in the Future in Mind plan
This framework allows us to understand if we are doing enough to support people, communities and the wider system to help us achieve the outcomes our local people want. The framework allows us to understand all that we are currently doing under each heading and where new initiatives will feature. It allows us to see if we have a balanced approach to our strategies that ensures we are not prioritising certain initiatives over others. We have aligned the specific outcomes people want to see that will enable us to achieve our vision against the Resilience Framework (Figure 4).

Figure 4: Building Personal, Community and System Resilience

This strategy sets out our five year plan to enhance the mental wellbeing of the population of the East Riding and to transform the experience and care of people with mental ill health and dementia, including the consequences this has for their families, carers and friends. It forms part of, and feeds in to, the wider strategic planning for the East Riding. It is driven by the ambition to deliver the best possible services, advice and support for our local people, embedding the individual at the heart of everything we do through personalisation of services, and providing a clear link between national policy and how this can be implemented at a local level. It gives our system and our local people a clear sense of direction for the future of mental health and dementia services. There is still much to do but we have a very clear set of ambitions that will improve people’s lives greatly, once these have been achieved.

East Riding system partners want to see a new way of working that creates a more person-led, collaboratively provided approach to care and support (Figure 5) that will help the delivery of this framework. Fundamentally, this will involve all system partners coming together for the benefit of the individual, recognising the role they

10 http://www2.eastriding.gov.uk/council/working-with-our-partners/east-riding-2020-partnership-and-board/
11 http://www2.eastriding.gov.uk/council/committees/health-and-wellbeing-board/
12 http://www2.eastriding.gov.uk/environment/planning-and-building-control/east-riding-local-plan/
14 The Five Year Forward View for Mental Health (February 2016)
15 Implementing The Five Year Forward View for Mental Health (2016)
16 Mental Health and New Models of Care (May 2017)
play as a professional but also identifying the wider needs of the person and making the necessary connections. We want person-led, coordinated support and care, meaning services will need to work together in a much more joined up, integrated way, centred around people and communities and only using specialist services when they really need to.

Our strategy focuses on the adult population (including those with dementia) and is aligned to our children’s mental health service plans¹⁷,¹⁸ and other related work. The wide ranging nature of this strategy means that much of it links to other sectors, strategies and initiatives in the East Riding and further afield. Figure 6 summarises what the strategy intends to accomplish.

The strategy is divided into two chapters:

**Chapter 1** focuses on why we need to change. It illustrates the priorities of our population and how these have been determined, the challenges and opportunities we have locally, as well as the national and local policy context.

**Chapter 2** explains how we will change to meet the needs of local people and the link between these actions and the outcomes we have described in this introduction. It also shows when we will deliver the components through a high level programme plan.

Figure 5: Revised Approach to Wellbeing, Health and Care Services

You, your health, and us
Improving and supporting personal, community and system resilience in the East Riding

Personal Resilience | Community Resilience | System Resilience
Figure 6: Summary of the Strategy

Everyone should enjoy good mental health, living in a community that supports each other’s needs with easy access to appropriate services that focus on recovery and independence.

1. Mental wellbeing and prevention of mental illness health
   - System partners to ensure consistent, accessible and accurate information is available
   - Promote healthy lifestyles including physical activity
   - Promote workplace Mental Health, utilising wellbeing assessment for local organisations
   - Develop ‘community champions’ to reduce stigma around mental illness health and dementia
   - Promote mental health awareness training to communities, developing a mental health guide to go to all households
   - Implement the Social Prescribing service

2. Early intervention and support in the community
   - Define and adopt a strengths based and recovery approach, supporting personal and community resilience
   - Support the continued development of the Recovery College
   - Ensure housing and employment needs and aspirations are built into care plans
   - Closer liaison with Housing Strategy Department, ensuring mental health needs are influencing policy
   - Work with local employers and the job centre to proactively support existing personnel and encourage opportunities for those living with mental illness health
   - Ensure housing and employment needs are built into care plans
   - Expand usage of Personal Health Budgets to over 100 per annum
   - Commissioned redesigned dementia assessment pathway and a non-medical post-diagnosis service
   - Support the further development of East Riding as a Dementia Friendly Community
   - Dementia training and support to domiciliary and care home sector, possibly through development of dementia liaison service
   - Work with partners to deliver better integration/jointly commissioned mental health and substance misuse and support intervention
   - Support delivery of the carers Strategy including improvements to our process for Carers Assessment
   - Offer Talking Therapies within Primary Care
   - Increase access to General Practice

3. Proactive and accessible support and services
   - Establish specialist community services for adults with ADHD and adults with complex eating disorders
   - Co-produce a redesigned pathway for people with complex personality disorders
   - Develop a service specification for dementia patients with challenging behaviour
   - Offer people the opportunity to be part of quality research and development
   - Support veterans to access the full range of mental health services and enable professionals to better support them
   - Pilot a core 24 mental health liaison service in A&E department
   - Advice and support via e-referral to be rolled out to mental health secondary care services
   - Improve experience of care at times of crisis
   - Reduce Out of Area placements

Outcomes
- I will feel like I have control because my services will be personalised
- I will feel confident in my ability to manage my condition
- I am able to build positive relationships with others in my community
- I have support to help me stay independent
- I know my services are sustainable and easy for people to access in the long term.

Culture and resources
- Personalised Services
- Co-Production, Personalisation, Carer Involvement, Strengths Based Approach
- Leadership and Governance
- Workforce Development and Training
- Financial and Contractual Management supporting Innovation and Transformation
- Consistent Quality Standards
- IT Infrastructure and Shared Data

Bold items are priorities for 2018-19
Chapter 1: Why we need to change

Outcomes of Engagement – Key Messages and Themes
This strategy has been developed through engagement with the people of the East Riding, including those who have direct experience of mental ill health and dementia and those who support or represent them (e.g. carers, family, etc.). We organised a series of engagement events across the summer and autumn of 2017. Specifically, this ranged from workshop events with professionals, community groups and local people, electronic feedback (including through the use of social media) as well as focus groups with local people in a smaller, more intimate, setting. These all helped to provide the current experiences of people and their representatives / carers.

All individuals / groups were requested to identify their key priority areas and were asked to focus on Common Mental Health Conditions, Severe Mental Illness and Dementia. The same questions were asked for all three groups utilising the framework of Personal Resilience, Community Resilience and System Resilience as defined earlier. Comments in response were mixed, with both positive and negative experiences being voiced, although the majority of feedback highlighted areas where needs were unmet. The full feedback report is available on the CCG’s website.

In addition to many specific points of feedback that we will capture in this chapter, we have heard strongly that people require proactive services that are centred on their needs, that they want to be treated with kindness and to be aware of what support is available to them. People want to be on an equal footing with professionals rather than passively receiving services.

‘What matters to you?’ is a fundamental question at the heart of all of our thinking. Knowing what is important to someone gives vital insight that enables people to help others in the best way for them. It recognises the strengths of the individual and the community they live in and builds upon this.

National Context
The percentage of people reporting common mental ill health (e.g. depression or anxiety) has risen from 15.5% of the population to 18.9% in 2014. There is a link between common mental ill health and substance misuse (including alcohol). People who misuse drug and alcohol, people with mental health problems and/or learning disabilities, Attention Deficit Hyperactivity Disorder (ADHD) or autism are disproportionately represented in the criminal justice system and it is important that

19 Mental Health Problems: Statistics on Prevalence and Services, 2017
20 http://www.eastridingofyorkshireccg.nhs.uk/get-involved-1/shaping-a-mindful-future/
21 http://www.whattmatterstoyou.scot/
23 Strategic Direction for health services in the justice system: 2016-2020
both local and national commissioning organisations work together to deliver alternatives to custody and to prevent detention where appropriate.

Common mental ill health is reportedly more prevalent in women than in men in every age group with the difference being most pronounced in those aged 16-24; the age of transition between childhood and adulthood. The prevalence has increased amongst young people. Prevalence of common mental health illness varies by ethnicity with black people more likely than average to experience these kinds of illnesses. Economically inactive or unemployed people are substantially more likely to experience a common mental health illness during their lifetime.24

The Mental Health Act (2007), Mental Capacity Act (2005), The Care Act (2014) and the Five Year Forward View for Mental Health (2016) remain the key national publications that define the legal and policy direction for the provision of support and services to those with mental ill health and Dementia.

The Five Year Forward View for Mental Health served to bring together the key themes for people with mental ill health, the majority of which remain relevant for the next 5 years (Figure 7). Our local outcomes align to these national themes clearly i.e. improving mental wellbeing and preventing mental ill health (utilising the approach advocated through the Prevention Concordat for Better Mental Health25), building relationships with the community to enable advice, support and care at the right time and in the right place, improving access to services and developing an integrated approach to enable people to be as independent as possible.

Figure 7:

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24 Mental Health Problems: Statistics on Prevalence and Services, 2017
A national study, focusing on dementia, outlined a number of clear statements that people with dementia, their families and carers want to see become a reality\textsuperscript{26} (Figure 8).

\textbf{Figure 8: The Dementia Statements}

Within the East Riding we have seen a renewed emphasis on mental health amongst our partner agencies to improve the advice, support and care people with mental ill health have access to. We understand that people can suffer from organic conditions (such as dementia) or functional conditions (such as mental ill health) and that there are both differences and commonalities in terms of risk and protective factors (Figure 2) but also in how these individuals are supported and some of the statutory services that provide care.

\textbf{Local Context}

East Riding of Yorkshire is a large rural area of around 1000 square miles, including coastal towns, urban fringe and remote rural towns and villages. It has a population of 337,696\textsuperscript{27}, an increase of 1.1\% since the 2011 census. Within this growth there has been a decrease of around 3,900 in the number of people aged 0-64 whilst the number of people aged 65 and over has increased by 6,500. Assuming these trends continue, this means that by 2023, the East Riding could have seen a further increase in the older population of a further 10\%.

\textsuperscript{26} Turning Up the Volume: Unheard Voices of People with Dementia, 2017
\textsuperscript{27} ONS 2016 Mid-Year Estimate
It is important to recognise the need for specific services for older people as both functional and organic problems present differently and often require different treatments in the elderly. In addition, large proportions of the elderly population, regardless of whether their problems are functional or organic, struggle to access working age adult services. Therefore for older adults to have parity of care with their working age counterparts there needs to be clarity that they need separate specialised services that include both functional and organic expertise.

96.2% of the East Riding population categorise themselves as White British, a greater number than the Humber, Yorkshire and the Humber and England comparatively. With such a high proportion of White British people in the East Riding it is important for us to not overlook those people from Black and Minority Ethnic (BME) groups as this can be a risk factor for mental ill health and this group of the population are under-represented within the Talking Therapies service. There is a similar issue for Lesbian, Gay, Bisexual and Transgender (LGBT) groups which is addressed in the Future in Mind plan whilst people who have a dual diagnosis of mental ill health and a learning disability should be able to access mental health services but occasionally find themselves falling between two services.

The East Riding is largely affluent although there are areas such as Bridlington, Goole, Withernsea and some parts of Beverley where this is not the case. There have been a number of challenges to health and wellbeing identified across the East Riding (e.g. smoking, social isolation, excess weight, people living with multiple long term physical conditions, etc.) through evidence, engagement and discussion with the people who live here. These challenges not only impact on a person’s physical health and wellbeing, but also on their mental health and wellbeing and can be risk factors for dementia.

There are intrinsic links between mental ill health, dementia, the socio-economic circumstances people live in and the services they receive. Often people are caught in vicious circles whereby ill health precludes or prevents them from fully integrating with society which in turn can exacerbate or lead to ill health and vice versa. For example, our emerging Homelessness Strategy 2018-2023 notes that homelessness and mental health are often closely related. Mental ill health can create the circumstances which can lead to homelessness in the first place. Yet poor housing and homelessness can also increase the chances of developing a mental health problem or exacerbating an existing condition. This in turn makes it harder for the

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* Better Mental Health for All: A public health approach to mental health improvement, 2016
* [http://dataobs.eastriding.gov.uk/profiles/profile?profileId=118&geoTypeId=#iasProfileSection5](http://dataobs.eastriding.gov.uk/profiles/profile?profileId=118&geoTypeId=#iasProfileSection5)
* [http://dataobs.eastriding.gov.uk/jsna/jsnahome](http://dataobs.eastriding.gov.uk/jsna/jsnahome)
* Livingston, G. et al ‘Dementia prevention, intervention, and care’ (2017). The Lancet online
person to develop good mental health, to secure stable housing, to find and maintain a job, to stay physically healthy and to maintain relationships. The same is true for employment and education.

Our draft Older People’s Housing Strategy (2018-2023) identifies that there will be an increasing demand for specialist homes to be provided both in the private and public sector, and this will include provision for those with mental ill health including dementia. A proportion of the support and services accessed by people with mental health needs, particularly people with dementia, is from the independent care sector. This includes both Care Homes and Home Care. It is estimated that up to 70% of care home residents in the East Riding have diagnosed or undiagnosed dementia. There are a range of challenges in this sector primarily in terms of recruiting, training and retaining an appropriately skilled workforce, the substantial regulatory and inspection framework and the provision of specialist services. However it is clear that a sustainable, diverse care market is needed to deliver elements of this strategy. However, overall, mental health need in the East Riding is lower than average.

Figure 9 outlines the key challenges and context for the people of the East Riding.

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*Draft East Riding of Yorkshire Strategy for Carers: 2018-23*

**Silent Partners: Working Age Male Mental Health (Healthwatch East Riding of Yorkshire), 2017**
Circa 11,000
People with a Personality Disorder. These individuals are more likely to have other mental health issues such as depression or drug and alcohol problems and to self-harm which can lead to serious risk of injury or death.

In the East Riding, people are largely treated in generic mental health services rather than specialist services.

Circa 8,000
People affected by an Eating Disorder. People with an Eating Disorder have the highest mortality rates of any mental or psychiatric illness.

In the East Riding, adults with Eating Disorders are largely treated in generic mental health services rather than specialist services. The rate of Eating Disorders locally is higher than other areas of the country.

Circa 100
People transition from children’s services in the East Riding each year but not all move to adult mental health services. A further group move from adult to old age services.

Some people nationally have a poor experience of this transition, this is replicated locally. Some children move from established services to a position where there is no adult service (ADHD) whilst the planning between different services to support people can also be much improved for some.

Circa 14,000
Veterans of the Armed Forces. Some Veterans can struggle to adjust to civilian life and find it difficult to access mainstream services.

The East Riding has higher numbers of Veterans than other areas of the country due to the number of bases in the area and the coastal areas being a retirement destination. Apart from people with PTSD, individuals have to access mainstream services and some professionals can find it difficult to know how to support them.
All of the different groups of people who suffer from mental ill health or dementia can experience times of crisis. Crisis cannot be adequately defined as it is intensely personal however, it is often described as an emergency state that can pose a direct and immediate danger to an individual’s emotional or physical wellbeing.34

People face a range of issues when in crisis; some will not recognise they are in crisis, some will be reluctant to ask for help, more will not know where to go for help and if they do, we are told that these services can be difficult to access. For these reasons people often resort to the emergency services for help including ambulances or attending hospital Emergency Departments. In some cases, they will come to the attention of criminal justice agencies, either as a result of their own or other people’s actions. We have been told we need to do a lot more to prevent crisis and de-escalate in a managed way when people are experiencing it.

Some individuals with severe and enduring mental ill health will require admission to inpatient facilities. There are also some individuals detained under the Mental health Act legislation admitted to inpatient units as community interventions are not as well developed as we would like. Recently, there has begun to be substantial pressure on our mental health inpatient units and some patients have had to be admitted to units outside Hull and East Riding, sometimes a substantial distance away because of a national shortage of available beds. Units are also operating at higher occupancy rates than in the past and pressures on the ongoing support and care required for people can lead to people being delayed in hospital for non-medical reasons.

There is no single reason for the increased pressure on inpatient services but rather a range of factors, including:

34 www.mentalhealth.org.uk
• Limited alternatives to admission; for some individuals their home environment is not conducive to treatment and are admitted when what they require is a safe place

• An increase in the number of people admitted to units as a consequence of their use of substances

• Accommodation; Once admitted, some patients lose tenancies or are unable to return to where they were living, usually combined with a lack of specialist care and support

Forensic or secure mental health inpatient services include low, medium and high secure hospitals and are commissioned regionally and nationally by NHS England Specialised Commissioning Teams. We know there are too many occasions where there is a lack of inpatient bed capacity in these facilities which means that people who are inpatients in our locally delivered services often have to wait for significant periods of time for a bed to become available.

Whilst there are times someone with a Dementia may need acute mental health inpatient support there are models of care that can support people very successfully in long term care settings that reduce or remove the need for acute care and these are being further developed in East Riding in line with our vision for Dementia.

It is our aim for all people with Dementia and their carers to continue to ‘Live Well’ from diagnosis to the end of life. It is important that in order to best support those with mental ill health or Dementia we create an environment where people:

• Are confident to seek help early
• Know where to go for help and what services to expect
• Have timely access to the care and support that they would benefit from and the quality of this care to be high
• Can access services which are safe
• Know that the public and professionals are well informed and where the fear and stigma associated with mental ill health and dementia has decreased
• Are able to access care closer to home
• Receive care which meets their physical health, mental health, social care and accommodation/housing needs through an integrated, joined-up approach
• Are able to participate in dementia research and in local involvement groups
• Live in dementia-friendly communities

As people’s needs and expectations are changing in relation to dementia we need to change the way we respond to individuals accessing services by creating a pathway which, raises awareness of the condition, embraces prevention, improves timely
diagnosis, provides post diagnostic support to help people live well, and ultimately supports a good death. We will deliver this by:

- **Raising public awareness** about dementia, reducing the stigma and fear associated with dementia, raising awareness of the modifiable risk factors and encouraging people to seek help and obtain a diagnosis

- **Focusing on prevention** and encouraging people to behave in ways which will improve their health outcomes to reduce those risk factors associated with some dementias which we can do something about, e.g.
  - Living a healthy lifestyle can reduce the risk of heart disease and stroke and may also reduce the risk of vascular dementia
  - Reducing alcohol abuse can prevent or reduce alcohol related dementias such as Korsakoff’s Syndrome

- **Focusing on earlier diagnosis** and intervention to improve outcomes for people with dementia and their carers

- **Providing a range of post diagnostic support** to help people live well and address *‘the wilderness years’* – *the period between diagnosis and when the disease becomes severely life limiting*. A diagnosis needs to be turned into an *act of empowerment and a positive experience for both the patient and carer (Dementia Today and Tomorrow)* which includes:
  - Educating and supporting people to self-care for as long as possible, reducing reliance on the public sector
  - Focusing on wellbeing, meaningful occupation and physical activity
  - Engaging with housing providers and third sector to provide lower level support to maximise independence and maintain skills for as long as possible
  - Exploring the range of assistive technologies available that will help individuals to maximise independence and to live safely at home
  - Providing access to enabling and rehabilitation services to maximise independence – people with dementia can still have rehabilitation potential and some skills can be relearned or new skills developed to compensate
  - Providing access to integrated health and social care at home, or closer to home, to prevent avoidable admission to hospital
  - Guaranteeing a fast response for those leaving hospital or experiencing a crisis – including out of hours support
  - Improving the diagnosis and care of patients in hospital who have dementia
Developing specialist support close to home for those people with complex needs and or long term health conditions such as diabetes, stroke, depression, incontinence, physical disabilities, terminal illness etc. as well as dementia and other mental health concerns

- Supporting carers to enable people to be supported at home, for example, through the provision of appropriate advice, information, respite care, education and peer support
- Exploring ways to reduce the risk of people falling – people with dementia have a higher risk of falling than their peers due to difficulty with thinking, perception, judgement and orientation
- Providing outcome-focussed services which refer to the impacts or end results of services on a person’s life, aiming to achieve the aspirations, goals and priorities identified by service users and in the Prime Minister’s challenge
- Giving people more choice and putting them in control of the services they receive, for example, supporting more people with dementia to use personal budgets to direct their own care and service solutions
- Providing a range of accommodation choices to include extra care and residential and nursing care

- Access to good quality care and support to ensure people with dementia have a good death in their preferred place of choice at the end of life

It is important that in order to deliver our vison the following happens:

- Listening to and involving people living with mental ill health and dementia, as well as their carers, recognising that they are experts by experience

- Enabling people to make informed choices and exercise choice and control over their lives by

- Offering a range of advice and information regardless of eligibility for services which includes prevention, reducing risk and self-care, and appropriate assistive technology, such as, GPS

- Giving people time to make important decisions at difficult times and provide them with the best possible information to do so

- Involving people in decisions about their lives and working co-productively

- Giving clear, realistic and timely information and advice around meeting housing needs
• Having effective clinical leadership

• Having an agreed care pathway across Health and Social Care for anyone with dementia which is explicit and straightforward

• Ensuring that mechanisms are in place to enable re-connection with services for people with deteriorating conditions such as dementia, which are straightforward, clear and timely

• Ensuring that everyone is clear about the lead professional, their responsibility to co-ordinate a multi-agency response and ensuring this is effectively communicated to agencies, professionals, the person and their family when the Care Programme Approach is used

• Delivering a trained multi-agency workforce to work with individuals living with dementia and their carers

• Respecting the dignity and privacy of people

• Recognising the individual differences

• Providing integrated services as close to home as possible

• Promoting dementia-friendly communities

• Increasing the number of dementia friends living in the East Riding
Summary

The information contained within this chapter informs the thematic analysis and response presented in Chapter 2. The key findings from the analysis of national policy, local need and service provision and the engagement with our local people is shown in Figure 10.

Figure 10: Key Challenges for the East Riding

- Increases in common mental health illness, particularly in young adults
- An ageing population in the East Riding and the relationship between the social determinants of health, physical health and family / carer support
- Pressures on the acute bed capacity resulting in increased numbers of people being placed outside of the East Riding
- Preventing crisis and de-escalating for people in crisis
- Particular needs of small volume but complex groups or individuals e.g. those with Personality Disorders and Veterans
Chapter 2: How we are going to change and what will be different

The findings from Chapter 1 have given us great insight into the needs of our local people and how we need to change to meet these. We have developed the four themes presented in Figure 11 to enable us to manage the way in which we make the changes people want to see. These will be supported by the cultural change and resources that underpin and support the delivery of all themes.

The following sections will discuss these themes in more detail.
## Mental Wellbeing and Prevention

<table>
<thead>
<tr>
<th>Outcome</th>
<th>By 2023 we will have</th>
<th>What are the key actions?</th>
<th>What are the key measures?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>An established Social Prescribing service</td>
<td>Implement the Social Prescribing service</td>
<td>Social Prescribing outcome measures</td>
</tr>
<tr>
<td>2</td>
<td>Accessible information, advice and support; Encouraged self-help when people suspect their mental health is deteriorating. Improved health literacy so people know when to seek help and where to go.</td>
<td>System partners to ensure consistent, accessible and accurate information is available</td>
<td>System-wide resources available from all partners and in all formats</td>
</tr>
<tr>
<td></td>
<td>Reduced stigma and improved mental / physical health promotion, including in schools by:</td>
<td>Promote healthy lifestyles including physical activity</td>
<td>Decrease in mental ill health stigma measured through adoption of recognised tool[^35] ,[^36] Increases in reported healthy lifestyles measured through adoption of a recognised tool[^37]. Note; this tool could be used to measure consistently a range of activities by partners / organisations who are trying to achieve a similar outcome.</td>
</tr>
<tr>
<td></td>
<td>• Openly talking about mental health / dementia</td>
<td>• Develop 'champions' within our communities to openly discuss mental ill health and dementia, breaking stigma and encouraging empowerment and openness.</td>
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</tr>
<tr>
<td></td>
<td>• Educating / myth busting</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Encouraging equality between physical and mental health</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>• Openly talking about treatment</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>• Empowering people</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

[^36]: Yang, LH. and Link, BG. *Measurement of Attitudes, Beliefs and Behaviours of Mental Health and Mental Illness.* (2015). National Academy of Sciences
| 3 | - Communities are skilled to recognise mental health problems, and know where to signpost for help.  
   - Improved community and individual resilience  
   - Worked with communities to identify mental health stressors e.g. job loss, relationship breakdown | - Promote mental health awareness training to communities, developing a mental health guide to go to all households  
   - Ensure Alzheimer’s Society dementia handbook is promoted and accessible across all partners | - Guides in place and information regarding download numbers / hard copy pick-ups / deliveries are available.  
   - Uptake of mental health courses offered in the community |
|---|---|---|---|
| 4 | - Reduced work place absenteeism resulting from mental ill health  
   - Worked with organisations / partners to ensure policies do not have a negative impact on mental wellbeing. | - Promote workplace Mental Health, utilising a wellbeing assessment for local organisations | - Decrease in work place absenteeism relating to mental ill health |
In order to support good mental wellbeing people need the ability to be resilient to the changing pressures and challenges life brings. This positive state is derived from the personal qualities and skills individuals have, and the support they can gain from family and relationships, home, their community, education and employment. It is the feeling of safety and being able to cope. Whilst important to all of us, for some groups in the East Riding it is more critical given the role they play in supporting others. For example, the 38,000 plus carers within the East Riding also need our support to ensure their mental wellbeing is resilient.

We can all influence a change in culture to promote mental wellbeing and identify the early signs of mental ill health. Through an approach based on people’s strengths and the adoption of Making Every Contact Count (MECC), each of us can play a part in promoting mental wellbeing and adopting a more preventative focus. Giving our workforce and individuals the tools and support they need to motivate and maintain change is critical to the success of this.38

Despite mental ill-health and dementia being such a widespread issue in our communities, it is often poorly understood, and where to go for help, advice and information is not as clear and straightforward as we want it to be. Consequently, awareness of the support and advice to people both in terms of messages directly to the public but also to professionals to enable effective signposting is a critical element of this theme.

One way in which we are already working to prevent mental illness is by building resilience within our children and young people as detailed in the Future in Mind Plan39. However, there is much more that can be done including identifying a Designated Senior Lead for Mental Health (‘Mental Health Champion’) in every school and college and new Mental Health Support Teams40.

We are working to build resilience, improve mental health and tackle social isolation in our adult population though a wide variety of initiatives including the ‘Men in Sheds’ project in Withernsea. There are also a wide number of community and voluntary sector groups working to build resilience, improve mental health and tackle social isolation for example the sobriety project in Goole.

Work place mental health promotion is also a key area of focus. Not only does it support people and help improve economic productivity, but for carers, health, care and other sectors supporting people with physical and mental health needs, having a

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38 Michie et al. *The behaviour change wheel: A new method for characterising and designing behaviour change interventions*, 2011
39 Local Transformation Plan
40 Transforming Children and Young People’s Mental Health Provision: a Green Paper, 2017
resilient workforce is essential. Having staff feeling anxious, stressed, etc. can not only be bad for those individuals but may have a knock on effect to those we are here to support for example, through cancelled appointments, etc. As such, workplace health promotion is critical to successful delivery of the outcomes within this theme. A recent report suggested the development of a wellbeing assessment for local organisations to access and to use to help support the mental health and wellbeing of their employees\(^{41}\). We adopt this recommendation as a key action to progress.

From May 2018, the East Riding will have in place for all local people, the Health and Wellbeing Social Prescribing Service. This aims to offer an alternative or to complement or reduce traditional NHS healthcare interactions, including GP appointments for non-medical needs and unplanned admissions to hospital. The service will work with the local VCS to support individuals, enable them to access activities and information. Evidence suggests that social prescribing works well for people with ‘mild’ mental ill health\(^{42}\).

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\(^{41}\) Silent Partners: Working Age Male Mental Health, 2017.

\(^{42}\) Bertotti, M. et al. “A realist evaluation of social prescribing: an exploration into the context and mechanisms underpinning a pathway linking primary care with the voluntary sector”, Primary Health Care Research & Development, 2017
<table>
<thead>
<tr>
<th>Outcome</th>
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<th>What are the key actions?</th>
<th>What are the key measures?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>• Considered and addressed Housing and Employment needs consistently within Care Plans;</td>
<td>• Ensure housing and employment needs and aspirations are built into care plans</td>
<td>• At least 95% of personal care plans include housing and employment needs where appropriate</td>
</tr>
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<td></td>
<td>• Support for people to manage financial issues including advice on debt management and the benefits system</td>
<td>• Closer liaison with Housing Strategy Department, ensuring mental health and Dementia needs are influencing policy</td>
<td>• Increase from 65% to at least 85% receiving Early Intervention in Psychosis within two weeks of referral</td>
</tr>
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<td></td>
<td></td>
<td>• Work with local employers and the job centre to proactively support existing personnel and encourage opportunities for those recovering from mental ill health</td>
<td>• Contribute toward a 25% increase nationally on 2017/18 baseline in access to Individual Placement and Support services (employment)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Offer support, advice and signposting as appropriate for people struggling with debt management and access to the benefits system including access for carers</td>
<td>• Individuals report improved experience and confidence in managing debt and accessing the benefits system</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Improve access and knowledge of services for BME and LGBT groups</td>
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</table>
|   | • Recovery, building on people’s strengths, at the heart of personalised care plans for people requiring longer term support  
• Robust support available in a timely and appropriate manner for East Riding residents living with severe mental illness and Dementia | • Support the continued development of the Recovery College  
• Review of the role, function and expected outcomes of commissioned community mental health services, including CMHT’s  
• Review of outcome indicators to ensure services are being delivered effectively  
• Develop a range of community resources that promote inclusion | • Increased use of the Recovery Star and results; use of the Recovery Star as a commissioning tool\(^{43}\)  
• Reductions in crisis interventions  
• Improved satisfaction ratings for services  
• Increased social inclusion, including settled housing and employment amongst those living with SMI or Dementia |
|---|---|---|
|   | • More than 100 people per year benefitting from Personal Health Budgets for mental ill health | • Expand usage of Personal Health Budgets | • Over 100 people with mental ill health to have a Personal Health Budget  
• Explore and potentially adopt the POET outcome measure for Personal Health Budget holders and family carers\(^{44}\) |
| 2 | • More Carers telling us that they have the necessary support;  
• Improve our process for Carers Assessment  
• Support delivery of the Carers Strategy | | • All carers of people with mental ill health, including dementia, have had a carer’s assessment and at least 70% report that they feel supported in their caring role |
| 3 | • Been designated as a Dementia-Friendly Community | • Support the further development of East Riding as a Dementia Friendly Community  
• Define and adopt a strengths based and Recovery approach, supporting personal and community resilience | • Registered as a Dementia-Friendly Community |

\(^{43}\) [http://www.humber.nhs.uk/about-our-trust/recovery-star.htm](http://www.humber.nhs.uk/about-our-trust/recovery-star.htm)  
\(^{44}\) Personal Health Budget Holders and Family Carers: The POET Surveys, 2015
| 4 | • Established peer support for people <65 years with dementia  
   • Redesigned and Implemented a new Dementia Pathway; | • Commission redesigned dementia assessment pathway and a non-medical post-diagnosis service providing support to plan, live with and manage the condition with effective end of life care pathways | • Sustained achievement of the dementia diagnosis rate of 67% of estimated prevalence  
   • Increased numbers of people who die in the place of their choice |
|---|---|---|---|
| 5 | • Increased the provision and access to Talking Therapies in Primary Care  
   • Implemented initiatives to improve services and support for people with mental ill health alongside substance misuse in the East Riding  
   • Worked with partners to shape the Care Market | • Offer Talking Therapies within Primary Care  
   • Increase access to General Practice  
   • Maintain current good liaison/connectivity between primary psychological therapies (IAPT) and secondary mental health services  
   • Dementia training and support to domiciliary and care home sector, possibly through development of dementia liaison service. | • Increase in people entering talking therapies to a minimum of 25% of prevalence, including in primary care settings and increased numbers of older people, people from black and minority ethnic and LGBT groups  
   • Jointly commissioned services  
   • Reduction in the number of mental health admissions linked to substance misuse  
   • Reduce the number of drug induced psychotic episodes  
   • Dementia liaison available and DiADeM screening tool used in all care homes |
We are seeking to build a recovery movement in the East Riding, and want this to be woven throughout all of our services. It needs to be a core ethos of all of our ambitions in this regard.

For many people, the concept of recovery is about staying in control of their life despite experiencing a mental health problem. Professionals in the mental health sector often refer to the 'recovery model' to describe this way of thinking.

Putting recovery into action means focusing care on supporting recovery and building the resilience of people with mental health problems, not just on treating or managing their symptoms.

There is no single definition of the concept of recovery for people with mental health problems, but the guiding principle is hope—the belief that it is possible for someone to regain a meaningful life, despite serious mental illness”.

_The Mental Health Foundation[^45]_

We acknowledge that some people are affected by severe mental health disorders that become chronic, long term conditions, and that they may not fully recover from their illness. In such cases we are committed to supporting individuals to experience the best quality of life that they can and accept that recovery may include a wide range of individual goals and aspirations. We will roll out the offer and improve uptake of Personal Health Budgets[^46] for people to enable choice and person-led services.

We recognise that responding quickly when mental health issues emerge is vital to ensuring that people recover as fully as possible. It is crucial that individuals, their carers and professionals working in services are well informed about mental health and the support and treatment available. We have heard that people want personalised, accessible support in the community.

Early intervention can only be effective if people, or those around them, are able to recognise if someone needs help and how they can best be supported. The stigma surrounding mental ill health is still very real and present in our communities. Theme 1 demonstrated how important it is to tackle this and what we intend to do. Self-help, guidance, advice and support can be made accessible and local VCS groups are already playing an important role in this arena although there is more that can be done.

[^45]: https://www.mentalhealth.org.uk/a-to-z/r/recovery
People with a dual diagnosis of substance abuse and mental ill health can often find themselves in situations where they fall between two established services. The CCG and Council will seek to jointly commission a service for these individuals that prevents these issues and offers a more holistic approach.

We recognise that the pathway and support for people who have been recently diagnosed with dementia can be improved. Current services are good but we are told that the support for people and their families should be broader (e.g. to cover end of life choices, financial advice, power of attorney, etc.). Connections to community groups and respite for carers are also a key part of the revised pathway we wish to design. With up to 70% of residents of care homes having diagnosed or undiagnosed dementia, much more needs to be undertaken to support these individuals, the workforce within these homes and to ensure there is sustainable capacity as the population increases.

We know that patients with dementia and delirium generally have the worst outcomes during and after unscheduled admission to acute hospitals. The front door Mental Health Liaison service highlighted is welcomed but we acknowledge that we need to be more ambitious in terms of prioritising support for people with dementia and delirium who are medically ready for discharge from acute services.

The pathway review will also give focus to the living well and dying well approach to dementia, particularly in relation to how we utilise local hospices, community hospitals and the community palliative care team. This is particularly important for people with dementia who may have lost cognitive function earlier. Anyone with a diagnosis of dementia should have an advance care planning discussion and visible plan in place.

For people who experience their first episode of psychosis it is important that there is timely access to evidence-based intensive support. We need to monitor the delivery of this early intervention in psychosis to ensure we continue to exceed the national access target and that people have early support to manage their condition and reduce the long-term impact of psychosis.

We have successfully implemented the national improving access to psychological therapies programme and over the next five years will continue to increase the numbers of people entering treatment, improve recovery rates, access times and progress towards greater integration with primary and community care of people with long term conditions. We will also target key demographic groups, such as older people and people from black or minority ethnic groups.

Through our engagement process, we learned that too often we medicalise pathways and we do not pay enough attention to supporting individuals in developing their lives in the wider context, such as improving social inclusion, physical health,
education, employment and housing. Chapter 1 noted the increased demand for appropriate housing across the East Riding of which an element of this demand will be met through the provision of extra care schemes, which increasingly address the specific needs of those with dementia, and can offer opportunities to maintain independent living rather than moving to more traditional residential care.

The particular housing needs of specific groups including people living with dementia and those experiencing mental health issues will also be explored in the Council’s Housing Strategy for Vulnerable People which is due to be updated during 2018. This will seek to establish the need for specialist provision in order to support new schemes where they are required. A small pilot scheme, Housing First, is being implemented across the East Riding which seeks to house those who are homeless or at risk of homelessness without the usual requirement to engage first with support services. Priority is given to those with complex needs including mental ill health.

We want to build on work already achieved in becoming a recognised Dementia Friendly community\(^{47}\). To do this, we will work across the East Riding with all system partners as well as our local people in order to successfully meet the requirements.

\(^{47}\) \url{https://www.alzheimers.org.uk/info/20115/making_your_community_more_dementia-friendly}
# Proactive and Accessible Support and Services

<table>
<thead>
<tr>
<th>Outcome</th>
<th>By 2023 we will have</th>
<th>What are the key actions?</th>
<th>What are the key measures?</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Greater number of participants in research studies in mental health and dementia.</td>
<td>Offer people the opportunity to be part of quality research and development</td>
<td>25% of people diagnosed with dementia registered on Join Dementia Research and 10 per cent participating in research</td>
</tr>
<tr>
<td>2</td>
<td>Developed and implemented an adult ADHD service</td>
<td>Establish specialist community services for adults with ADHD and adults with complex eating disorders</td>
<td>Agreed pathways based on best evidence, NICE and other appropriate guidelines</td>
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<tr>
<td></td>
<td>A comprehensive pathway for people with an eating disorder</td>
<td>Co-produce a redesigned pathway for people with complex personality disorders</td>
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<tr>
<td></td>
<td>Developed and implemented a redesigned pathway for people with complex personality disorders</td>
<td>Work with STP partners to develop a locality model of care home liaison to support people with challenging behaviour in dementia to remain in their current care setting</td>
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</tr>
<tr>
<td></td>
<td>Offered greater support to people with dementia who have complex behaviours that challenge care delivery.</td>
<td>Redesign older people’s crisis services to align with working age adult services – consider merging workforce to ensure equitable 24/7 coverage for whole adult population, whilst bearing in mind that crises amongst older people arise for different reasons than in working age adults, and intensive support may be required for longer, particularly where a person is living alone.</td>
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<td></td>
<td>Services for the older age population that continue to offer both functional and organic expertise</td>
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<td></td>
<td>Developed and embedded an end of life pathway that ensures people with dementia have a dignified death.</td>
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<tr>
<td>4</td>
<td>Ensured Armed Services Veterans will have timely access to support and services</td>
<td>Support veterans to access the full range of mental health services</td>
<td>Veterans report greater access and understanding of mental health services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provide training to professionals to enable them to support veterans better</td>
<td>Professionals are more able to support veterans</td>
</tr>
</tbody>
</table>
| 5 | • Improved our cross agency response to crisis presentation – ‘No Wrong Door’  
- Reduced the number and cost of Out of Area placements  
- Reduced the number and costs associated with Delayed Transfers of Care (DTOC) in mental health inpatient units.  
- Ensure a comprehensive range of alternatives to inpatient care is in place to reduce the need for detention under the Mental Health Act  
- Ensure the nobody living with a severe mental illness or complex dementia is discharged without a reliable and speedy pathway into specialist mental health services should the need arise | • Improve experience of care at times of crisis  
- Piloted Core 24 Mental Health Liaison in A&E Departments, establishing them sustainably where evidence supports financial sustainability.  
- Undertake a whole system review of DTOC in mental health inpatient settings to ensure flow is optimised.  
- Offer a broader range of community based interventions and support mechanisms to prevent escalation to inpatient services (see section 2)  
- Offer a range of non-medical accommodation as alternatives for people in crisis, 24/7  
- Monitor the outcomes and experience people with learning disabilities and/or autism to adult mental health services to ensure equity of access, experience and outcomes  
- Redesigned discharge process to ensure signposted support services are robust, functional and effective | • Improvement in our crisis response  
- Halve the total number of Out of Area placements by 2021  
- Reduction in Out of Area Placements to 0 days per month for acute inpatient care  
- Decrease in s136 detentions  
- Appropriate response to 999 calls relating to mental ill health crisis  
- Decrease in acute attendances at A&E and hospital admissions  
- Reduction in DTOC in mental health inpatient settings  
- Crisis Pad and step down accommodation utilisation  
- Supported and transitional housing options from Mind – utilisation metrics.  
- Individuals (or their families / carers) report improved experience and confidence in accessing services when presenting with a dual diagnosis  
- Individuals (or their families / carers) report improved experience and confidence in stepping down into community services knowing enhanced support will be available when needed | • Improved communication between secondary mental health services and other partners | • Advice and Support via e-referral to be rolled out to mental health secondary care services  
- Number of Advice and Support contacts between GPs and secondary care mental health clinicians |
Across the East Riding we offer a wide range of community based services and support, delivered by local people and groups as well as statutory organisations such as NHS Trusts and the Police. Many of these are excellent but we have heard that in some cases the resource and support is not well known and / or that it can be difficult to access e.g. long waiting times, the need for specialist referral, etc.

Whilst this is of concern for people who can wait for support, it is a critical issue for those in urgent need (crisis). For these individuals (or their representatives e.g. carers, the Police, etc.) rapid response and access is paramount. During the engagement process we learned that there were too many occasions when people were let down because of these access issues. For these reasons, in November 2014, agencies across East Riding and Hull signed up to the national Mental Health Crisis Care Concordat, committing them to:

- work together to improve the system of care and support so that people in crisis because of a mental health condition are kept safe. We will help them to find the help they need – whatever the circumstances – from whichever of our services they turn to first.
- work together to prevent crises happening whenever possible, through intervening at an early stage
- make sure we meet the needs of vulnerable people in urgent situations, getting the right care at the right time from the right people to make sure of the best outcomes
- do our very best to make sure that all relevant public services, Approved Mental Health Professionals (AMHP), contractors and independent sector partners support people with a mental health problem to help them recover.

Each agency that signed this declaration will work towards developing ways of sharing information to help front line staff provide better responses to people in crisis. Equally, a number of these issues can be managed more efficiently by working at scale with partners beyond the footprint of the East Riding. For that reason, East Riding partners are also fully engaged with and committed to the Mental Health and Workforce work streams that are managed under the Humber, Coast and Vale Sustainability and Transformation Partnership (HCV STP).

We are also aware that we have some areas where our services need further development to ensure they are evidence based and compliant with appropriate guidance including those produced by the National Institute for Clinical Excellence.

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48 Humber, Coast and Vale STP Workforce Report, 2017
49 http://humbercoastandvale.org.uk/
(NICE). This is particularly the case for vulnerable groups and those people with relatively uncommon conditions that require significant support.

For example, the development of a local Personality Disorder pathway needs to be built on to ensure all agencies are able to work constructively together, particularly when an individual presents at a time of crisis. Care coordination across system partners is critical for the safe management of some very vulnerable people including adults with ADHD and those with Eating Disorders. We would want people with ADHD and eating disorders to be able to access evidence-based interventions delivered through specific services with specialist teams, in conjunction with key stakeholders including general practice.

People with learning disabilities and/or autism who have mental health needs may require complex packages of support that are described in the Humber Transforming Care Partnership plan. For some people with learning disabilities and/or autism, however, local adult mental health services, including IAPT, are appropriate and the dual diagnosis must not act as a barrier to access to these services. Older people with functional mental illness (e.g. psychosis, bipolar disorder, depression, anxiety) must have parity of care with working age adults with those conditions.

Our GPs and secondary care mental health Consultants have told us that they would value closer working relationships and therefore we intend to expand the current advice and guidance facility used in the e-referral system for physical health into mental health services.

The Five Year Forward View for Mental Health gave significant consideration to Research and Development opportunities whilst the Dementia Statements recognise the importance of research and development (Figure 8) and therefore we will take steps to improve our offer to these people. Although this need was identified by people with dementia, it could just as easily apply to all adult mental health and therefore our broad offer will cover these individuals as well.

Additionally we need to work closely with NHS England in their aim to deliver consistent high quality integrated care for serving armed forces personnel and veterans, to ensure that local mental health services fit with more specialist services commissioned nationally. We will ensure veterans are able to access support for mental ill health needs and that our professionals are appropriately equipped to manage these individuals.
## Integration of Support and Care

<table>
<thead>
<tr>
<th>Outcome</th>
<th>By 2023 we will have</th>
<th>What are the key actions?</th>
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</tr>
</thead>
</table>
| 1       | • Improved the transition between children, adult and old age services | • Analyse the results of the local CQUIN to understand scale of problem  
• Improve forward planning for continuity of services | • Increase in the number of young people who felt prepared for transition whether to adult mental health or other service/no service, compared to 2017-18 baseline |
| 2       | • Established Community Rehab for people with complex needs, linked to the uptake of personal health budgets | • Agree scope and scale of service for people with complex needs, including role of the VCS | • Increase in the number of people whose mental health rehabilitation takes place in a community rather than inpatient setting, compared to 2018-19 baseline.  
• By 2021, a minimum of 30 people with mental health rehabilitation package funded / part funded through a PHB |
| 4       | • Routinely commission for mental and physical health needs with all partners | • Ensure mental health providers address physical health needs including IAPT for long term conditions | • 25% increase in the number of people with mental ill health offered an annual physical health check |
| 5       | • Embedded Community Mental Health Teams in our Community Hubs | • Community Mental Health Teams to be part of an integrated team based around a Community Hub of circa 50,000 people  
• Implement the Trusted Assessor model between CMHT and other partners | • Community Mental Health Teams integral part of the Community Hub model  
• Simple cross referral between all partners e.g. VCS, Police, etc.  
• Trusted Assessor model implemented |
<table>
<thead>
<tr>
<th>Worked locally and with partners to develop our workforce</th>
<th>Through the STP Mental Health and Workforce work streams, ensure mental health is fully represented and issues addressed</th>
<th>Reduction in the number of people leaving the profession</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Develop a workforce plan to deliver high quality, sustainable services</td>
<td>Staff report improvement in training and development</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Workforce capacity and demand analysis across each point of delivery</td>
</tr>
</tbody>
</table>

| Integrated commissioning to improve services for people and to generate financial efficiency | Encouraged and incentivised deeper partnerships between VCS and health/care, resulting in greater numbers of co-delivered services and support | Increased contractual arrangements with the VCS |
|                                                                                         | Encourage partnerships between VCS and other providers for every pathway | Develop integrated action plans for key delivery areas including specialist mental health services and Dementia |
Integration of service provision across the East Riding is a strategic objective that encompasses mental and physical wellbeing, health and care. Across the East Riding, all partners are leading a change in how we work to achieve our vision of person-led coordinated care and support that feels like one service. We already know that people feel that services are often fragmented, that communication between professionals from different disciplines can be patchy and that individuals feel they are passed from one service to another. Our engagement around this mental health strategy reinforced these messages.

We were told that services should work more collaboratively, rather than being in ‘competition’ with each other, as this does not support the person leading their care. Partnership / joint working and co-production; working better together across different organisations and sectors, including more integration and better communication focused around primary care were all advocated. The distinction between primary, community and secondary care is less important than the aim of seamless and well-integrated holistic care. People told us of having to undertake multiple assessments with different professionals from physical and mental health services. We will roll out the Trusted Assessor initiative which enables one professional to complete an holistic assessment that all other professionals trust and use. These approaches will go a long way to truly achieving equality between physical and mental health.

However, more closely aligning the commissioning functions between the CCG and the council will also be important in enabling a change to how services are funded and how they work with each other to improve outcomes. Traditionally, services of this nature have, in the majority, been provided by statutory services. The VCS and other partners want to play a much stronger role in this area, supporting people through recovery and to stay well in the community.

Workforce and organisational development will be a critical part of this objective. We will need our dedicated staff to consider people in a holistic way, listening to the individual and building a care plan around their needs and wishes. Our workforce will need support to consider a broader range of issues and to work with the individual to agree what they need and how this can best be tailored to their needs. We will need to provide formal and informal support to our workforce to enable this. We are not attempting to turn our skilled workforce into generalists but to enable people from all sectors to be able to spot common signs and symptoms, offer lifestyle advice (using the principles of Behavioural Change 50 and MECC) and have the knowledge and confidence to help people to the most appropriate support.

50 The Behaviour Change Wheel: A new method for characterising and designing behaviour change interventions (2011)
## Culture and Resources

**Figure 12: Supporting elements and enablers to the implementation of the strategy**

<table>
<thead>
<tr>
<th>Person led</th>
<th>Leadership &amp; Governance</th>
<th>Workforce development</th>
<th>Consistent Quality Standards</th>
<th>Finance &amp; Contracts 51</th>
<th>Shared Data</th>
</tr>
</thead>
</table>
| - Decision making  
  - Choice & control  
  - Information & advice | - Strong leadership  
  - Commitment to delivery  
  - Utilise existing governance structures effectively | - Sustainable Services  
  - Supported staff  
  - Learning & development  
  - Empowerment  
  - Culture of ideas and improvement  
  - Flexible & adaptable | - Five Year Forward View quality measures  
  - Collective delivery across the system  
  - Blend some existing key performance indicators with other measures of success | - Share risk  
  - Measure the gap between service provision and need  
  - Maximise efficiency through transformation  
  - Enable resource shift to mental health services  
  - Increase resilience building  
  - Use a community first approach  
  - Shape local markets  
  - Embrace Personal Health Budgets  
  - Greater use of VCS to provide services | - Use existing governance structures,  
  - Build a holistic picture of need |

51 In alignment with the Five Year Forward View for Mental Health intentions regarding investment.
Workforce Development

Locally, our statutory services are stretched with more people leaving particular professional roles in mental health than are commencing employment. We also know locally that the age profile of our workforce is skewed towards older people in employment, meaning that over the lifetime of this strategy a large number of experienced staff could leave the services. This reflects a national picture which has seen the government recently respond by committing to establish thousands more posts and new roles by 2020\textsuperscript{52}. However, there is some concern over the achievability of these ambitions at a national level and whether this will put increased pressure on the existing workforce\textsuperscript{53}.

We will give equal focus to transforming not only the services and support for individuals but the roles and responsibilities of the people offering this support. This will take many forms from mentorship, rotation through disciplines, formal training (including academic) and new and diverse roles, in community settings. We will continue to work closely with the Hull and York Medical School (HYMS), developing new opportunities and training to attract people into the profession and retain those who wish to leave for reasons we can remove. The Humber, Coast and Vale STP has a work stream dedicated to workforce and we will contribute to this, ensuring that the mental health workforce gains equal focus, addressing short and long term requirements.

Research and Development

The importance of continued research and development cannot be underestimated, a sentiment clearly reflected in the Five Year Forward View for Mental Health (FYFVMH) which dedicates considerable space to research, including the recommendation that more use be made of digital technology, an area that we are/have already been involved in various studies. Research and Development promotes an increase in quality, enables the discovery and development of new treatments and can improve services. In addition, patients and families tell us they enjoy the extra contact, have improved health outcomes and improved wellbeing linked to feelings of increased empowerment.

The FYFVMH also raises the ambition of the UK aspiring to be a world leader in the development and application of new mental health research.

\textsuperscript{52} Stepping Forward to 2020-21: The Mental Health Workforce Plan for England, 2017
\textsuperscript{53} Rising Pressure: The NHS Workforce Challenge, The Health Foundation 2017
Estates

Across the county, we all have different types of buildings and facilities aligned to supporting people with mental ill health and / or dementia. Some of these are used for patient care and support whilst others accommodate our workforce. The diversity of facilities and the varying condition of this estate means we have the opportunity to improve the locations in which we currently offer services and review how we use existing estate. This, inevitably, will require further funding to enable this change and we will commit to exploring different options of bringing funding into the East Riding to improve the quality of our estate.

Ongoing Engagement with our Local People

It has been widely agreed that the involvement and engagement of local people, carers and their families with experience of mental health problems is fundamental to the effectiveness of this strategy. Ongoing engagement, which includes people being involved in good quality research studies, will take place within the East Riding throughout the life of this strategy to gather more thoughts and opinions. First points of contact should be to:

**East Riding of Yorkshire Clinical Commissioning Group**
Health House
Grange Park Lane
Willerby
East Yorkshire
HU10 6DT

**East Riding of Yorkshire Council**
County Hall
Cross Street
Beverley
East Yorkshire
HU17 9BA

**Tel:** (01482) 650700 **Tel:** 01482 393939

**Email:** ERYCCG.ContactUs@nhs.net **Email:** leethompson@eastriding.gov.uk

A Direction for the Future and Next Steps

This strategy has set out our future direction until 2023. It represents a significant shift in focus as we move toward a recovery based approach with a strong focus on mental wellbeing and the prevention of mental ill health. We will continue to ensure a focus on individuals in crisis and those who are in need of specialist services. We will develop an Action Plan to drive the change. Figure 13 depicts an outline programme plan with indicative timescales. Timescales are predicated not only on the complexity of the initiative but also capacity and resource to deliver them. Our next steps are to:
1. Start making the changes through our **top priorities for 2018-19** which are:
   a. Promotion of mental wellbeing including developing and promoting advice and support resources for individuals and carers
   b. Building resilience in our people and our communities
   c. Promotion of work place mental health
   d. Implementation of the Social Prescribing service
   e. Redesign the Dementia Pathway (including young people early onset dementia) to include:
      i. Raise awareness of Dementia across communities
      ii. Ensuring people with dementia and their carers access early help and advice
      iii. improving dementia diagnosis to the national standard and maintaining this position as a minimum including through implementation of the DiADeM model in Care Homes;
      iv. the post-diagnostic pathway for people with dementia
      v. Developing a robust end of life pathway
   f. Reduce the number of out of area placements
   g. Improve Crisis Care and responsiveness with all partners including the Criminal Justice System
   h. Negotiate risk / gain share contractual arrangements with principal providers to facilitate transformation of services
   i. Pilot a Core 24 Mental Health Liaison service in acute A&E department as part of the nationally funded NHS initiative to improve quality and performance outcomes
   j. Support local partners in a review of Crisis Pad and Mental Health Inpatient Services
   k. Deepen the partnership between the ERYC and ERY CCG to develop opportunities around the commissioning of mental and physical health needs.
   l. Build on the range of activity that has so far been achieved in making East Riding a Dementia Friendly community.

2. **Co-produce** the changes outlined above with our local people, instilling the ethos of person-led support and services in all that we do.

3. Agree the specific indicators we will use to **measure success**.

4. Agree the **governance arrangements** for implementing the strategy to ensure outcomes are delivered and opportunities maximised.

5. To support the people of the East Riding directly or **through established groups** that operate across a broader geography e.g. Crisis Care Concordat and the STP Mental Health work stream.
### Mental Wellbeing and the Prevention of Mental Ill Health
- System partners to ensure consistent, accessible and accurate information is available
- Promote healthy lifestyles including physical activity
- Promote workplace Mental Health, utilising a wellbeing assessment for local organisations
- Promote mental health awareness training to communities, developing a mental health guide to go to all households
- Implement the Social Prescribing service

<table>
<thead>
<tr>
<th>Year</th>
<th>2018-19</th>
<th>2019-20</th>
<th>2020-21</th>
<th>2021-22</th>
<th>2022-23</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

### Early Intervention and Support in the Community
- Define and adopt a strengths based and Recovery approach, supporting personal and community resilience
- Support the continued development of the Recovery College
- Ensure housing and employment needs and aspirations are built into care plans
- Closer liaison with Housing Strategy Department, ensuring mental health needs are influencing policy
- Work with local employers and the job centre to proactively support existing personnel and encourage opportunities for those living with mental ill health
- Expand usage of Personal Health Budgets to over 100 pa
- Commission redesigned dementia assessment pathway and a non-medical post-diagnosis service
- Support the further development of East Riding as a Dementia Friendly Community
- Dementia training and support to domiciliary and care home sector, possibly through development of dementia liaison service.
- Work with partners to deliver better integration / jointly commissioned mental health and substance misuse support and intervention
- Support delivery of the Carers Strategy including improvements to our process for Carers Assessment
- Offer Talking Therapies within Primary Care
- Increase access to General Practice

### Proactive and Accessible Support and Services
- Establish specialist community services for adults with ADHD and adults with complex eating disorders
- Co-produce a redesigned pathway for people with complex personality disorders
- Develop a service specification for dementia patients with challenging behaviour
- Offer people the opportunity to be part of quality research and development
- Support veterans to access the full range of mental health services and enable professionals to support them better
- Pilot a core 24 mental health liaison service in A&E departments
- Advice and Support via e-referral to be rolled out to mental health secondary care services
- Improve experience of care at times of crisis
- Reduce Out of Area placements

### Integration of Support and Care
- Increase in the number of young people who feel prepared for transition whether to adult mental health or other service/no service
- Embed Community Mental Health teams within Community Hubs
- Ensure mental health providers address physical health needs and vice versa including IAPT for long term conditions
- Implement the Trusted Assessor model between CMHT and other partners
- Develop a workforce plan to deliver high quality, sustainable services
- Through the STP Mental Health and Workforce work streams, ensure mental health and dementia is fully represented and issues addressed
- Encouraged and incentivised deeper partnerships between VCS and health/care, resulting in greater numbers of co-delivered services and support
- Agree scope and scale of service for people with complex needs, including the role of the VCS
## Appendix 1: Equality Impact Analysis

### 1. Equality Impact Analysis: Local Profile Data

<table>
<thead>
<tr>
<th>Local Profile/Demography of the Groups affected (population figures)</th>
<th>Consideration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General</strong></td>
<td>These issues have been considered in the development of the strategy and will be further explored at service level, particularly in relation to locality based services and interventions.</td>
</tr>
<tr>
<td>In 2014 the population was estimated at <strong>337,115</strong> (2014 Office for National Statistics Mid-Year Estimates). A key characteristic of the East Riding is the rurality of the land –93% is classified as rural, with <strong>44%</strong> of people living in these areas. Whilst much of the East Riding is considered relatively affluent, there are pockets of high deprivation with areas in Bridlington, Goole and Withernsea ranked in the <strong>10% most deprived</strong> in the country.</td>
<td></td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>These issues have been considered in the development of the strategy and will be further explored at service level, particularly in relation to services and support for older people.</td>
</tr>
<tr>
<td>One of the most prominent trends is the ageing population of the East Riding. From the mid-year estimates in <strong>2014</strong>, there were <strong>80,611</strong> people recorded aged 65 or over, making up <strong>23.9%</strong> of the total population. This is higher than the national proportion of the pensionable age population which equated to <strong>16%</strong> of all usual residents in England.</td>
<td></td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td>These issues have been considered in the development of the strategy and will be further explored at service level, particularly in relation to knowledge of and access to</td>
</tr>
<tr>
<td>The ethnic makeup of the East Riding has seen some changes since <strong>2001. 96.2%</strong> (or <strong>321,309</strong>) of <strong>East Riding of Yorkshire</strong> residents now class themselves as being of White British origin - a change of <strong>-1.4%</strong> since 2001. The remaining 3.8% of East Riding’s population are from other ethnic backgrounds. Since 2001, the only groups to see a decline in numbers is those of White Irish and Bangladeshi background. The largest increases have been amongst those Other Asian origin (+70.7%), Black African (+62.8%) and Other White groups (+49.4%). However, these groups still account for a low proportion of East Riding residents overall (0.23%,</td>
<td></td>
</tr>
</tbody>
</table>
0.20% and 1.6% respectively).

With the exception of White British, the largest single ethnic group in **East Riding of Yorkshire** is Other White, with 1.6% of residents considering this to be their ethnic background.

![Ethnicity Chart](image)

The proportion of East Riding residents born outside the UK on Census day 2011 was **3.9%**, compared with **8.8%** regionally and **13.8%** nationally.

(Source: East Riding Data Observatory – [http://dataobs.eastriding.gov.uk/profiles/profile?profileId=177&geoTypId=](http://dataobs.eastriding.gov.uk/profiles/profile?profileId=177&geoTypId=))

<table>
<thead>
<tr>
<th>Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is a difference between the genders in the older age groups: life expectancy for females is older and so there are more females in the older age groups. The gap between life expectancy of each gender is narrowing and this is reflected between the censuses with a greater number of males reaching the older age groups. The reason behind males having a lower life expectancy is the likelihood of them doing traditional manual labour jobs, in recent years this likelihood has decreased and thus health (and life expectancy) has improved for males.</td>
</tr>
</tbody>
</table>

These issues have been considered in the development of the strategy and will be further explored at service level, particularly in relation to how services and support are developed for different genders.
Gender reassignment

There are no official statistics nationally or regionally regarding transgender populations, however, GIRES (Gender Identity Research and Education Society - www.gires.org.uk) estimated that, in 2007, the prevalence of people who had sought medical care for gender variance was 20 per 100,000, i.e. 10,000 people, of whom 6,000 had undergone transition. 80% were assigned as boys at birth (now trans women) and 20% as girls (now trans men).

Disability

The percentage of the population with a Long Term Health Problem or Disability is 19.1%.

<table>
<thead>
<tr>
<th>2012 Estimates</th>
<th>ERY*</th>
<th>ERY %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning Disability (Age 18 – 64)</td>
<td>4,757</td>
<td>1.4%</td>
</tr>
<tr>
<td>Learning Disability (Age 65 and over)</td>
<td>1,570</td>
<td>0.5%</td>
</tr>
<tr>
<td>Disability Type</td>
<td>Number</td>
<td>Percentage</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>---------</td>
<td>------------</td>
</tr>
<tr>
<td>Physical Disability – Moderate (Age 18 – 64)</td>
<td>16,750</td>
<td>5%</td>
</tr>
<tr>
<td>Physical Disability – Serious (Age 18 – 64)</td>
<td>5,185</td>
<td>1.6%</td>
</tr>
<tr>
<td>Visual Impairment (Age 18 – 64)</td>
<td>128</td>
<td>0.04%</td>
</tr>
<tr>
<td>Visual Impairment – Moderate or Severe (Age 18 – 64)</td>
<td>6,576</td>
<td>2%</td>
</tr>
<tr>
<td>Hearing Impairment (Age 65 and over)</td>
<td>9,080</td>
<td>2.7%</td>
</tr>
<tr>
<td>Hearing Impairment – Moderate or Severe (Age 65 and over)</td>
<td>31,348</td>
<td>9.4%</td>
</tr>
<tr>
<td>Hearing Impairment – Profound (Age 18 – 64)</td>
<td>83</td>
<td>0.02%</td>
</tr>
<tr>
<td>Hearing Impairment – Profound (Age 65 and over)</td>
<td>817</td>
<td>0.2%</td>
</tr>
</tbody>
</table>

**Sexual Orientation**

There are no local statistics for how many Lesbian, Gay or Bisexual (LGB) people live within the East Riding however, nationally, the Government estimates that 5% of the population are lesbian, gay, bi and transgender communities.

**Religion, faith and belief**

Christianity is still the most prominently practised religion in the East Riding, although there has been a notable decrease of 11.6% in figures since 2001. This largely appears to have been lost to people not stating a religion, with an increase of 11.5% since 2001. The higher proportion of Christians may be due to the East Riding’s ageing population with 22% of Christians aged 65 or over.

The East Riding remains relatively lacking in religious diversity in comparison to England as a whole. There has been a fall in the number of people practising Judaism and Sikhism recorded in the 2011 census, with a rise in people stating their religion as Buddhism (0.2%) or Islam.

These issues have been considered in the development of the strategy as part of the LGBT cohort and will be further explored at service level, particularly in relation to knowledge of and access to services and support. These issues will be explored further at service level when considering the design of support and care.
Together with Hinduism, these five religions account for **0.93%** of the East Riding population, comparable with **8.27%** of the overall population of England.

<table>
<thead>
<tr>
<th>Marriage and civil partnership</th>
</tr>
</thead>
<tbody>
<tr>
<td>In 2011, there has been an increase in the number of people listed as single – never married, up by 3% from <strong>58,812</strong> in 2001 to <strong>72,618</strong> in 2011. <strong>54%</strong> of the East Riding's population were registered as married in the 2011 census, compared to England with <strong>47%</strong> of the population married. This higher proportion in the East Riding could be linked to the ageing population, as retired couples move and settle to rural and coastal areas in the region.</td>
</tr>
<tr>
<td>These issues have been considered in the development of the strategy as part of the links to isolation, anxiety, depression, breakdown of relationship, etc. These will be further explored at service level, in relation to knowledge of and access to services and support.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pregnancy and maternity</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of live births for East Riding (mother’s usual place of residence) for 2014 is 3009.</td>
</tr>
<tr>
<td>Not considered as part of this strategy. Peri-natal mental health is addressed within the Future in Mind plan.</td>
</tr>
</tbody>
</table>